NATIONAL QUALITY FORUM

# Measure Applications Partnership Pre-Rulemaking Report: Reaction Draft Segment 1 (Introduction; Approach to Pre-Rulemaking; Hospital, Clinician, PAC/LTC, System Performance Measurement Programs; Affordability; Alignment for Dual Eligible Beneficiaries)

*MAP COORDINATING COMMITTEE IN-PERSON MEETING*

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# INTRODUCTION

The Measure Applications Partnership (MAP) is a public-private partnership convened by the National Quality Forum (NQF) for the purpose of providing input to the Department of Health and Human Services (HHS) on the selection of performance measures for public reporting, performance-based payment programs, and other purposes. MAP's unique collaboration and careful balance of interests is designed to provide HHS and the field with thoughtful and varied input from organizations that are invested in the use of measures (see MAP Coordinating Committee and workgroup rosters). MAP also promotes alignment of measure use across federal programs and between public- and private-sector initiatives.

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

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

The Affordable Care Act (ACA) requires HHS to publish annually a list of measures under consideration for future federal rulemaking and to consider MAP's recommendations about the measures. This annual pre-rulemaking process allows MAP the opportunity to review the measures under consideration and provide upstream input to HHS in a global and strategic manner.

This year, MAP employed several of its strategies and tactics outlined in the MAP Strategic Plan 2012-2015 to provide more granular pre-rulemaking input, while continuing to emphasize alignment across programs and to identify high-priority measure gaps. This MAP Pre-Rulemaking Report provides recommendations on 524 measures under consideration by HHS for twenty clinician, hospital, and post-acute care/long-term care performance measurement programs.

# APPROACH TO PRE-RULEMAKING

To make progress against the MAP goals and objectives, MAP enhanced its 2013 pre-rulemaking process utilizing the following step-wise approach:

## 1. Build on MAP's Prior Recommendations

MAP's prior strategic input and pre-rulemaking decisions informed MAP's pre-rulemaking deliberations.

- **Coordination Strategies** elucidated opportunities for public and private stakeholders to accelerate improvement and synchronize measurement initiatives. The recommendations in the MAP performance measurement coordination strategies served as setting-specific background for MAP pre-rulemaking.

- **2012 Pre-Rulemaking Report** provided program-specific input that included MAP's recommendations about measures previously finalized for federal performance measurement programs and about measures on HHS' list of measures under consideration. HHS' uptake of MAP's prior recommendations was provided as background for MAP pre-rulemaking.
- **Families of Measures** served as an initial starting place for evaluation of program measure sets, identifying measures that should be added to a program measure set or measures that should replace previously finalized measures in a program measure set.
- **Measure gaps** were identified across all MAP reports. When reviewing program measure sets, MAP re-evaluated the previously identified gaps, noting where gaps persist. Additionally, specific program measure gaps are highlighted in the discussion of each program.

### 2. Evaluate Finalized Program Measure Sets

Next, MAP used the MAP Measure Selection Criteria to evaluate each finalized program measure set (see MAP Measure Selection Criteria). Information relevant to assessing the adequacy of the finalized program measure sets was provided to MAP workgroup members. This assessment led to the identification of measure gaps, potential measures for inclusion, potential measures for removal, and other issues regarding program structure.

### 3. Evaluating Measures Under Consideration

Building off the program measure set evaluation, MAP determined whether, and if so, how the measures under consideration enhanced the program measure sets. For each measure under consideration, MAP provided rationale for one of the following recommendations:

- **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, after specific issues are addressed.
- **Phased Removal** indicates measures that should be phased out of the program measure set.
- **Do Not Support** indicates measures or measure concepts that are not recommended for inclusion in 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.

### 4. Identifying High-Priority Measure Gaps

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

## Hospital Performance Measurement Programs

MAP reviewed currently finalized program measure sets and measures under consideration for nine hospital programs that have varying purposes and constructs. As MAP deliberated about the relationships among these programs, MAP identified key issues that led to the development of Guiding Principles for Applying Measures to Hospital Programs. These Guiding Principles were then used to

inform decision-making regarding the measures under consideration for each hospital program. The following section covers the key issues, the Guiding Principles, and an overview of MAP's recommendations for each hospital program.

## Key Issues

As MAP began to work through the decision-making process for determining which measures should be included in federal programs, two major challenges arose. The first challenge centered on the overlapping nature of the hospital programs and individual measures within the programs. A large number of the measures on HHS' list were under consideration for more than one program or previously finalized in another program. This highlighted the need to differentiate valuable measure alignment from unnecessary measurement duplication. The second challenge focused on the evolution of hospital quality measurement programs and its relationship to the rigor of performance measures. As these programs move from pay-for-reporting to pay-for-performance approaches, performance measures must also be more rigorous to match the increasing level of accountability.

MAP worked to distinguish effective alignment across programs from undesirable overlap of measures. Some MAP members voiced concern regarding double and triple payment adjustments for hospitals, especially those hospitals serving large proportions of vulnerable populations. Other members acknowledged that for certain areas of quality measurement, tying significant dollars to performance may be necessary to send a strong signal to providers about the need for improvement and to adequately reward improvement. MAP members also raised issues regarding clarity of message. Measuring the same or very similar concepts within multiple programs can cause confusion for consumers, purchasers, and providers. Displaying related, but differing, performance scores for a single provider is confusing; likewise, conflicting performance scores for similar measures across programs sends mixed signals to providers about where to focus their improvement efforts. Given the programmatic structures of the Hospital Value-Based Purchasing Program (HVBP) and the Hospital-Acquired Condition Payment Reduction Program, it is possible for a provider to receive a positive score for improving on an HAC measure in the HVBP program while receiving a negative payment adjustment for the Hospital-Acquired Condition Payment Reduction Program as a result of performance on the same measure.

The differing types and structures of the hospital performance measurement programs under review also have implications for the measures used within those programs. Some MAP members were concerned about applying new measures directly into payment adjustment programs without first having the opportunity to gain experience collecting and reporting the measures to uncover any measure feasibility issues. For instance, under statute, measures must first be reported for one year in the Hospital Inpatient Reporting Program prior to implementation in the HVBP program. MAP agreed with this approach and believed it should be applied to other pay-for-performance programs. MAP members also raised that potential unintended consequences related to use of a measure should be identified and addressed prior to implementing the measure in a payment adjustment program. Further, a few MAP members stated concern that measures may be implemented differently than originally specified, which can impact the reliability and validity of those measures.

MAP determined that the complex relationships among the programs must be considered when applying measures to the various hospital programs. While MAP's Measure Selection Criteria are useful to evaluate the adequacy of program measure sets, MAP found that further guidance in the form of Guiding Principles was needed to determine that individual measures are fit for specific program purposes and structures.

## Guiding Principles

MAP developed the following Guiding Principles for Applying Measures to Hospital Programs (see MAP Hospital Guiding Principles document) to support pre-rulemaking decisions for specific types of programs.

### *Pay-for-Reporting Programs*

MAP emphasized the importance of gaining experience with measures in a public reporting program before applying them to pay–for-performance programs. Through a public reporting program, such as the Hospital Inpatient Quality Reporting Program (IQR), program implementers and providers can ensure that measures accurately and fairly reflect hospital performance. Measures for public reporting should generate useful information to support consumer and purchaser decision-making and also guide provider improvement efforts. Further, a public reporting period allows hospitals to hone data collection practices and provide feedback regarding the feasibility, usability, and unintended consequences of the data collection methodology. MAP acknowledges that if compelling evidence exists to support the immediate inclusion of the measure within a payment adjustment program, then the measures should be applied to those programs more rapidly.

### *Pay-for-Performance Programs*

For pay-for-performance programs where there is an improvement component to the payment structure, such as Hospital Value-Based Purchasing (HVBP), certain measures are more appropriate for inclusion than in programs that only include payment adjustments. Measures should address areas of known variation and opportunities for improvement. Topics where hospitals are earlier in their understanding of how best to make improvements in care are particularly appropriate for application to a program with an improvement incentive. Where there may be concerns regarding unintended consequences and gaming from use of a measure, monitoring mechanisms, such as balancing measures, should also be included to understand and mitigate concerns. Measures for which the optimal benchmark is uncertain, and may not be zero, should also be included in this program, rather than in payment adjustment programs. To capture the value aspect of value-based purchasing, measures of clinical quality, particularly outcomes, should be linked to cost of care measures.

Pay-for-performance programs that include only reductions in their payment structures, such as the Hospital Readmission Reduction and Hospital-Acquired Condition Payment Reduction Programs, send strong incentive signals. Measures for these programs should address high prevalence, severity, or cost areas where there is variation in quality with opportunities for improvement. When selecting measures for these programs, the use of those measures within other pay-for-performance programs should be taken into account. Measures implemented in more than one payment program may result in potential unintended consequences related to additive adjustments, such as overuse of antibiotics to prevent any patient from contracting a healthcare-acquired infection. To protect vulnerable populations, appropriate adjustments to measurement data, such as through stratification, are particularly important for payment adjustment programs.

### *Additional Considerations*

Additional considerations included in MAP's Guiding Principles for Applying Measures to Hospital Programs relate to program monitoring, composite measures, and measure testing. All hospital programs should be monitored for overall impact and unintended consequences that could result from the use of performance measures. Program implementers should be particularly sensitive to low volume

providers when applying program measure sets and incentive structures. If composite measures are selected for hospital programs, then individual measures contained within those composites should not be included. Finally, prior to application, measures should be tested for reliability and validity using data from the relevant population for that program.

## Hospital Setting Program-Specific Input

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

### *Hospital Inpatient Quality Reporting*

MAP reviewed 21 measures under consideration for the Hospital Inpatient Quality Reporting (IQR) program, a pay for reporting program for acute care hospitals (see Hospital Tables, IQR Tab). As reflected in the Guiding Principles, measures should initially be included in IQR to gain experience with data collection and reporting of performance scores.

A few points from MAP's Measure Selection Criteria are particularly salient for selecting measures for public reporting. NQF-endorsed measures are preferred over measures that are not endorsed or endorsed in reserve status. Similarly, MAP recommended that measures that are not NQF-endorsed, are topped out, or no longer represent the standard of care should be removed or suspended from IQR reporting. Measures selected should be meaningful to consumers, purchasers, and providers and address the NQS aims and priorities, as well as high-impact conditions. The program measure set should be parsimonious, balancing conciseness and comprehensiveness.

MAP supported including updated methodologies for the readmissions measures in IQR to better exclude planned readmissions. MAP also supported updated Centers for Disease Control and Prevention (CDC) – National Healthcare Safety Network (NHSN) measures under consideration with additional risk-adjustment for volume of exposure within a facility. In all, MAP reviewed seven readmission measures, five safety measures, and two mortality measures for IQR.

Recognizing the need for more measures addressing affordability, MAP agreed that additional cost measures should be included in the program measure set. MAP supported the Medicare Spending per Beneficiary measure, noting the statutory requirement for this measure, and recommended that this measure be submitted for NQF-endorsement as soon as possible. MAP supported the direction of the AMI Episode of Care measure, recognizing the need for further development of the episode methodology.

Using the MAP Previously Identified Measure Gaps, MAP highlighted priority gaps in the IQR program measure set. To expand the populations covered by the IQR program, MAP supported additional pediatric and maternal/child health measures for this set. MAP also suggested including cancer and behavioral health measures from the PCHQR and IPFQR programs in IQR to better align measurement for these populations. MAP stressed the need for additional safety measures, especially in the areas of medication reconciliation and culture of patient safety. Additional IQR measure gaps noted include

affordability, especially overall costs, and measures that drive toward system-wide improvement in care transitions.

To keep the IQR measure set parsimonious, MAP identified six current finalized measures within the program for phased removal (see Hospital Tables, IQR Tab). MAP focused on removing measures that are no longer NQF-endorsed or endorsed in reserve status, according to the Guiding Principles. Three measures were identified for phased removal because NQF endorsement has been removed. An additional three measures were recommended for phased removal because they are NQF-endorsed in reserve status, indicating that performance is topped out. One additional measure was identified for phased removal because MAP believed performance was topped out, though the measure has not yet been moved to reserve status.

### *Hospital Value-Based Purchasing*

MAP reviewed 18 measures under consideration for Hospital Value-Based Purchasing (HVBP), a pay-for-performance program in which hospitals receive the higher of two scores, one based on their performance relative to other hospitals and the other reflecting their improvement over time (see Hospital Tables, HVBP Tab). Measures within this program should emphasize areas of critical importance for high performance and quality improvement, and ideally, link clinical quality and cost measures to capture value. For the HVBP Program, particularly relevant points from MAP's Measure Selection Criteria are that NQF-endorsed measures are strongly preferred and the program measure set should be parsimonious to avoid diluting the payment incentives.

MAP supported including outcome measures and process measures strongly tied to positive outcomes for the HVBP program measure set. Measures under consideration for the HVBP program that were supported by MAP addressed safety, prevention, affordability, and care transitions. Additionally, MAP strongly supported the direction of emergency department (ED) throughput measures, recognizing the significance of ED overcrowding and improving wait times, but noting reliability concerns regarding the ED measures under consideration. Further, MAP identified a number of key gap areas that should be addressed within the HVBP program measure set, including medication errors, mental and behavioral health, and patient and family engagement.

MAP recommended phased removal of two measures that are no longer NQF-endorsed to maintain a more parsimonious measure set (see Hospital Tables, HVBP Tab). Since HVBP measures are a subset of the IQR program measure set, the two measures identified for phased removal from HVBP were also recommended for removal from IQR.

### *Hospital Meaningful Use*

MAP reviewed one measure under consideration for the Meaningful Use for Hospitals and Critical Access Hospitals program, a pay-for-reporting program (see Hospital Tables, Hospital MU Tab). Overall, MAP noted that the Hospital Meaningful Use program is quite complex, and hospitals have had difficulty understanding and implementing the program requirements. At this time, many hospitals are undergoing initial implementation of electronic health records and are struggling to ensure all clinicians practicing within the facility can access and operate the systems effectively, with the future expectation of demonstrating meaningful use. One MAP member also raised concerns about the comparability of performance scores calculated for a measure using data collected through manual chart abstraction versus through automated electronic data collection.

MAP identified five measures for phased removal from the Hospital Meaningful Use program (see Hospital Tables, Hospital MU Tab). Two measures related to heart disease were also identified for removal from IQR because their NQF endorsement status has been changed to reserve status. Two additional measures have lost their NQF endorsement and were not supported for inclusion in other hospital programs. A measure related to healthy term newborns was identified for phased removal at this time while the developer makes changes to the measure specifications; however, MAP strongly supported the direction of this measure.

### *Hospital Readmissions Reduction Program*

The Hospital Readmissions Reduction Program is a pay-for-reporting program that adjusts payments for hospitals found to have an excessive number of readmissions. Using the Guiding Principles and MAP's Guidance for the Selection of Avoidable Admission and Readmission Measures, MAP reviewed six measures under consideration for this program (see Hospital Tables, Readmission Tab). According to MAP's Guidance for the Selection of Avoidable Admission and Readmission Measures, measures for this program should exclude planned readmissions and include stratification by factors such as race, gender, and socioeconomic status to enable fair comparisons. Based on these principles, MAP supported three measures under consideration that are updated versions of currently finalized measures with new methodology excluding planned readmissions. Additionally, MAP supported two measures under consideration addressing high-volume elective hip and knee surgeries as well as supported the direction of a chronic pulmonary obstructive disorder (COPD) readmission measure.

MAP encouraged the development of additional condition-specific readmission measures to address high-impact conditions, such as diabetes and cancer, behavioral health conditions, and conditions particularly relevant to the adult commercial population (individuals aged 18-64). Additionally, MAP noted the need to consider unrelated readmissions, beyond planned readmissions. Further, MAP recognized that readmissions are multi-factorial and are often related to broader issues, such as access to care, socioeconomic status, presence of community supports, and other psychosocial factors; therefore, implementation of balancing measures and risk-stratification methodologies related to race, gender, and socioeconomic status may be needed.

### *Hospital-Acquired Condition Payment Reduction Program*

The Hospital-Acquired Condition Payment Reduction Program is a pay-for-performance program. There are no current finalized measures for this program, so HHS asked MAP to review 25 measures under consideration to help shape the initial program measure set (see Hospital Tables, HAC Tab).

When considering measures for this program, MAP's deliberations were particularly focused on the Guiding Principle related to overlapping incentives and potential unintended consequences from additive payment adjustments. For example, a MAP member voiced concern that there could be an increase in inappropriate antibiotic use as providers try to avoid multiple payment adjustments related to infections such as catheter-associated urinary tract infections. MAP also expressed a strong preference that measures be publically reported prior to adoption for this program, in light of concerns regarding potential unintended consequences. Given the program structure, MAP struggled with the inclusion of some serious reportable events, as the occurrence of just one of these events during a year could potentially put a hospital in the bottom 25$^{th}$ percentile to receive the payment adjustment.

When discussing the possible inclusion of composite measures in the program, MAP cautioned that composites require careful testing and weighting of all individual components to ensure a scientifically

rigorous measure. MAP concluded that if composites were applied to this program, then individual measures that are part of the composite should not be included in the program. Consistent with previous recommendations, MAP preferred the CDC-NHSN methodology for data collection and measurement, since this approach does not use administrative claims data and the measures have been well tested, vetted, and publically reported. Finally, MAP named several measure gaps for this program, including adverse drug events (e.g., wrong dose, wrong patient, drug-drug interactions, drug-allergy interactions), ventilator-associated events (VAEs), sepsis, and an obstetric complications composite measure.

### *PPS-Exempt Cancer Hospital Quality Reporting*

MAP reviewed 19 measures under consideration for the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) program, a pay-for-reporting program (see Hospital Tables, PCHQR Tab). This program provides the first opportunity for the 11 PPS-exempt cancer hospitals to gain experience with federal reporting of quality measures.

Consistent with prior recommendations, MAP reinforced the need for alignment of measures for this cancer hospital-specific program with IQR and OQR measures. The quality of care for other medical conditions, beyond cancer, should be as high in a PPS-exempt cancer hospital as in a general acute care hospital. While some of the measures under consideration for PCHQR may be considered "topped out" in other programs, MAP noted that potential performance variation or disparities in care quality within these facilities are not known. For example, a measure with high performance in IQR, such as NQF #0528 Prophylactic Antibiotic Selection for Surgical Patients with performance scores of 98% in 2010 and 2011, should be reported in the PCHQR program to determine whether there is a need for improvement in PPS-exempt cancer hospitals.

Given the unique nature of cancer care and its overall effect on cancer patients and their families and caregivers, MAP placed a high priority on measures of patient and family/caregiver experience as well as other patient-reported outcome measures. To address this, MAP supported the direction of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) measure while a cancer-specific CAHPS survey module is piloted at a number of PPS-exempt cancer hospitals. Other measure gaps for this program include measures of survival, patient-reported symptoms and clinical outcomes, palliative and hospice care, and psychosocial/supportive services for the patient and family or caregiver.

### *Inpatient Psychiatric Facility Quality Reporting*

MAP reviewed five measures under consideration for the Inpatient Psychiatric Facility Quality Reporting (IPFQR) program, a pay-for-reporting program (see Hospital Tables, IPFQR Tab). This program provides the first opportunity for psychiatric care providers to gain experience with federal reporting of quality measures.

Consistent with prior recommendations, MAP encouraged alignment, as appropriate, of measures for this psychiatric care-specific program with IQR measures to ensure that the quality of care remains high for other medical conditions for patients treated in these facilities. Further, MAP supported the extension of psychiatric care quality measurement to outpatient settings, particularly emergency departments, and inpatient hospitals without psychiatric units. MAP supported measures related to patient follow-up after hospitalization, signaling the broader responsibility of hospitals for their patients even after discharge from the facility.

Efforts by hospitals to improve person-centered psychiatric care, such as assessing patient and family/caregiver experience and engagement and establishing relationships with community resources are priority measure gap areas. As starting place, MAP supported the direction of the Inpatient Consumer Survey (ICS) measure. Additional measure gaps in IPFQR program include behavioral health assessments and care in the emergency department, readmissions, effect of psychiatric medications on medical conditions, partial hospitalization or day programs, and a psychiatric care module for CAHPS.

### *Hospital Outpatient Quality Reporting*

MAP reviewed seven measures under consideration for the Hospital Outpatient Quality Reporting (OQR) program, a pay-for-reporting program (see Hospital Tables, OQR Tab). MAP noted that measures for outpatient hospital programs should be aligned with ambulatory measures in programs such as PQRS and Physician Compare. MAP supports measures for OQR related to fostering important ties to community resources to enhance care coordination efforts, increasing patient follow-up after procedures, and tracking patients longitudinally.

Specific gaps areas for the OQR program measure set include measures of emergency department overcrowding and disparities in care, specifically disproportionate use of emergency departments by vulnerable populations. Additional gaps include measures of cost, patient-reported outcomes, and patient and family engagement and experience of care. One emergency department measure was identified for phased removal from the OQR program because it lost NQF-endorsement (see Hospital Tables, OQR Tab).

### *Ambulatory Surgical Center Quality Reporting*

MAP reviewed five measures under consideration for the Ambulatory Surgical Center Quality Reporting (ASCQR) program, a pay-for-reporting program (see Hospital Tables, ASCQR Tab). These five measures were also under consideration for OQR, and MAP supported the efforts by HHS to move toward greater alignment across these two programs. One member raised that these measures are specified for the individual clinician or group practice level of analysis and not for the facility level, a concern also reinforced by a public commenter. MAP supports the inclusion of ASCs within a broader system-wide approach to measuring performance and improving care; however, measures should be tested, endorsed, and implemented for the intended level of analysis.

MAP found the ASCQR program measure set to be inadequate considering the wide variety of procedures now being performed in this setting, and MAP encourages swift progress in developing, testing, and endorsing applicable measures. Priority measure gap areas for the ASCQR program include follow-up after procedures, complications, cost, patient and family experience of care and engagement, and patient-reported outcome measures.

## Clinician Performance Measurement Programs

In reviewing measures for use in the Physician Quality Reporting System (PQRS), Physician Compare, the Value- Based Payment Modifier (VBPM), and the Medicare and Medicaid EHR Incentive Program for Eligible Professionals (Meaningful Use), MAP discussed key issues related to clinician performance measurement. To address the key issues, MAP developed Guiding Principles for Applying Measures to

Clinician Programs and then applied those principles to the programs. The key issues, Guiding Principles, and an overview of MAP's recommendations for the clinician programs are presented below.

## Key Issues

An overarching goal for all federal clinician performance measurement programs is engaging clinician participation in meaningful quality reporting. To date, participation has been low; in 2010, only 25% of eligible clinicians participated in PQRS[1]. Encouraging clinician participation is imperative as the significance of performance measurement increases over time: clinicians who do not participate in PQRS will begin receiving payment penalties in 2015; clinician performance data will be publicly available on Physician Compare in 2015; and the VBPM will be applicable to all clinicians in 2017. MAP seeks to encourage clinician participation in these programs by identifying measures for all clinician specialties that are considered clinically relevant.

To encourage participation, MAP also aims to reduce clinician reporting burden resulting from a lack of alignment across federal programs and between public- and private-sector programs. MAP recommends leveraging measurement data for multiple purposes to decrease reporting burden. For example, Board Maintenance of Certification programs (e.g., American Board of Internal Medicine) represent a significant contribution to quality improvement and their measures, particularly patient-reported survey measures and composites, would be valuable for clinician public reporting and payment incentive programs. Clinicians are also increasingly participating in health plan performance measurement programs (e.g., Integrated Healthcare Association, Massachusetts Blue Cross Blue Shield Alternative Quality Contract) and federal programs should align with these efforts.

To support alignment, MAP recommends identifying a set of measures that all clinicians could report across programs, regardless of specialty. MAP specifically highlighted the importance of consistent patient experience and engagement measures being available for all clinicians, and also encouraged consistent or complementary measures for coordination of care and population health (e.g., health risk assessment, prevention). All of these are cross-cutting NQS priorities; future MAP families of measures addressing these priorities will support identification of measures that could be reported by all clinicians. Selecting measures that are in use in other settings (e.g., IQR) or levels of analysis (e.g., Medicare Shared Savings Program) presents opportunities for alignment; however, measures must be tested at the appropriate level of analysis prior to inclusion in clinician public reporting and payment programs. MAP also recognizes the need to continue to drive toward greater adoption of health IT to build capacity for more sophisticated measurement with less burdensome data collection and reporting.

Furthermore, MAP aims to balance encouraging clinician participation and reducing clinician reporting burden with identifying measures that drive performance improvement and result in greater value. To achieve this, MAP recommends that measures for clinician public reporting and payment incentive programs focus on outcomes most relevant to patients and to those who purchase care on behalf of

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

patients. To capture value for the VBPM, outcome measures should ideally be associated with related cost or resource use measures (i.e., efficiency measures).

## Guiding Principles for Applying Measures to Clinician Programs

To stimulate broad clinician participation, HHS asked MAP to consider a large number of measures—731 measures total—for inclusion in federal clinician programs. Specifically:

- For PQRS, MAP reviewed over 200 measures under consideration that would be new to federal clinician measurement programs. In addition, all existing measures and measures under consideration for the Hospital Inpatient Quality Reporting Program and the Hospital Outpatient Quality Reporting Program—113 measures—were submitted for consideration for use in PQRS to accommodate hospital-based physicians. The hospital performance rates for these measures would be applied to individual clinicians.
- For Physician Compare and VBPM, all measures under consideration and existing measures for PQRS—618 measures total—are also under consideration for use in these programs. The recent final rule, Revisions to Payment Policies Under the Physician Fee Schedule, released on November 1, 2012, included all currently finalized PQRS measures in the VBPM.

MAP reviewed the measures under consideration by condition, based on the qualities that make a measure suitable for payment incentives (i.e., VBPM), public reporting (i.e., Physician Compare), only for quality reporting (i.e., PQRS) at this time, or not for any of these purposes. MAP's rationale regarding the fit of the measures for the purposes of the programs will support MAP's future efforts to refine the MAP Measure Selection Criteria and, to meet immediate needs for MAP decision-making, led to the development of MAP's Guiding Principles for Applying Measures to Clinician Programs (see the Clinician Guiding Principles document).

### *PQRS*

Under the Guiding Principles, measures should first be used in PQRS to obtain experience before being used in public reporting and payment incentive programs. Recognizing that performance results do not effect payment for reporting, MAP recommends that PQRS be more broadly inclusive of measures to encourage clinician participation while still striving for measures that drive performance improvement. Specifically, MAP recommends:

- Including NQF-endorsed measures relevant to clinician reporting to encourage clinician participation, noting that the endorsement process addresses harmonization of competing measures.
- Measures that are not NQF-endorsed may be included if the measure supports alignment (e.g., outcome measures also used in maintenance of certification programs), is an outcome measure for a topic not already addressed by an outcome measure included in the program, or is clinically relevant to specialties that do not currently have clinically relevant measures. To be recommended by MAP for PQRS, measures that are not NQF-endorsed must be fully specified. MAP recognizes that some measures that are not NQF-endorsed may not yet be fully tested, and PQRS can serve as a vehicle for gaining implementation experience with these measures.

- Measures that are not NQF-endorsed, whether currently finalized in the program or recommended for inclusion in the program, should be submitted for endorsement. NQF is committed to working with measure stewards to bring promising measures into the endorsement process. Subsequently, if a measure is submitted for endorsement but is not endorsed, it should be removed from the program. Additionally, measures with NQF endorsement in reserve status (i.e., topped out) should be removed from the program unless the measures are clinically relevant to specialties that do not currently have clinically relevant measures in the program.

### *Physician Compare*

MAP recommends including NQF-endorsed measures in Physician Compare that are meaningful to consumers (i.e., have face validity) and purchasers, to meet the public reporting purpose of supporting consumer and purchaser decision-making. Additionally, measures included in Physician Compare should:

- Focus on patient experience, patient-reported outcomes (e.g. functional status), care coordination, population health (e.g., risk assessment, prevention), and appropriate care.
- Be aggregated (e.g., composite measures), with drill-down capability for specific measure results to generate a comprehensive picture of quality.

### *VBPM*

While the recent Physician Fee Schedule final rule signaled CMS' intent to include all measures used in PQRS for the VBPM, MAP recommends a more targeted approach for measures to be used in this program. Specifically, measures used for the VBPM should ideally drive toward value by linking the outcomes most important to patients with measures of cost of care. For payment incentive programs, NQF-endorsed measures are strongly preferred and measures should have been reported in a national program, such as PQRS, for a year. Additionally, measures used in VBPM should:

- Focus on outcomes, composites, process measures that are proximal to outcomes, appropriate care, and care coordination measures (measures included in the MAP family of measures generally reflect these characteristics).
- Monitor for unintended consequences to vulnerable populations, such as through the use of stratification methodologies.

### *Meaningful Use*

The goal of the Meaningful Use program is to encourage clinician adoption and use of EHRs. Similar to PQRS, MAP's initial recommendation is to balance broad inclusion of measures with identifying measures that promote performance improvement. Specifically, MAP recommends including endorsed measures that have eMeasure specifications available. As health IT becomes more effective and interoperable, MAP recommends that the measures focus on a demonstrated and meaningful impact on care:

- Health IT-sensitive measures that provide information on whether electronic health records are changing care processes.

- Health IT-enabled measures that require data from multiple settings/providers or are longitudinal and would require an integrated system-wide health IT-enabled collection platform to be fully operational.

## Overview of Recommendations for Clinician Programs

Using the Guiding Principles, MAP reviewed measures for use in federal programs. Given the large number of measures under consideration and the complexity of the task, MAP identified specific measures for PQRS and Meaningful Use, but did not identify specific measures for inclusion in Physician Compare or VBPM. Illustrations of measures MAP would likely support for inclusion in Physician Compare and VBPM based on the Guiding Principles are provided below. As an essential partner in the pre-rulemaking process, CMS encouraged MAP to develop the Guiding Principles in lieu of individual measure recommendations for Physician Compare and VBPM, and indicated that having the principles will provide a valuable foundation for measure selection for clinician programs.

MAP proposes that CMS seek focused input from MAP prior to release of the next Physician Fee Schedule proposed rule, and that CMS make clinician measures under consideration available earlier in the year to allow for more thorough review. For example, MAP could convene Technical Expert Panels to provide a preliminary review of clinician measures by condition prior to convening the MAP Clinician Workgroup. MAP will collaborate with CMS to determine a process for applying the Guiding Principles to all clinician programs during the next pre-rulemaking cycle.

In addition to reviewing individual measures under consideration, MAP identified four high-priority gaps that when addressed would contribute to a set of measures that could be reported by all clinicians, regardless of specialty:

- Patient and family engagement
- Population health
- Appropriateness, in particular measures that align with the ABIM Choosing Wisely campaign
- Vulnerable populations (e.g., individuals with multiple chronic conditions, dual eligible beneficiaries) and disparities. MAP favored measures included in the Dual Eligible Beneficiaries Family of Measures and measures that are identified as disparities-sensitive according to NQF's criteria.

### *PQRS*

To encourage broad clinician participation, MAP recommends including 52 NQF-endorsed measures under consideration in PQRS. MAP also recommends including 2 measures under consideration that are not NQF-endorsed as they are composites which support alignment: the *Diabetes Composite* and the *Hypertension Composite* are used in ABIM's maintenance of certification program. MAP supports the direction of 86 measures; of these, over half support alignment as they are used in ACS' Surgeon Specific Registry (SSR) and National Surgical Quality Improvement Program (NSQIP). Additionally, MAP recommends removing 44 measures currently finalized in the program that have been previously

submitted for endorsement and were not endorsed. See the Clinician Measures Table, PQRS tab for recommendations on individual measures.

### *Physician Compare*

When applying the Guiding Principles, MAP would likely support the following measures for Physician Compare:

- *CG CAHPS,* while not finalized for use in any federal clinician measurement program, it is an NQF-endorsed patient experience measure that MAP recommends for incorporation into all clinician programs. MAP viewed this measure as a high priority that should be implemented quickly.
- *NQF #0576 Follow-up After Hospitalization for Mental Illness,* an NQF-endorsed care coordination measure that is included in the MAP Care Coordination Family of Measures and also address vulnerable populations.
- Two diabetes measures (*NQF #0575, #0729)* and several cardiac imaging measures *(NQF #0670, 0671, and 0672)* are NQF-endorsed outcome measures related to prevention and treatment that are currently reported in PQRS and included in a MAP Family of Measures.

### *VBPM*

Currently, the Physician Feedback program serves as a pilot for VBPM, providing confidential feedback reports to clinicians. MAP supported the direction of six episode grouper-based resource use measures under consideration for use in the Physician Feedback program (see the Clinician Measures Table, VBPM tab). MAP recommends that these measures be submitted for NQF endorsement and ideally be linked with clinical outcome measures before being used in the VBPM. For example, *Episode Grouper: Acute Myocardial Infarction (AMI)* could be linked with *NQF #0018 Controlling High Blood Pressure*, which is an outcome measure currently finalized for use in PQRS and is also included in the MAP Cardiovascular Family of Measures. MAP may also identify outcome measures related to follow-up care and additional clinical outcome measures to link to episode grouper measures in the program.

### *Meaningful Use*

MAP did not support the inclusion of two measures under consideration for the clinician Meaningful Use program that are not NQF-endorsed, as the concepts of these measures overlap with endorsed measures currently finalized in the measure set (see the Clinician Measures Table, Meaningful Use tab). Both measures assess care provided during an annual wellness visit—whether patients received a variety of age appropriate screenings and whether patients received management of identified risks. While MAP would favor preventive care composite measures, these measures overlap with several individual NQF-endorsed measures that are currently finalized in the set that are not limited to the context of an annual visit. More generally, MAP would strongly prefer measures that reflect the use of health IT to coordinate care, improve clinical processes, and improve outcomes.

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

MAP utilized its prior coordination strategies for post-acute care/long-term care (PAC/LTC) and hospice performance measurement to guide its input on measures for use in these PAC/LTC programs: Long-Term Care Hospital Quality Reporting Program (LTCH), Inpatient Rehabilitation Facility Quality Reporting Program (IRF), End Stage Renal Disease Quality Improvement Program (ESRD-QIP), Hospice Quality Reporting Program, Nursing Home Quality Initiative (NHQI) and Nursing Home Compare (NH Compare), and Home Health Quality Reporting Program (HH). This section presents key issues related to performance measurement in PAC/LTC settings, applicable recommendations from MAP's prior coordination strategies, and an overview of MAP's pre-rulemaking recommendations for each PAC/LTC program.

### Key Issues

In reiterating the need to align performance measurement across PAC/LTC settings, MAP emphasized that measurement should also be aligned with other acute settings, such as hospitals. Alignment must be balanced with consideration for the heterogeneity of patient needs across settings. For example, treatment goals for patients in post-acute care settings focus on improvement while treatment goals for patients in long-term care settings are more likely to focus on maintenance. MAP suggests robust risk adjustment methodologies, to address the variability of patient populations across settings. For some programs, patient populations are distinguished as short-stay (i.e., patients who are recovering from an illness and are in a facility for less than 100 days) and long-stay (i.e., patients with chronic medical problems who reside in a facility or institution for more than 100 days). MAP suggests revisiting these measures to determine whether: (1) there are opportunities to combine the long-stay and short-stay measures using risk adjustment to account for patient variations and (2) any of the measures could be applied to other PAC/LTC programs to align measures across settings.

Admission and readmission measures are also examples of measures that MAP recommends be standardized across settings, yet customized to address the unique needs of the heterogeneous PAC/LTC population. MAP has continually noted the need for care transition measures in PAC/LTC performance measurement programs. Setting-specific admission and readmission measures under consideration would address this need. However, MAP would like a more parsimonious approach, utilizing fewer measures to address readmissions across settings. Attention would need to be given to defining the index event (e.g., acute hospital admission vs. LTCH admission) so that the measure can serve multiple settings. Additionally, MAP suggests that shared accountability across settings be considered when utilizing results from admission and readmission measures so that providers are not unfairly penalized.

MAP suggests that measures besides readmission measures be expanded beyond addressing single settings or conditions. The majority of patients in PAC/LTC settings have multiple chronic conditions. For measures to drive performance, they must address the complexities of this population. Functional status, care coordination, and shared decision-making are measurement areas that address the complexities of multiple chronic conditions from a patient perspective. Total cost of care is another type

of measure that crosses multiple settings and conditions; MAP recommends that cost measures be included in all PAC-LTC programs. Additionally, MAP sought to recommend high-impact measures and remove low-impact measures. For example, while immunization measures could be applied across all settings, MAP requested further evidence regarding the impact of these measures.

MAP continues to recognize that the lack of an information infrastructure across PAC/LTC settings, which are not eligible for Meaningful Use incentives, will continue to be an impediment to measurement. A robust health IT infrastructure is needed to reduce data collection and reporting burden for providers and to enhance care coordination and transmission of information essential to better patient care.

## Application of Prior Coordination Strategies to Pre-Rulemaking Decisions

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

In the PAC/LTC coordination strategy, MAP defined high-leverage areas for performance measurement and identified 13 core measure concepts to address each of the high-leverage areas.

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

In the Hospice coordination strategy, MAP identified 28 high-leverage measurement opportunities that are important for hospice and palliative care. Further MAP prioritized seven measurement opportunities for both hospice and palliative care, three specific to hospice care, and three specific to palliative care. The three opportunities specific to hospice care reflect patients' needs for increased access and

communication and include: timeliness/responsiveness of care, access to the healthcare team on a 24-hour basis, and avoiding unwanted treatments.

This year when reviewing the program measure sets and measures under consideration for PAC/LTC programs, MAP determined that the following core measurement concepts represent the most critical gaps that when filled would greatly improve care across all PAC/LTC settings: goal attainment; medication management, medication reconciliation, and adverse drug events; functional and cognitive status; patient and family experience of care and engagement in care, and shared decision-making; and transitions in care.

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

### *Long-Term Care Hospital Quality Reporting Program*

MAP reviewed five measures currently finalized for the program measure set and 29 measures under consideration for the LTCH Quality Reporting Program. MAP noted that many measures under consideration would support alignment with other settings; however, measures should be tested in LTCHs to determine if they are feasible for implementation. Accordingly, MAP supported the direction of 23 measures that address the post-acute and long-term care core measure concepts but are not ready for implementation in the LTCH setting. MAP also supported the direction of one cost measure, noting that the measure under consideration would exclude most of the LTCH population. MAP recommends that additional measures be added to address cost. For example, assessing whether individuals are appropriately placed in LTCHs would help determine whether they could receive care in less costly settings. MAP did not support five measures under consideration that did not address PAC/LTC core concepts or had lost NQF endorsement. Core measure concepts that remain as gaps include cognitive status assessment (e.g., dementia identification), advanced directives, and medication management (e.g., use of antipsychotic medications).

### *Inpatient Rehabilitation Facility Quality Reporting Program*

MAP reviewed two measures currently finalized for the program measure set and ten measures under consideration for the IRF Quality Reporting Program. MAP found the program measure set too limited and noted that it could be greatly enhanced by addressing the core measures concepts not addressed in the set—care coordination, functional status, and medication reconciliation—and addressing safety issues that have high incidence in IRFs, such as MRSA, falls, CAUTI, and C. difficile. Accordingly, MAP supported two measures that address CAUTI and C. difficile. MAP supported the direction of three functional status outcome measures and one avoidable admissions measure, noting that the measures are important but are still in development. MAP did not support three low-impact immunization measures and one CLABSI measure, which has a low incidence in this setting.

### *End Stage Renal Dialysis Facility Quality Improvement Program*

MAP reviewed 12 measures currently finalized for the program measure set and 21 measures under consideration for the ESRD Quality Improvement Program. MAP previously recommended that the measure set expand beyond dialysis procedures to include non-clinical aspects of care, such as care

coordination. This issue persists as only one measure under consideration addresses a cross-cutting topic—NQF #0258 CAHPS In-Center Hemodialysis Survey; MAP supports the use of this measure. Recognizing that the program is statutorily required to include measures of dialysis adequacy, MAP supported 11 measures under consideration that are clinically-focused. Similarly, MAP supported the direction of an additional nine clinically-focused measures under consideration, as the measures would address statutory requirements but they need to be brought forward for NQF endorsement. MAP did not support one measure under consideration because its NQF endorsement has been removed. MAP recommends exploring whether the clinically-focused measures could be combined in a composite measure for assessing optimal dialysis care. The core measure concepts not addressed in this measure set include advance care planning, care coordination, functional status, pain, and falls.

### *Hospice Quality Reporting Program*

MAP reviewed two measures currently finalized for the program measure set and seven measures under consideration for the Hospice Quality Reporting Program. MAP's Hospice and Palliative Care Coordination Strategy identified measures for inclusion in a MAP Hospice Family of Measures. All of the measures under consideration are included in the family, so MAP supported including the measures in the hospice program. Additionally, MAP recommends that other measures in the MAP Hospice Family of Measures be added to the measure set. Specifically, MAP recommends including NQF # 1647 Percentage of hospice patients with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss. Overall, the measure set fails to address several core measure concepts including pain, goal attainment, patient engagement, care coordination, and depression. Additionally, the measure set would be enhanced with measures that address the caregiver's role and timely referral to hospice. MAP notes that attribution would be an issue for a timely referral measure as hospice programs cannot control referrals, so timely referral should be assessed in other settings.

### *Nursing Home Quality Initiative and Nursing Home Compare*

MAP reviewed 26 measures currently finalized for the program measure set and five measures under consideration for the NH Quality Initiative and NH Compare. MAP supported the direction of two measures that addressed the PAC/LTC core concept of inappropriate medication use, noting that the measures should have as few diagnoses excluded as possible and that balancing measures should be incorporated into the program set to mitigate unintended consequences. MAP also supported the direction of two measures addressing avoidable admissions, a core measure concept. MAP recognized the importance of measuring readmissions in the nursing home setting but, as noted earlier, would prefer fewer measures to address readmissions across settings. MAP also supported the direction of one measure that assesses whether short-stay residents are discharged to the community, noting that this is an important goal for short-stay residents and that additional measures should assess the quality of transition planning.

#### *Home Health Quality Reporting Program*

MAP reviewed 97 measures currently finalized for the program measure set and two measures under consideration for the Home Health Quality Reporting Program. While both measures under consideration address the PAC/LTC core concept of avoidable admissions, MAP did not support either measure as this information is already collected for measures that are currently finalized in the set. Overall, MAP noted that the large measure set reflects the heterogeneity of home health population; however, the measure set could be more parsimonious. MAP recommends adding the CAHPS Home Health Survey to the measure set, though this measure was not included in HHS' list of measures under consideration.

## System Performance Measurement Programs

While providing input on the finalized measure set for the Medicare Shared Savings Program (MSSP), MAP also identified key issues for system-level performance measurement.

### Key Issues

System-level measurement provides an opportunity for a truly patient-centered approach to measurement as performance can be assessed across the settings where patients or populations are receiving care. Accordingly, measure sets can be structured to address all aspects of the NQS three-part aim. Additionally, system-level measurement provides an opportunity to assess topics that may be difficult to measure at setting-specific levels of analyses due to small numbers or difficulty attributing patients to providers. MAP recommends that system-level measure sets align with the measures used for setting-specific performance measurement programs to leverage measurement data, decrease provider data collection burden, and align care delivery goals across programs.

### Medicare Shared Savings Program Measure Set

MAP noted that the MSSP program measure set is a comprehensive set as it addresses patient experience, other cross-cutting measurement priorities, high-impact conditions, and key quality outcomes. However, MAP raised that the measure set has a heavy emphasis on ambulatory care and could be enhanced with additional acute and post-acute care measures, and measures more relevant to patients with complex medical needs. Additionally, MAP recognized that the measure set currently has a mix of process, outcome, and patient experience measures; and while these measures are important, MAP would prefer to move to outcome measures (e.g., clinical depression improvement, rather than screening). MAP also recommends that the addition of measures of patient identification of a usual source of care, health information exchange, and functioning of the system would be useful for understanding access to care and coordination of services across the system. Further, while MAP recognizes that the shared savings aspect of the MSSP program is designed to generate cost savings and that the per-capita cost benchmarks included in the MSSP program provide comprehensive cost measures, the measure set should incorporate further cost measures to assess value and encourage transparency. From a program implementation perspective, MAP suggested that longer time periods for calculating savings and losses could strengthen the shared savings incentives.

MAP previously recommended that the MSSP measure set and the Medicare Advantage 5-Star Quality Rating System measure set should be aligned. MAP strongly reiterated this recommendation during this pre-rulemaking cycle. In support of this goal, MAP identified five NQF-endorsed measures used in the 5-Star program that would enhance the MSSP measure set and alignment across the two programs: NQF #0576 Follow-up After Hospitalization for Mental Illness, NQF #0037 Osteoporosis Testing in Older Women, NQF #0040 Flu Shot for Older Adults, NQF #0053 Osteoporosis Management in Women Who Had a Fracture, and NQF #0553 Care for Older Adults – Medication Review. Additionally, MAP reviewed several measures in the set that are not NQF-endorsed and recommended that one measure be submitted for NQF-endorsement, one measure be removed from the measure set as it overlaps with another NQF-endorsed measure in the set, and one measure be suspended for reporting until the measure is updated to reflect current guidelines (see the Clinician Measures Table, MSSP tab for individual measure recommendations and rationale).

## Affordability

One of the three aims of the NQS is to make health care more affordable by reducing the cost of care for individuals, families, employers, and government[2]. Further, the NQS establishes two goals for making care more affordable: ensuring affordable and accessible high quality health care for people, families, employers, and governments; and supporting and enabling communities to ensure accessible, high quality care while reducing waste and fraud. The Institute of Medicine (IOM) has identified several excess cost domains: unnecessary services, inefficiently delivered services, excessive administrative costs, prices that are too high, missed prevention opportunities, and fraud. Accordingly, affordability can be assessed through a variety of measure types, such as overuse, appropriateness, resource use, and efficiency. Price transparency through consistent price measures is also critical.

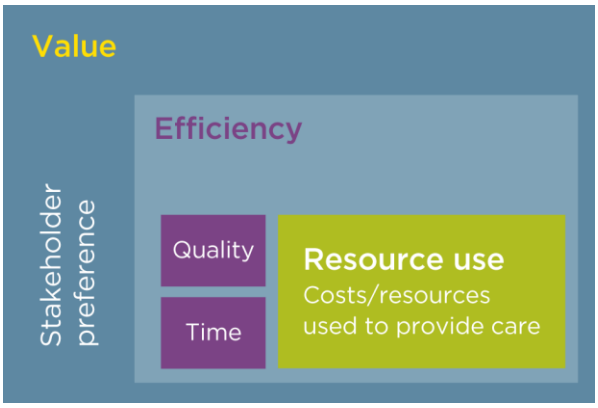
MAP has continually cited resource use and efficiency measures as critical measure gaps. Additionally, several federal public reporting programs (e.g., Hospital Inpatient Quality Reporting, Hospital Outpatient Quality Reporting) and value-based purchasing initiatives (e.g., Hospital Value-Based Purchasing,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

Resource use and efficiency are building blocks for understanding value (see graphic below). NQF's Cost and Resource Use Consensus Development Project (RU-CDP) 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 and endorsed eight resource use measures that are used in private sector efforts; all of the measures evaluate systems and individual conditions, six measures are condition-specific and two are total cost/resource use.

[2] http://www.ahrq.gov/workingforquality/nqs/nqs2012annlrpt.pdf

Additionally, the cost and resource use endorsement 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:

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

During this pre-rulemaking cycle, MAP was asked to consider whether several resource use and efficiency measures would add value to the program measure sets of specific federal programs. None of the measures under consideration had been submitted 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 determined that the measures under

consideration could add value to the programs (see the Clinician Measures Table, VBPM tab). NQF is committed to working with measure stewards to bring these measures into the endorsement process.

Additionally, MAP elaborated on the key findings of the RU-CDP, providing additional guidance on the application of resource use measures:

- Resource use measures ideally should be linked with outcome measures.. A future MAP Affordability Family of Measures will identify specific quality measures to link with resource use measures, and provide additional guidance for monitoring unintended consequences and mitigating risks.
- To be patient-centered, resource use and efficiency measurement approaches should address individuals with multiple chronic conditions. For example, emerging methods of assessing resource use for patients with multiple chronic conditions may include methods for rolling up procedural episodes into acute episodes, or acute episodes into chronic episodes, in order to gain a better understanding of the total cost for a patient. MAP requests that the RU-CDP Steering Committee consider how condition-specific measures address multiple chronic conditions when evaluating measures for endorsement.
- Resource use approaches should align across populations and settings, using the same measure when feasible. When developing an Affordability Family of Measures, MAP will consider whether any private sector resource use measures, which are becoming more widely used, could be applied to federal programs in addition to determining the best uses for various resource use approaches (e.g., episode-based approaches versus per-capita approaches). To support alignment across settings, MAP requests that the RU-CDP Steering Committee consider how risk-adjustment and attribution methodologies could align across populations and settings.

## Alignment of Measures in Support of Higher-Quality Care for Dual Eligible Beneficiaries

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 service needs, the healthcare and supportive services accessed by these individuals are often highly fragmented.

The MAP Dual Eligible Beneficiaries Workgroup has identified the subject areas in which performance measurement can provide the most leverage in improving the quality of healthcare: quality of life, care coordination, screening and assessment, mental health and substance use, and structural measures. A list of measures that are collectively considered core is provided in table below. The Evolving Core Set of Measures for Dual Eligible Beneficiaries was updated in 2012 to reflect current priorities and the best available measures.

## Results of Prior Pre-Rulemaking Input

HHS uptake of measures in 2012 rulemaking was generally consistent with MAP's specific recommendations made as a result of input regarding measures important to the dual eligible beneficiary population. Twelve core measures are finalized for use in two or more HHS programs. Six core measures are finalized for use in one HHS program.

## Current Pre-Rulemaking Input

Liaisons from the Dual Eligible Beneficiaries Workgroup participated in other workgroups' pre-rulemaking meetings to add the dual eligible perspective across the discussions of measures under consideration. The perspective integrated well into MAP deliberations, especially when measure alignment was the topic. Different facets of alignment were considered, including across programs and across the episode of care. In addition, alignment between Medicare and Medicaid program requirements is a leading issue in improving care coordination for dual eligible beneficiaries.

In all cases where measures from the Evolving Core Set for Dual Eligible Beneficiaries were under consideration for addition to one or more programs, MAP workgroups supported them for inclusion or supported their direction for further development, testing, or endorsement. This demonstrates MAP's success and consistency in pushing for the adoption of high-value measures for vulnerable beneficiaries.

Measurement topics for further discussion by the Coordinating Committee include:

- Accounting for different types of diversity and disparities in care
- Creative approaches to patient and family engagement
- Presence of risk adjustment, including stratification methodologies, to appropriately protect providers and health plans treating more vulnerable beneficiaries
- Measure gaps in:
    - Shared accountability for care coordination through transitions
    - Advanced care planning
    - Mental and behavioral health
    - Structural measures as they apply to providers and health plans integrating with community organizations or other providers of LTSS

| Measure and NQF Status | Measure Title | Measure Description | Federal Programs: Under Consideration | Federal Program: Current Finalized | Pre-Rulemaking Guidance |
|---|---|---|---|---|---|
| **0004 Endorsed** | Initiation and Engagement of Alcohol and Other Drug Dependence Treatment | The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following.<br>a. Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.<br>b. Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit. | | Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Meaningful Use (EHR Incentive Program) - Eligible Professionals; Physician Quality Reporting System (PQRS) | |
| **0005 Endorsed** | CAHPS Clinician/Group Surveys - (Adult Primary Care, Pediatric Care, and Specialist Care Surveys) | Adult Primary Care Survey: 37 core and 64 supplemental question survey of adult outpatient primary care patients.<br>Pediatric Care Survey: 36 core and 16 supplemental question survey of outpatient pediatric care patients.<br>Specialist Care Survey: 37 core and 20 supplemental question survey of adult outpatients specialist care patients.<br>Level of analysis for each of the 3 surveys: group practices, sites of care, and/or individual clinicians | Physician Compare; Value-Based Payment Modifier Program | Medicare Shared Savings Program | |

| Measure and NQF Status | Measure Title | Measure Description | Federal Programs: Under Consideration | Federal Program: Current Finalized | Pre-Rulemaking Guidance |
|---|---|---|---|---|---|
| **0006 Endorsed** | CAHPS Health Plan Survey v 4.0 - Adult questionnaire | 30-question core survey of adult health plan members that assesses the quality of care and services they receive. Level of analysis: health plan – HMO, PPO, Medicare, Medicaid, commercial | | Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Medicare Part C Plan Rating; Medicare Shared Savings Program | |
| **0007 Endorsed** | NCQA Supplemental items for CAHPS® 4.0 Adult Questionnaire (CAHPS 4.0H) | This supplemental set of items was developed jointly by NCQA and the AHRQ-sponsored CAHPS Consortium and is intended for use with the CAHPS 4.0 Health Plan survey. Some items are intended for Commercial health plan members only and are not included here. This measure provides information on the experiences of Medicaid health plan members with the organization. Results summarize member experiences through composites and question summary rates.<br><br>In addition to the 4 core composites from the CAHPS 4.0 Health Plan survey and two composites for commercial populations only, the HEDIS supplemental set includes one composite score and two item-specific summary rates.<br>1. Shared Decision Making Composite<br>1. Health Promotion and Education item<br>2. Coordination of Care item | | Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Medicare Part D Plan Rating | |

| Measure and NQF Status | Measure Title | Measure Description | Federal Programs: Under Consideration | Federal Program: Current Finalized | Pre-Rulemaking Guidance |
|---|---|---|---|---|---|
| **0008 Endorsed** | Experience of Care and Health Outcomes (ECHO) Survey (behavioral health, managed care versions) | 52- questions including patient demographic information. The survey measures patient experiences with behavioral health care (mental health and substance abuse treatment) and the organization that provides or manages the treatment and health outcomes. Level of analysis: health plan-HMO, PPO, Medicare, Medicaid, commercial | | | |
| **0022 Endorsed** | Use of High Risk Medications in the Elderly | a: Percentage of Medicare members 65 years of age and older who received at least one high-risk medication.<br><br>b: Percentage of Medicare members 65 years of age and older who received at least two different high-risk medications. For both rates, a lower rate represents better performance. | | Meaningful Use (EHR Incentive Program) - Eligible Professionals; Medicare Part D Plan Rating; Physician Feedback; Physician Quality Reporting System (PQRS); Value-Based Payment Modifier Program | |
| **0028 Endorsed** | Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention | Percentage of patients aged 18 years and older who were screened for tobacco use at least once during the two-year measurement period AND who received tobacco cessation counseling intervention if identified as a tobacco user | Physician Compare; Value-Based Payment Modifier Program | Meaningful Use (EHR Incentive Program) - Eligible Professionals; Medicare Shared Savings Program; Physician Quality Reporting System (PQRS) | |

| Measure and NQF Status | Measure Title | Measure Description | Federal Programs: Under Consideration | Federal Program: Current Finalized | Pre-Rulemaking Guidance |
|---|---|---|---|---|---|
| **0097 Endorsed Time-Limited** | Medication Reconciliation | Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented. | Long-term Care Hospital Quality Reporting; Physician Compare; Value-Based Payment Modifier Program | Medicare Shared Savings Program; Physician Feedback; Physician Quality Reporting System (PQRS) | Long-term Care Hospital Quality Reporting: Support direction, Not ready for implementation; measure concept is promising but requires modification or further development |
| **0101 Endorsed Time-Limited** | Falls: Screening for Future Fall Risk | Percentage of patients aged 65 years and older who were screened for fall risk (2 or more falls in the past year or any fall with injury in the past year) at least once within 12 months | Physician Compare; Value-Based Payment Modifier Program | Meaningful Use (EHR Incentive Program) - Eligible Professionals; Medicare Shared Savings Program; Physician Quality Reporting System (PQRS) | |
| **0166 Endorsed** | HCAHPS | 27-items survey instrument with 7 domain-level composites including: communication with doctors, communication with nurses, responsiveness of hospital staff, pain control, communication about medicines, cleanliness and quiet of the hospital environment, and discharge information | Long-term Care Hospital Quality Reporting; PPS-Exempt Cancer Hospital Quality Reporting | Hospital Inpatient Quality Reporting; Hospital Value-Based Purchasing | Long-term Care Hospital Quality Reporting: Support direction, Not ready for implementation; measure concept is promising but requires modification or further development |
| **0209 Endorsed** | Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment | Number of patients who report being uncomfortable because of pain at the initial assessment (after admission to hospice services) who report pain was brought to a comfortable level within 48 hours. | Physician Quality Reporting System (PQRS) | Hospice Quality Reporting | |

| Measure and NQF Status | Measure Title | Measure Description | Federal Programs: Under Consideration | Federal Program: Current Finalized | Pre-Rulemaking Guidance |
|---|---|---|---|---|---|
| **0228 Endorsed** | 3-Item Care Transition Measure (CTM-3) | Uni-dimensional self-reported survey that measure the quality of preparation for care transitions. | Hospital Value-Based Purchasing; Long-term Care Hospital Quality Reporting | Hospital Inpatient Quality Reporting | Long-term Care Hospital Quality Reporting MUC: Support direction, Not ready for implementation; measure concept is promising but requires modification or further development; Hospital VBP MUC: Support, Addresses a NQS priority not adequately addressed in the program measure set / Addresses a high-leverage opportunity for dual eligible beneficiaries / Enables measurement across the person-centered episode of care |
| **0258 Endorsed** | CAHPS In-Center Hemodialysis Survey | Percentage of patient responses to multiple testing tools. Tools include the In-Center Hemomdialysis Composite Score: The proportion of respondents answering each of response options for each of the items summed across the items within a composite to yield the composite measure score. ( Nephrologists' Communication and Caring, Quality of Dialysis Center Care and Operations, Providing Information to Patients)Overall Rating: a summation of responses to the rating items grouped into 3 levels | End-Stage Renal Disease Quality Reporting | | ESRD MUC: Support, Addresses a NQS priority not adequately addressed in the program measure set |

| Measure and NQF Status | Measure Title | Measure Description | Federal Programs: Under Consideration | Federal Program: Current Finalized | Pre-Rulemaking Guidance |
|---|---|---|---|---|---|
| **0260 Endorsed** | Assessment of Health-related Quality of Life in Dialysis Patients | Percentage of dialysis patients who receive a health-related quality of life assessment using the KDQOL-36 (36-question survey that assesses patients´ functioning and well-being) at least once per year. | | | |
| **0326 Endorsed** | Advance Care Plan | Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan | Long-term Care Hospital Quality Reporting | Physician Feedback; Physician Quality Reporting System (PQRS) | Long-term Care Hospital Quality Reporting MUC: Support direction, Not ready for implementation; measure concept is promising but requires modification or further development |
| **0418 Endorsed** | Screening for Clinical Depression | Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool and follow up plan documented. | Physician Compare; Value-Based Payment Modifier Program | Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Meaningful Use (EHR Incentive Program) - Eligible Professionals; Medicare Shared Savings Program; Physician Feedback; Physician Quality Reporting System (PQRS); HRSA | |
| **M233 Not Endorsed** | Pain Assessment Prior to Initiation of Patient Therapy | Percentage of patients with documentation of a pain assessment (if pain is present, including location, intensity and description) through discussion with the patient including the use | | Physician Feedback; Physician Quality Reporting System (PQRS) | |

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| | | of a standardized tool on each initial evaluation prior to initiation of therapy and documentation of a follow up plan. | | | |
| **0421 Endorsed Time-Limited** | Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up | Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside of normal parameters, a follow-up plan is documented Normal Parameters: Age 65 and older BMI > than or = to 23 and <30 Age 18 – 64 BMI > than or = to 18.5 and <25 | Physician Compare; Value-Based Payment Modifier Program | Meaningful Use (EHR Incentive Program) - Eligible Professionals; Medicare Shared Savings Program; Physician Feedback; Physician Quality Reporting System (PQRS); HRSA | |
| **0430 Endorsed Time-Limited** | 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. It was built using Item Response Theory (IRT) methods to achieve feasible, practical, and precise measurement of functional status (Hambleton 2000, Hambleton 2005). Based on factor analytic work and IRT analyses, 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 (Haley, 2004, 2004a, 2004b). | | | |

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| **Not Endorsed** | 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: Improved access and communication Measure 2: Care management using evidence-based guidelines Measure 3: Patient tracking and registry functions Measure 4: Support for patient self-management Measure 5: Test and referral trackingMeasure 6: Practice performance and improvement functions | | | |
| **0517 Endorsed** | CAHPS® Home Health Care Survey | The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Home Health Care Survey, also referred as the "CAHPS Home Health Care Survey" or "Home Health CAHPS" is a standardized survey instrument and data collection methodology for measuring home health patients´ perspectives on their home health care in Medicare-certified home health care agencies. AHRQ and CMS supported the development of the Home Health CAHPS to measure the experiences of those receiving home health care with these three goals in mind: (1) to produce comparable data on patients´ perspectives on care that allow objective and meaningful comparisons between home health agencies on domains that are important to consumers, (2) to create | | Home Health Quality Reporting | |

| Measure and NQF Status | Measure Title | Measure Description | Federal Programs: Under Consideration | Federal Program: Current Finalized | Pre-Rulemaking Guidance |
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| | | incentives for agencies to improve their quality of care through public reporting of survey results, and (3) to enhance public accountability in health care by increasing the transparency of the quality of care provided in return for public investment. As home health agencies begin to collect these data and as they are publicly reported, consumers will have information to make more informed decisions about care and publicly reporting the data will drive quality improvement in these areas. | | | |
| **0557 Endorsed** | HBIPS-6 Post discharge continuing care plan created | Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan created overall and stratified by age groups: Children (Age 1 through 12 years), Adolescents (Age 13 through 17 years), Adults (Age 18 through 64 years), Older Adults (Age greater than and equal to 65 years). Note: this is a paired measure with HBIPS-7: Post discharge continuing care plan transmitted to next level of care provider upon discharge. | | Inpatient Psychiatric Hospital Quality Reporting | |

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| **0558 Endorsed** | HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge | Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan provided to the next level of care clinician or entity overall and stratified by age groups: Children (Age 1 through 12 years), Adolescents (Age 13 through 17 years), Adults (Age 18 through 64 years), Older Adults (Age greater than and equal to 65 years).<br>Note: this is a paired measure with HBIPS-6: Post discharge continuing care plan created. | | Inpatient Psychiatric Hospital Quality Reporting | |
| **0576 Endorsed** | Follow-Up After Hospitalization for Mental Illness | This measure assesses the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported. Rate 1. The percentage of members who received follow-up within 30 days of discharge Rate 2. The percentage of members who received follow-up within 7 days of discharge. | Inpatient Psychiatric Hospital Quality Reporting; Physician Compare; Value-Based Payment Modifier Program | Children's Health Insurance Program Reauthorization Act Quality Reporting; Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Medicare Part C Plan Rating; Physician Feedback; Physician Quality Reporting System (PQRS) | IPFQR MUC: Support, Addresses a NQS priority not adequately addressed in the program measure set / Addresses a high-leverage opportunity for dual eligible beneficiaries / Enables measurement across the person-centered episode of care |

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| **0647 Endorsed** | Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) | Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the specified elements | Long-term Care Hospital Quality Reporting; Physician Quality Reporting System (PQRS) | | Long-term Care Hospital Quality Reporting MUC: Support direction, Not ready for implementation; measure concept is promising but requires modification or further development |
| **0648 Endorsed** | Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) | Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge | Long-term Care Hospital Quality Reporting; Physician Quality Reporting System (PQRS) | Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults | Long-term Care Hospital Quality Reporting MUC: Support direction, Not ready for implementation; measure concept is promising but requires modification or further development |

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| **0691 Endorsed** | Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Discharged Resident Instrument | The CAHPS® Nursing Home Survey: Discharged Resident Instrument is a mail survey instrument to gather information on the experience of short stay (5 to 100 days) residents recently discharged from nursing homes. This survey can be used in conjunction with the CAHPS Nursing Home Survey: Family Member Instrument and the Long Stay Resident Instrument. The survey instrument provides nursing home level scores on 4 global items. In addition, the survey provides nursing home level scores on summary measures valued by consumers; these summary measures or composites are currently being analyzed. The composites may include those valued by long stay residents: (1) Environment; (2) Care; (3) Communication & Respect; (4) Autonomy and (5) Activities. | | | |

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| **0692 Endorsed** | Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Long-Stay Resident Instrument | The CAHPS® Nursing Home Survey: Long-Stay Resident Instrument is an in-person survey instrument to gather information on the experience of long stay (greater than 100 days) residents currently in nursing homes. The Centers for Medicare & Medicaid Services requested development of this survey, and can be used in conjunction with the CAHPS Nursing Home Survey: Family Member Instrument and Discharged Resident Instrument. The survey instrument provides nursing home level scores on 5 topics valued by residents: (1) Environment; (2) Care; (3) Communication & Respect; (4) Autonomy and (5) Activities. In addition, the survey provides nursing home level scores on 3 global items. | | | |

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| **0693 Endorsed** | Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Family Member Instrument | The CAHPS Nursing Home Survey: Family Member Instrument is a mail survey instrument to gather information on the experiences of family members of long stay (greater than 100 days) residents currently in nursing homes. The Centers for Medicare & Medicaid Services requested development of this questionnaire, which is intended to complement the CAHPS Nursing Home Survey: Long-Stay Resident Instrument and the Discharged resident Instrument. The Family Member Instrument asks respondents to report on their own experiences (not the resident's) with the nursing home and their perceptions of the quality of care provided to a family member living in a nursing home. The survey instrument provides nursing home level scores on 4 topics valued by patients and families: (1) Meeting Basic Needs: Help with Eating, Drinking, and Toileting; (2) Nurses/Aides´ Kindness/ Respect Towards Resident; (3)Nursing Home Provides Information/Encourages Respondent Involvement; and (4) Nursing Home Staffing, Care of Belongings, and Cleanliness. In addition, the survey provides nursing home scores on 3 global items including an overall Rating of Care. | | | |

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| **0729 Endorsed** | Optimal Diabetes Care | The percentage of adult diabetes patients who have optimally managed modifiable risk factors (A1c, LDL, blood pressure, tobacco non-use and daily aspirin usage for patients with diagnosis of ischemic vascular disease) with the intent of preventing or reducing future complications associated with poorly managed diabetes.Patients ages 18 - 75 with a diagnosis of diabetes, who meet all the numerator targets of this composite measure: A1c < 8.0, LDL < 100, Blood Pressure < 140/90, Tobacco non-user and for patients with diagnosis of ischemic vascular disease daily aspirin use unless contraindicated.<br><br>Please note that while the all-or-none composite measure is considered to be the gold standard, reflecting best patient outcomes, the individual components may be measured as well. This is particularly helpful in quality improvement efforts to better understand where opportunities exist in moving the patients toward achieving all of the desired outcomes. Please refer to the additional numerator logic provided for each component. | Physician Compare; Value-Based Payment Modifier Program | Medicare Shared Savings Program; Physician Quality Reporting System (PQRS) | |
| **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 | Physician Quality Reporting System (PQRS) | | PQRS MUC: Support, NQF endorsed measure |

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| | | not done. | | | |
| **1632 Endorsed** | CARE - Consumer Assessments and Reports of End of Life | The CARE survey is mortality follow-back survey that is administered to the bereaved family members of adult persons (age 18 and older) who died of a chronic progressive illness receiving services for at least 48 hours from a home health agency, nursing homes, hospice, or acute care hospital. The survey measures perceptions of the quality of care either in terms of unmet needs, family reports of concerns with the quality of care, and overall rating of the quality of care. The time frame is the last 2 days of life up to last week of life spent in a hospice, home health agency, hospital, or nursing home. This is the "parent" survey of the Family Evaluation of Hospice Care Survey. | | | |

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| **1641 Endorsed** | Hospice and Palliative Care – Treatment Preferences | Percentage of patients with chart documentation of preferences for life sustaining treatments. | Hospice Quality Reporting; Physician Quality Reporting System (PQRS) | | PQRS MUC: Support, NQF endorsed measure; Hospice Quality Reporting MUC: Support, Addresses a NQS priority not adequately addressed in the program measure set |
| **1741 Endorsed** | Patient Experience with Surgical Care Based on the Consumer Assessment of Healthcare Providers and Systems (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 | Physician Quality Reporting System (PQRS) | | PQRS MUC: Support, NQF endorsed measure |

| Measure and NQF Status | Measure Title | Measure Description | Federal Programs: Under Consideration | Federal Program: Current Finalized | Pre-Rulemaking Guidance |
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| | | (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. | | | |
| **1768 Endorsed** | Plan All-Cause Readmissions | For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories:1. Count of Index Hospital Stays (IHS) (denominator)2. Count of 30-Day Readmissions (numerator)3. Average Adjusted Probability of Readmission 4. Observed Readmission (Numerator/Denominator)5. Total VarianceNote: For commercial, only members 18–64 years of age are collected and reported; for Medicare, only members 18 and older are collected, and only members 65 and older are reported. | | Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Medicare Part C Plan Rating | |

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| **1789 Endorsed** | Hospital-Wide All-Cause Unplanned Readmission Measure (HWR) | This measure estimates the hospital-level, risk-standardized rate of unplanned, all-cause readmission after admission for any eligible condition within 30 days of hospital discharge (RSRR) for patients aged 18 and older. The measure reports a single summary RSRR, derived from the volume-weighted results of five different models, one for each of the following specialty cohorts (groups of discharge condition categories or procedure categories): surgery/gynecology, general medicine, cardiorespiratory, cardiovascular, and neurology, each of which will be described in greater detail below. The measure also indicates the hospital standardized risk ratios (SRR) for each of these five specialty cohorts. We developed the measure for patients 65 years and older using Medicare fee-for-service (FFS) claims and subsequently tested and specified the measure for patients aged 18 years and older using all-payer data. We used the California Patient Discharge Data (CPDD), a large database of patient hospital admissions, for our all-payer data. | Hospital Inpatient Quality Reporting; Physician Quality Reporting System (PQRS) | Hospital Inpatient Quality Reporting | PQRS MUC: Support, NQF endorsed measure; IQR MUC/FIN: Support, New specifications are improvement over the existing finalized measure |
| **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. | | | |

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| **1902 Endorsed** | Clinicians/Groups' 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's 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) | | | |

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| **1904 Endorsed** | Clinician/Group's 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's 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). | | | |

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| **1909 Endorsed** | Medical Home System Survey (MHSS) | 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 continuityMeasure 2: Identify and manage patient populationsMeasure 3: Plan and manage careMeasure 4: Provide self-care support and community resourcesMeasure 5: Track and coordinate careMeasure 6: Measure and improve performance | | | |
| **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 | | | |

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| | | for public reporting. | | | |
| **Not Endorsed** | SNP 6: Coordination of Medicare and Medicaid Coverage | Intent: The organization helps members obtain services they are eligible to receive regardless of payer, by coordinating Medicare and Medicaid coverage. This is necessary because the two programs have different rules and benefit structures and can be confusing for both members and providers. | | | |