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January 28, 2013

George Isham, M.D, and Elizabeth McGlynn, PhD  
Co-Chairs, Measure Applications Partnership  
The National Quality Forum  
601 Thirteenth Street, NW  
Suite 500 North  
Washington, DC 20005

RE: Measure Applications Partnership Pre-Rulemaking Report: Public  
Comment Draft

Dear Co-Chairs Isham and McGlynn:

On behalf of the over 78,000 members of American College of Surgeons (ACS), I am writing to provide feedback to the Measure Applications Partnership (MAP) Pre-Rulemaking Report. The ACS is a scientific and educational association of surgeons, founded in 1913, to improve the quality of care for the surgical patient by setting high standards for surgical education and practice. The ACS has a strong interest in the development and endorsement of consensus standards that will help surgeons improve the quality and safety of their care and thereby improve outcomes for patients. The comments below are listed by report section.

### *Pre-Rulemaking Input on Clinician Performance Measurement Programs*

#### Clinician Workgroup's Guiding Principles

ACS generally supports the MAP's Clinician Workgroup's Guiding Principles. We believe that it is important for the national quality improvement enterprise that PQRS be broadly inclusive of measures to encourage physician participation and to act as a test bed to find measures which drive improvement in practice. Specifically, we support the following statement from MAP Pre-Rulemaking Report:



Measures that are not NQF-endorsed may be included if the measure supports alignment (e.g., outcome measures also used in MOC 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. Some measures that are not NQF-endorsed may not yet be fully tested, and PQRS can serve as a vehicle for gaining access to data for testing and provide implementation experience with these measures.<sup>1</sup>

We would also like to note our concern that the Clinician Workgroup's review of the clinician measures—led by the guiding principles—may not have analyzed the measures with the appropriate level of detail. Unlike the Hospital Workgroup which reviewed each measure individually, the Clinician Workgroup more broadly used the guiding principles to determine their recommendations. This may have resulted in missing subtleties in the measure specifications. We recommend that the Centers for Medicaid and Medicare Services (CMS) consider this in their internal review of the MAP recommendations for clinician-level measures.

### PQRS

ACS supports the MAP's conclusion and rationale to “*support the direction*” of the ACS surgical Measure Groups. The measures include:

- Appendectomy 1-4;
- AV Fistula 1-5;
- Cholecystectomy 1-4;
- Colectomy 1-6;
- Colonoscopy 1-4;
- Esophagogastroduodenoscopy (EGD) 1-2;

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<sup>1</sup> National Quality Forum. Measure Application Partnership Pre-Rulemaking Report: Public Comment Draft. January 2013: 21.

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- Hemorrhoidectomy 1-4;
- Inguinal Hernia 1-3;
- Mastectomy +/- Lymphadenectomy or SLNB 1-4;
- Partial Mastectomy or Breast Biopsy/Lumpectomy +/- Lymphadenectomy or SNLB 1-4;
- Skin/Soft Tissue Lesion Excision 1-4;
- Thyroidectomy 1-5;
- Inguinal Hernia 1-3;
- Ventral Hernia 1-5.

<b>Appendectomy Measures Group</b>	
M2817	Appendectomy 1: Iatrogenic injury to adjacent organ/structure (1 of 4)
M2818	Appendectomy 2: Unplanned reoperation within the 30 day postoperative period (2 of 4)
M2819	Appendectomy 3: Unplanned hospital readmission within 30 days of principal procedure (3 of 4)
M2791	Appendectomy 4: Surgical site infection (SSI) (4 of 4)
<b>AV Fistula Measures Group</b>	
M2792	AV Fistula 1: Iatrogenic injury to adjacent organ/structure(1 of 5)
M2822	AV Fistula 2: Post-operative death within 30 days of procedure (2 of 5)
M2823	AV Fistula 3: Unplanned reoperation within the 30 day postoperative period (3 of 5)
M2824	AV Fistula 4: Unplanned hospital readmission within 30days of principal procedure (4of 5)
M2825	AV Fistula 5: Surgical site infection (SSI) (5 of 5)
<b>Cholecystectomy Measures Group</b>	
M2846	Cholecystectomy 1: Iatrogenic injury to adjacent organ/structure (1 of 4)
M2847	Cholecystectomy 2: Unplanned reoperation within the 30 day postoperative period (2of 4)
M2848	Cholecystectomy 3: Unplanned hospital readmission within 30 days of principal procedure (3 of 4)
M2849	Cholecystectomy 4: Surgical site infection (SSI) (4 of 4)
<b>Colectomy Measures Group</b>	
M2850	Colectomy 1: Anastomotic Leak Intervention (1 of 6)
M2851	Colectomy 2: Iatrogenic injury to adjacent organ/structure (2 of 6)
M2852	Colectomy 3: Post-operative death within 30 days of procedure (3 of 6)
M2853	Colectomy 4: Unplanned reoperation within the 30 day postoperative period (4 of 6)
M2854	Colectomy 5: Unplanned hospital readmission within 30 days of principal procedure (5 of 6)
M2855	Colectomy 6: Surgical site infection (SSI) (6 of 6)
<b>Colonoscopy Measures Group</b>	

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M2856	Colonoscopy 1: Iatrogenic injury to adjacent organ/structure (1 of 4)
M2857	Colonoscopy 2: Cecal Intubation Rate (2 of 4)
M2858	Colonoscopy 3: Unplanned hospital readmission within 30 days of principal procedure (3 of 4)
M2859	Colonoscopy 4: Examination time during endoscope withdrawal, when no biopsies or polypectomies are performed (4 of 4)
<b>Esophagogastroduodenoscopy (EGD) Measures Group</b>	
M2864	Esophagogastroduodenoscopy (EGD) 1: Iatrogenic injury to adjacent organ/structure (1 of 2)
M2865	Esophagogastroduodenoscopy (EGD) 2: Unplanned intubation (2 of 2)
<b>Hemorrhoidectomy Measures Group</b>	
M2867	Hemorrhoidectomy 1: Bleeding requiring transfusion (1 of 4)
M2868	Hemorrhoidectomy 2: Iatrogenic injury to adjacent organ/structure (2 of 4)
M2869	Hemorrhoidectomy 3: Unplanned reoperation within the 30 day postoperative period (3 of 4)
M2870	Hemorrhoidectomy 4: Unplanned hospital readmission within 30 days of principal procedure (4 of 4)
<b>Inguinal Hernia Measures Group</b>	
M2895	Inguinal Hernia 1: Iatrogenic injury to adjacent organ/structure (1 of 3)
M2896	Inguinal Hernia 2: Unplanned reoperation within the 30 day postoperative period (2 of 3)
M2897	Inguinal Hernia 3: Unplanned hospital readmission within 30 days of principal procedure (3 of 3)
<b>Mastectomy +/- Lymphadenectomy or SLNB Measures Group</b>	
M2901	Mastectomy +/- Lymphadenectomy or SLNB 1: Iatrogenic injury to adjacent organ/structure (1 of 4)
M2902	Mastectomy +/- Lymphadenectomy or SLNB 2: Unplanned reoperation within the 30 day postoperative period (2 of 4)
M2903	Mastectomy +/- Lymphadenectomy or SLNB 3: Unplanned hospital readmission within 30 days of principal procedure (3 of 4)
M2904	Mastectomy +/- Lymphadenectomy or SLNB 4: Surgical site infection (SSI) (4 of 4)
<b>Partial Mastectomy or Breast Biopsy/Lumpectomy +/- Lymphadenectomy or SLNB Measures Group</b>	
M2910	Partial Mastectomy or Breast Biopsy/Lumpectomy +/- Lymphadenectomy or SLNB 1: Iatrogenic injury to adjacent organ/structure (1 of 4)
M2911	Partial Mastectomy or Breast Biopsy/Lumpectomy +/- Lymphadenectomy or SLNB 2: Unplanned reoperation within the 30 day postoperative period (2 of 4)
M2912	Partial Mastectomy or Breast Biopsy/Lumpectomy +/- Lymphadenectomy or SLNB 3: Unplanned hospital readmission within 30 days of principal

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	procedure (3 of 4)
M2913	Partial Mastectomy or Breast Biopsy/Lumpectomy +/- Lymphadenectomy or SLNB 4: Surgical site infection (SSI) (4 of 4)
<b>Skin / Soft Tissue Lesion Excision Measures Group</b>	
M2940	Skin / Soft Tissue Lesion Excision 1: Iatrogenic injury to adjacent organ/structure (1 of 4)
M2941	Skin / Soft Tissue Lesion Excision 2: Unplanned reoperation within the 30 day postoperative period (2 of 4)
M2942	Skin / Soft Tissue Lesion Excision 3: Unplanned hospital readmission within 30 days of principal procedure (3 of 4)
M2943	Skin / Soft Tissue Lesion Excision 4: Surgical site infection (SSI) / wound dehiscence (4 of 4)
<b>Thyroidectomy Measures Group</b>	
M2945	Thyroidectomy 1: Recurrent laryngeal nerve injury (1 of 5)
M2946	Thyroidectomy 2: Neck hematoma / bleeding (2 of 5)
M2947	Thyroidectomy 3: Iatrogenic injury to adjacent organ/structure (3 of 5)
M2948	Thyroidectomy 4: Unplanned reoperation within the 30 day postoperative period (4 of 5)
M2949	Thyroidectomy 5: Unplanned hospital readmission within 30 days of principal procedure (5 of 5)
<b>Ventral Hernia Measures Group</b>	
M2957	Ventral Hernia 1: Iatrogenic injury to adjacent organ/structure (1 of 5)
M2958	Ventral Hernia 2: Postoperative death within 30 days of procedure (2 of 5)
M2959	Ventral Hernia 3: Unplanned reoperation within the 30 day postoperative period (3 of 5)
M2790	Ventral Hernia 4: Unplanned hospital readmission within 30 days of principal procedure (4 of 5)
M2789	Ventral Hernia 5: Surgical site infection (SSI) (1 of 5)

The American Board of Surgery (ABS) has endorsed these measures because they deemed these procedures and outcomes to be the most important to measure for individual surgeons. Likewise, they are some of the most common procedures performed in the U.S. Inclusion of these measures also follows the Clinician Workgroup's Guiding Principles which supports alignment with MOC programs and registries, as the ABS will base their MOC on these Measure Groups. These measures will function as a way for surgeons to learn their strengths and identify areas for improvement which will promote life-long learning and enhancement of patient quality of care.

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MAP did not support the direction of several ACS surgical Measure Groups. These measures include:

- Bariatric Lap Band Procedure 1-3;
- Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass 1-6;
- Bariatric Sleeve Gastrectomy 1-6; and
- Varicose Veins 1-3.

<b>Bariatric Lap Band Procedure Measures Group</b>	
M2828	Bariatric Lap Band Procedure 1: Iatrogenic injury to adjacent organ/structure (1 of 3)
M2826	Bariatric Lap Band Procedure 2: Unplanned reoperation within the 30 day postoperative period (2 of 3)
M2827	Bariatric Lap Band Procedure 3: Unplanned hospital readmission within 30 days of principal procedure (3 of 3)
<b>Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass Measures Group</b>	
M2829	Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass 1: Anastomotic Leak Intervention (1 of 6)
M2830	Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass 2: Iatrogenic injury to adjacent organ/structure (2 of 6)
M2831	Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass 3: Unplanned reoperation within the 30 day postoperative period (3 of 6)
M2832	Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass 4: Unplanned hospital readmission within 30 days of principal procedure (4 of 6)
M2833	Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass 5: Surgical site infection (SSI) (5 of 6)
M2834	Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass 6: Bleeding Requiring Transfusion (6 of 6)
<b>Bariatric Sleeve Gastrectomy Measures Group</b>	
M2835	Bariatric Sleeve Gastrectomy 1: Leak Intervention (1 of 6)
M2836	Bariatric Sleeve Gastrectomy 2: Iatrogenic injury to adjacent organ/structure (2 of 6)
M2837	Bariatric Sleeve Gastrectomy 3: Unplanned reoperation within the 30 day postoperative period (3 of 6)
M2838	Bariatric Sleeve Gastrectomy 4: Unplanned hospital readmission within 30 days of principal procedure (4 of 6)
M2839	Bariatric Sleeve Gastrectomy 5: Surgical site infection (SSI) (5 of 6)
M2840	Bariatric Sleeve Gastrectomy 6: Bleeding Requiring Transfusion (6 of 6)
<b>Varicose Veins Measures Group</b>	
M2954	Varicose Veins 1: Iatrogenic injury to adjacent organ/structure (1 of 3)

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M2955	Varicose Veins 2: Venous thromboembolism (VTE) (2 of 3)
M2956	Varicose veins 3: Surgical site infection (SSI) (3 of 3)

It is inconsistent that the MAP “supported direction” of the ACS surgical Measure Groups listed in the previous section and did not support direction for these ACS surgical Measure Groups. The ABS has endorsed these measures because they deemed these procedures and outcomes to be the most important to measure for individual surgeons. They are also some of the most common procedures performed in the U.S. Inclusion of these measures follows the Clinician Workgroup’s Guiding Principles which supports alignment with MOC programs and registries.

The MAP report states that “bariatric surgery is of low importance to this (PQRS) program.” However, we would like to share some important information that may not have been recognized during the evaluation of the bariatric procedures. Indeed, the Medicare population is specifically an at-risk population for obesity and its consequences. Eligibility for Medicare benefits include age >65 and disability including end-stage renal disease (ESRD). Numerous studies have also detailed the impact of obesity leading to disability. In a 2008 Obesity Review article, Neovius and colleagues found that patients with a BMI>35 had a three-fold risk of being disabled.<sup>2</sup> The same article highlighted the strong impact of bariatric surgery upon potential reversal of disability with a doubling of return to work for obese disabled patients who had surgical treatment for their obesity. Flegal in a 2010 JAMA article found a 12.1 percent incidence of BMI>35 in the population age >60.<sup>3</sup> Obesity has also been found to lead to increased waiting times for ESRD patients awaiting transplant leading to weight-related disparities in care for these Medicare patients in need.<sup>4</sup>

<sup>2</sup> Neovius K, Johansson K, Kark M, Neovius M. Obesity status and sick leave: a systematic review. *Obes Rev.* 2009; 10(1):17-27.

<sup>3</sup> Flegal KM, Carroll MD, Ogden CL, Curtin LR. Prevalence and trends in obesity among US adults, 1999-2008. *JAMA.* 2010;303(3):235-41.

<sup>4</sup> Segev DL, Simpkins CE, Thompson RE, Locke JE, Warren DS, Montgomery RA. Obesity impacts access to kidney transplantation. *J Am Soc Nephrol.* 2008;19(2):349-55.

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In point of fact, Medicare beneficiaries include age >65, disabled, have ESRD, or beneficiaries who have dual eligibility for both Medicare and Medicaid. The overall Medicare population aged <65 is conservatively at least 17 percent of the overall Medicare population.<sup>5</sup> Furthermore, the disabled Medicare population age <65 is disproportionately at risk for being or becoming obese with significantly more comorbidities than the average bariatric population or, in general, they would not have been categorized as disabled. Similarly, ESRD patients may be disenfranchised from kidney transplantation because of their weight, as referenced earlier. Finally, the Medicare Social Security Disability Insurance population represents a very high-risk group who would benefit from bariatric surgery. Coverage of the bariatric surgery could lower the total cost of management of the high risk Medicare patient (such as those with obesity hypoventilation syndrome, chronic congestive heart failure (CHF), re- or post transplant patients), while providing a more effective procedure, especially for Type 2 Diabetes Mellitus, than the gastric band, also covered by CMS.

In addition, another of the Clinician Workgroup's principles is to ensure that measures are included that are "clinically relevant to specialties that do not currently have clinically relevant measures." The inclusion of these measures would ensure that bariatric surgeons have measures included in PQRS and are able to participate in the program.

For these reasons, the quality of care being delivered to this population should be measured. In conclusion, we disagree that bariatric surgery was thought to be of "low importance" to the PQRS program, and we recommend that the MAP support the direction of these measures.

#### *Surgical Site Infection (SSI) Measures*

ACS would like to clarify the rationale supporting individual surgical site infection (SSI) measures within each proposed surgical Measure Group. We included an SSI component in each of the following surgical measure groups:

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<sup>5</sup> The Henry J. Kaiser Family Foundation. Medicare and nonelderly people with disabilities: fact sheet. 2010. Accessed on January 28, 2013 at <http://www.kff.org/medicare/upload/8100.pdf>.

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- Appendectomy 4,
- AV Fistula 5,
- Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass 3,
- Bariatric Sleeve Gastrectomy 5,
- Cholecystectomy 4,
- Colectomy 6,
- Mastectomy +/- Lymphadenectomy or SLNB 4,
- Partial Mastectomy or Breast Biopsy/Lumpectomy +/- Lymphadenectomy or SLNB
- Skin/Soft Tissue Lesion Excision 4,
- Varicose Veins 3, and
- Ventral Hernia 5.

While the MAP supported the direction of including SSI measures within each measure group, it also commented that they have previously recommended the measure entitled ACS-CDC Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure (NQF #0753) “be expanded to address SSI’s for other conditions; a clinician-level measure aligned with the endorsed facility-level measure is preferred.”

ACS agrees that for other reasons there is value in including a broad SSI measure for surgery generally—particularly to track SSI in procedures that are not part of the surgeries specified for the measures submitted as part of these Measure Groups. However, we believe it is important to recognize that these measures are part of Measure Groups directed at tracking the quality of specific common and important procedures, given these are what the ABS has endorsed as the important information for tracking quality of care for general surgeons. Several procedure-specific outcomes are examined to have a more comprehensive snapshot of the success of the procedure. Likewise, they are some of the most common procedures performed in the U.S. Inclusion of these measures also follows the Clinician Workgroup’s Guiding Principles which supports alignment with MOC programs and registries.

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In response to the NQF's "additional finding" response, if NQF #0753 were to be specified for clinician-level measurement and include multiple procedures, the information would not be as meaningful for surgeons or to the ABS for MOC. A broader measure may not be as actionable for quality improvement compared to a procedure-specific Measure Group. For example, it is important to know if a surgeon has higher odds of an SSI compared to the average surgeon for a given procedure. This rationale was similarly applied to the ACS-CDC measure (NQF #0753) which was endorsed for colectomy and hysterectomy. For the reasons outlined, we recommend the MAP to consider deleting the "additional findings" of the SSI measures which recommends broader measures.

*Post-Operative Death within 30 days of Principal Procedure Measures*

ACS would like to clarify the rationale supporting ACS Post-operative Death within 30 Days of Principal Procedure measures. The MAP supported the direction of these measures but commended that "Broader mortality measures are preferred." The measures were included for the following Measure Groups:

- AV Fistula 2,
- Colectomy 3, and
- Ventral Hernia 2.

It is important to recognize that these measures are part of surgical Measure Groups. Several procedure-specific outcomes are examined to have a more comprehensive snapshot of the success of the procedure. Furthermore, the ABS has endorsed these measures because they deemed these procedures and outcomes to be the most important to measure for individual surgeons. Likewise, they are some of the most common procedures performed in the U.S. Inclusion of these measures follows the Clinician Workgroup's Guiding Principles which supports alignment with MOC programs and registries.

In response to NQF's "additional findings" which recommend a broader mortality measure, it is important to note that in order to be more meaningful for quality improvement and for purposes of MOC, surgeons need to know mortality rates by procedure and in relation to elective versus emergent rates. A

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broader measure may not be as actionable for individual surgeons to improve quality and safety compared to a procedure-specific Measure Group. Therefore, we recommend the MAP to consider deleting the “additional findings” of the mortality measures within these measure groups which recommends the preference of broader measures.

*Unplanned Hospital Readmission within 30 Days of Principal Procedure Measures*

ACS would like to clarify the rationale supporting the ACS Unplanned Hospital Readmission within 30 Days of Principal Procedure measures. These measures were included in the following Measure Groups:

- Appendectomy 3;
- AV Fistula 4;
- Bariatric Lap Band Procedure 3;
- Bariatric Laparoscopic or Open Roux-en Y Gastric 4;
- Bariatric Sleeve Gastrectomy 4;
- Cholecystectomy 3;
- Colectomy 5;
- Colonoscopy 3;
- Hemorrhoidectomy 4;
- Inguinal Hernia 3;
- Mastectomy +/- Lymphadenectomy or SLNB 3;
- Partial Mastectomy or Breast Biopsy/Lumpectomy +/- Lymphadenectomy or SNLB 3;
- Skin/Soft Tissue Lesion Excision 3;
- Thyroidectomy 5; and
- Ventral Hernia 4.

The MAP supported the direction of these measures but commended that “broader readmission measures are preferred.” It is important to recognize that these measures are part of the ACS surgical Measure Groups. Several procedure-specific outcomes are examined to have a more comprehensive snapshot of the success of the procedure. Additionally, the ABS has endorsed

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these measures because they deemed these procedures and outcomes to be the most important to measure for individual surgeons. Likewise, they are some of the most common procedures performed in the U.S. Inclusion of these measures follows the Clinician Workgroup's Guiding Principles which supports alignment with MOC programs and registries.

In response to NQF's "additional findings" which recommend a broader readmission measure, it is important to note that in order to be more meaningful for quality improvement purposes, surgeons need to know readmission rates by procedure. A broader measure may not be as actionable for individual surgeons to improve quality and safety compared to a procedure-specific measure group. Therefore, we recommend the MAP to consider deleting the "additional findings" of the ACS readmission measures which recommends the preference of broader measures.

#### *Percutaneous Central Line Placement*

NQF did not support the direction of the Percutaneous Central Line Placement (M2919, M2920, M2921) measure group, including the central line-associated bloodstream infection (CLABSI) measure. NQF stated that the "measure does not adequately address any current needs of the program," and that the "NQF-endorsed CLABSI should be explored for use at the individual clinician level of analysis." However, this measure group addresses the National Quality Strategy priorities, and is a high-impact condition that is one of the most common procedures performed by surgeons in the U.S. The ABS has endorsed this Measure Group and the included measures because they deemed these procedures and outcomes to be the most important to measure for individual surgeons. Inclusion of these measures follows the Clinician Workgroup's Guiding Principles which supports alignment with MOC programs and registries. Therefore, we recommend the MAP support the direction of this measure group, including analysis at the clinician level and delete the "additional findings" which recommends specifying the current NQF-endorsed CLABSI measure for use at the individual clinician level of analysis.

#### *Patient-Centered Surgical Risk Assessment Measure*

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NQF's MAP did not support the measure entitled Patient-Centered Surgical Risk Assessment: the percent of patients who underwent non-emergency major surgery who received preoperative risk assessment for procedure-specific postoperative complications using a data-based patient-specific risk calculator and who had a personal discussion of these risks with a surgeon (M2916). This may be one of the most important measures to include in PQRS. The report did not provide rationale behind MAP's decision. ACS believes that measuring risk assessment and communication between surgeons and patients is critical to ensure informed consent and shared decision-making. The Patient-Centered Surgical Risk Assessment "risk calculator" provides a personalized, empirically-based estimate of a patient's risk of post-operative complications based on their demographics, comorbidities, and indication for the operation. Evidence suggests that sharing numeric estimates of patient-specific risk will engage patients, improve informed consent, and may enhance patient trust in providers.<sup>6</sup> This measure is at the core of patient-centered surgical care. To this end, we strongly recommend that MAP support this measure because it aligns with both the "patient and family engagement" and "communication and care coordination" priorities of the National Quality Strategy.

#### Physician Compare

MAP stated that Clinician and Group CAHPS (CG-CAHPS), "while not finalized for use in any federal clinician measurement program, 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." ACS wants to stress that the CG-CAHPS is not equally meaningful to surgical patients, and therefore the CAHPS Surgical Care Survey (S-CAHPS) should also be recommended for inclusion on Physician Compare after a year of being reported in PQRS. If CG-CAHPS is the sole patient experience of care measure, CMS runs the risk of applying an inappropriate patient experience of care survey to surgical practice groups.

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<sup>6</sup> Gurmankin AD, Baron J, Armstrong K. The effect of numerical statements of risk on trust and comfort with hypothetical physician risk communication. *Medical decision making: an international journal of the Society for Medical Decision Making*. May-Jun 2004;24(3):265-271.

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S-CAHPS has been tested by the same standards as the CG-CAHPS, is NQF-endorsed, follows the same collection mechanism as the CG-CAHPS, and is just as accurate. S-CAHPS expands on the CG-CAHPS by focusing on aspects of surgical quality which are important from the patient's perspective and for which the patient is the best source of information. The survey asks patients to provide feedback on surgical care, surgeons, their staff, and anesthesia care. It assesses patients' experiences with surgical care in both the inpatient and outpatient settings by asking respondents about their experience before, during, and after surgery. If S-CAHPS is included as an option to be reported on Physician Compare, physicians could then select the patient experience of care survey that is most appropriate to their group practice and patients could receive information which better reflects the care provided by a surgical group.

### ***Pre-Rulemaking Input on Hospital Performance Measurement Programs***

#### **Hospital Inpatient Quality Reporting**

The MAP supported the inclusion of the Hospital-Wide All-Cause Unplanned Readmission Measure (HWR) measure (NQF #1789). ACS has previously provided comments to NQF that we do not support the inclusion of this measure until it is better specified and evaluated. We especially opposed this measure for use in performance-based payment as it was previously specified. Our past concerns have highlighted that that this measure is very broad with respect to populations evaluated and yet constrained to one outcome of uncertain meaning, therefore running contrary to "state of the art" modeling considerations for focusing carefully on patient subgroups and the risk factors and outcomes that are relevant to targeted subgroups. As a result, meaningful performance distinctions between different institutions for certain subpopulations appear likely to be clouded and does not provide actionable data. We understand that this measure is currently being updated and is pending NQF endorsement. We will follow its progress closely to be sure that there is consensus that it meets the state of the art modeling for risk factors and is appropriate for quality improvement and public reporting.

#### ***General Comments***

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We are very appreciative of the opportunity to provide feedback and recognize the volume of work and strict timeline under which the MAP operates. However, we strongly believe that a two week comment period is not a reasonable amount of time for public comment for the MAP Pre-Rulemaking Report. The Report reviewed more than 500 measures and did not provide clear supporting materials for the public and NQF members. A thirty day comment period would allow for more thoughtful public comment and greater provider participation.

We appreciate the opportunity to comment on MAP's Pre-Rulemaking Report. The ACS looks forward to continuing dialogue with the MAP on these important issues. If you have any questions about our comments, please contact Jill Shelly, Senior Quality Associate in the Division of Advocacy and Health Policy for questions. She may be reached at [jshelly@facs.org](mailto:jshelly@facs.org) or at (202) 672-1507.

Sincerely,

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