NATIONAL QUALITY FORUM

Measure Applications Partnership

MAP Member Guidebook

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Document Version Log

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Contents

I. The National Quality Forum

Who is NQF?

The National Quality Forum (NQF), established in 1999, is a nonprofit, nonpartisan, membership-based organization that is recognized and funded in part by Congress and entrusted with an important public service responsibility: NQF brings together various public- and private-sector organizations to reach consensus on how to measure quality in healthcare to make it better, safer, and more affordable.

NQF was created by a coalition of public- and private-sector leaders in response to the recommendation of the *Advisory Commission on Consumer Protection and Quality in the Health Care Industry*.[i] In its final report, published in 1998, the commission concluded that an organization like NQF was needed to promote and ensure patient protections and healthcare quality through measurement and public reporting.

Who is involved at NQF?

NQF has more than 430 organizational members that give generously of their time and expertise. In 2017, more than 755 individuals volunteered on more than 40 NQF-convened committees, working groups, and partnerships. The NQF Board of Directors governs the organization and is composed of key public- and private-sector leaders who represent major stakeholders in America's healthcare system. Consumers and those who purchase healthcare hold a simple majority of the at-large seats.

Member organizations of NQF have the opportunity to take part in a national dialogue about how to measure healthcare quality and publicly report the findings. Members participate in NQF through one of eight Member Councils:

- Consumer Council
- Health Plan Council
- Health Professionals Council
- Provider Organizations Council
- Public/Community Health Agency Council
- Purchasers Council
- Quality Measurement, Research, and Improvement Council
- Supplier and Industry Council

Each of these councils provides unique experiences and views on healthcare quality that are vital to building broad consensus on improving the quality of healthcare in America. Together, NQF members promote a common approach to measuring and reporting healthcare quality and fostering system-wide improvements in patient safety and healthcare quality. NQF's membership spans all those interested in healthcare. Consumers and others who purchase healthcare sit side-by-side with those who provide care and others in the healthcare industry. Expert volunteers and members are the backbone of NQF work.

What does NQF do?

In 2002, working with all major healthcare stakeholders, NQF endorsed its first voluntary, national consensus performance measures to answer the call for standardized measurement of healthcare services. Over the years, NQF has assembled a portfolio of more than 600 NQF-endorsed measures—most of which are in use by both private and public sectors—and an enormous body of knowledge about measure development, use, and performance improvement. NQF plays a key role in shaping our national health and healthcare improvement priorities, including the National Quality Strategy, through its convening of the National Quality Partners. NQF also provides public input to the federal government and the private sector on optimal, aligned measure use via its convening of the Measure Applications Partnership.

NQF reviews, endorses, and recommends use of standardized healthcare performance measures. Performance measures are essential tools used to evaluate how well healthcare services are being delivered. NQF's endorsed measures often are invisible at the clinical bedside, but quietly influence the care delivered to millions of patients every day. Performance measures can:

- make our healthcare system more information rich;
- point to actions that physicians, other clinicians, and organizations can take to make healthcare safe and equitable;
- enhance transparency around quality and cost of healthcare;
- ensure accountability of healthcare providers; and
- generate data that helps consumers make informed choices about their care.

Working with members and the public, NQF also helps define our national healthcare improvement 'to-do' list, and encourages action and collaboration to accomplish performance improvement goals.

Who benefits from this work?

Standardized healthcare performance measures help clinicians and other healthcare providers understand whether the care they provided their patients was optimal and appropriate, and if not, where to focus their efforts to improve the care they deliver. Measures are also used by all types of public and private payers for a variety of accountability purposes, including public reporting and payment incentives. Measures are an essential part of making quality and cost of healthcare more transparent to all, importantly for those who receive care or help make care decisions for loved ones. Use of standardized healthcare performance measures allows for comparison across clinicians, hospitals, health plans, and other providers.

Where do I find NQF-endorsed measures?

The Quality Positioning System (QPS) is a web-based tool that helps you find NQF-endorsed measures. Search by measure title or number, as well as by condition, care setting, or measure steward. Driven by feedback from users, QPS 2.0 now allows users to search for measures by their inclusion in federal reporting and payment programs; to provide feedback any time about the use and usefulness of measures; and to view measures that are no longer NQF-endorsed. QPS can also be used to learn from

other measure users about how they select and implement measures in their performance improvement programs. The QPS may be accessed online.

Where do I find more information about NQF?

The Field Guide to NQF Resources is a dynamic, online resource to help those involved with measurement and public reporting to access basic information and NQF resources related to performance measurement.

Glossary of Terms

A comprehensive glossary of terms used in NQF activities as well as performance measurement and quality improvement in general can be found on the NQF website. You may also find the NQF Phrasebook to be a useful quick reference to understanding measurement jargon.

II. Measure Applications Partnership (MAP) Overview

What is the MAP?

The Measure Applications Partnership (MAP) was created by section 3014 of the Patient Protection and Affordable Care Act to provide input to the Department of Health and Human Services (HHS) on the selection of performance measures for Medicare public reporting and performance-based payment programs. MAP is a public-private partnership convened by NQF. MAP was created NQF was selected by HHS to fulfill a statutory requirement to convene multistakeholder groups to:

- identify the best available performance measures for use in specific applications;
- provide input to HHS on measures for use in public reporting, performance-based payment, and other programs; and
- encourage alignment of public- and private-sector performance measurement efforts.

In convening MAP, NQF brings together stakeholder groups in a unique collaboration that balances the interests of consumers, businesses and purchasers, labor, health plans, clinicians and providers, communities and states, and suppliers.

What are the objectives of MAP?

To help advance national healthcare priorities, MAP informs the selection of performance measures in federal programs to achieve the goal of improvement, transparency, and value for all. With that, the specified objectives of this partnership 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 across programs and across the public and private sectors to accelerate improvement, enhance system efficiency, and reduce provider data collection burden.

When MAP reviews performance measures, MAP prioritizes the selection of NQF-endorsed measures for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective. NQF-endorsed measures have undergone a rigorous multi-stakeholder evaluation to ensure that they address aspects of care that are important and feasible to measure, provide consistent and credible information, and can be used for comparing providers, public reporting, quality improvement and decision-making.

Additionally, NQF provides guidance and recommendations to enhance and update the Medicaid Adult and Child Core Sets of measures. NQF convenes the MAP Adult and Child Workgroups to provide this input.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) provided for the identification of a core set of healthcare quality measures for children enrolled in Medicaid and CHIP.

CMS and the Agency for Healthcare Research and Quality (AHRQ) jointly charged a group of experts with creating this core set of measures in 2009. The Child Core Set measures are relevant to children ages 0-18 as well as pregnant women in order to encompass both prenatal and postpartum quality-of-care issues. CHIPRA also required CMS to update the initial Core Set annually beginning in January 2013. MAP annually provides input on the Child Core Set.

The Affordable Care Act called for the creation of a core set of healthcare quality measures to assess the quality of care for adults enrolled in Medicaid. HHS published the initial Adult Core Set of measures in January 2012 in partnership with a subcommittee to AHRQ's National Advisory Council. It has been updated annually since 2014, with recent iterations reflecting input from MAP.

HHS established both the Child and Adult Core Sets to standardize the measurement of healthcare quality across state Medicaid and CHIP programs, assist states in collecting and reporting on the measures, and facilitate use of the measures for quality improvement.

The MAP Medicaid Workgroups facilitate this work and advise HHS on strengthening the Child and Adult Core Sets of measures by:

- Reviewing states' experiences reporting measures to date,
- Refining previously identified measure gap areas and recommending potential measures for addition to the sets, and
- Recommending measures for removal from the sets that are found to be ineffective.

How does MAP achieve its objectives?

MAP focuses on recommending high-quality measures that address national healthcare priorities, fill critical measurement gaps, and increase alignment of measures among public and private measurement programs.

Types of High-Priority Measures

For more than a decade the quality measurement enterprise— the many organizations focused on performance measurement to drive improvement in the quality and cost of healthcare provided in the United States—has rapidly grown to meet the needs of a diverse and demanding marketplace. As a result of greater experience with measurement, stakeholders have identified priorities for certain types of performance measures, described below. NQF's Standing Committees for measure endorsement are charged with reviewing measures to determine if they meet NQF's criteria to gain endorsement.

Outcome measures—Stakeholders are increasingly looking to outcome measures because the end results of care are what matter to everyone. Outcome measures assess rates of mortality, complications, and improvement in symptoms or functions. Outcome measures, including consumer experiences and patient- reported outcomes, seek to determine whether the desired results were achieved. Measuring performance on outcomes encourages a "systems approach" to providing and improving care.

Composite measures—Composite performance measures, which combine information on multiple individual performance measures into one single measure, are of increasing interest in healthcare

performance measurement and public accountability applications. According to the Institute of Medicine, such measures can enhance the performance measurement enterprise and provide a potentially deeper view of the reliability of the care system.

Measures over an episode of care—To begin to define longitudinal performance metrics of individual-level outcomes, resource use, and key processes of care, NQF has endorsed a measurement framework for patient-focused episodes of care. This framework proposes a patient-centered approach to measurement that focuses on patient-level outcomes over time—soliciting feedback on patient and family experiences; assessing functional status and quality of life; ensuring treatment options are aligned with informed patient preferences; and using resources wisely.

Measures that address healthcare disparities—NQF has established a broader platform for addressing healthcare disparities and cultural competency by identifying a set of disparities-sensitive measures among the existing NQF portfolio of endorsed measures. These disparities-sensitive measures should be routinely stratified and reported by race/ethnicity and language. Additionally, the disparities-sensitive criteria were finalized and incorporated into a prospective approach for the assessment of disparities sensitivity for all new and maintenance measures submitted to NQF.

Measures that are harmonized—The current quality landscape contains a proliferation of measures, including some that could be considered duplicative or overlapping, while other measures evaluate the same concepts and/or patient populations somewhat differently. Such duplicative measures and/or those with similar but not identical specifications may increase data collection burden and create confusion or inaccuracy in interpreting performance results for those who implement and use performance measures. Recognizing that NQF can take on more of a facilitator role while accounting for the needs of measure developers, NQF has proposed a revised process to foster harmonization and competing measures issues are adequately addressed and provide adequate time for measure developers to resolve questions.

Measures for patients with multiple chronic conditions—Under the direction of the multistakeholder Multiple Chronic Conditions (MCCs) Committee, NQF has developed a person-centric measurement framework for individuals with MCCs. Specifically, this framework provides a definition for MCCs, identifies high-leverage domains for performance measurement, and offers guiding principles as a foundation for supporting the quality of care provided to individuals with MCCs.

eMeasures (eCQMs) and Health Information Technology (HIT)—NQF is committed to improving healthcare quality through the use of health information technology (IT). Care can be safer, more affordable, and better coordinated when electronic health records (EHRs) and other clinical IT systems capture data needed to measure performance, and when that data are easily shared between IT systems. Our health IT initiatives— made up of several distinct yet related areas of focus— are designed to support an electronic environment based on these ideals; more importantly, these initiatives are designed to help clinicians improve patient care.

III. NQF Measure Endorsement

According to the Institute of Medicine (IOM) definition, a performance measure is the "numeric quantification of healthcare quality." IOM defines quality as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." Thus, performance measures can quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the provision of high-quality care.

Performance measures are widely used throughout the healthcare arena for a variety of purposes. Not all measures are suitable for NQF's dual purpose of accountability (including public reporting) and performance improvement. NQF does not endorse measures intended only for internal quality improvement.

NQF's ABCs of Measurement brochure describes various aspects of performance measurement:

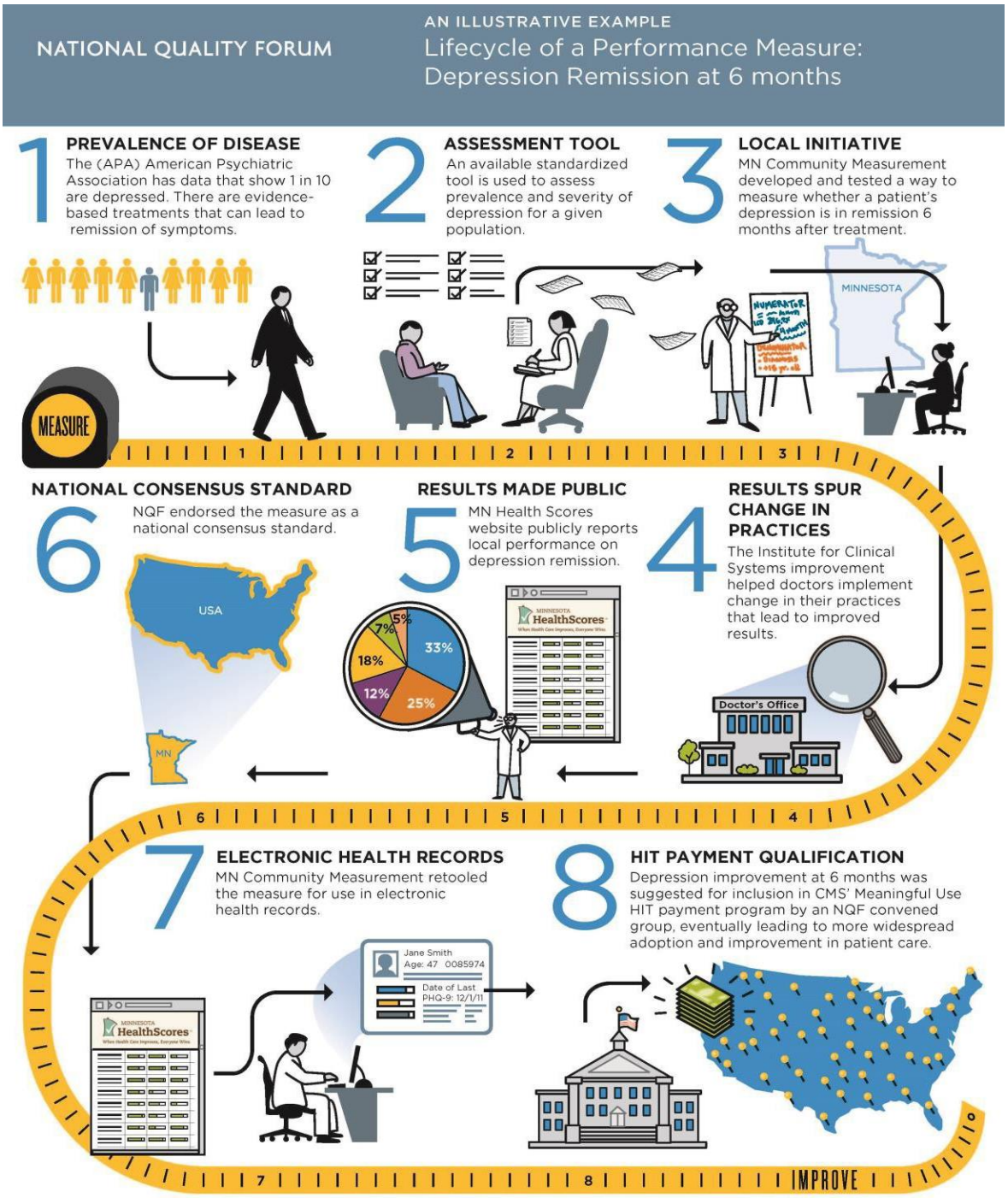
- The Difference a Good Measure Can Make
- Choosing What to Measure
- The Right Tools for the Job
- Patient-Centered Measures = Patient-Centered Results
- What NQF Endorsement Means
- How Endorsement Happens
- How Measures Can Work: Safety
- How Measures Will Serve Our Future
- What You Can Do

How does NQF endorse measures?

NQF uses a formal Consensus Development Process (CDP) to evaluate and endorse consensus standards, including performance measures, best practices, frameworks, and reporting guidelines. The CDP is designed to call for input and carefully consider the interests of stakeholder groups from across the healthcare industry. NQF's Consensus Development Process involves six principal steps. Each contains several substeps and is associated with specific actions. Because NQF uses this formal process, it is recognized as a voluntary consensus standards-setting organization as defined by the National Technology Transfer and Advancement Act of1995 and Office of Management and Budget Circular A-119.

The CDP plays an integral role in helping the Measure Applications Partnership assess the suitability of measures for use in various programs. The results of evaluation for endorsement inform MAP's decisions about measures' implementation in federal programs. For example, if a measure has been reviewed for endorsement through the CDP but failed to gain endorsement, MAP might be cautious in recommending it be used in a high-stakes federal program. Conversely, if a measure is NQF-endorsed, MAP can advise its use in a program with high confidence in its scientific properties.

The infographic below provides an illustrative example of the lifecycle of a performance measure from start to finish, including NQF's role in the process. MAP's role in measure selection is described in step 8. Endorsed measures are often recommended by MAP for use in federal quality measurement programs.


NATIONAL QUALITY FORUM
AN ILLUSTRATIVE EXAMPLE
Lifecycle of a Performance Measure: Depression Remission at 6 months
1
PREVALENCE OF DISEASE
The (APA) American Psychiatric Association has data that show 1 in 10 are depressed. There are evidence-based treatments that can lead to remission of symptoms.
2
ASSESSMENT TOOL
An available standardized tool is used to assess prevalence and severity of depression for a given population.
3
LOCAL INITIATIVE
MN Community Measurement developed and tested a way to measure whether a patient's depression is in remission 6 months after treatment.
MEASURE
MINNESOTA
4
RESULTS SPUR CHANGE IN PRACTICES
The Institute for Clinical Systems improvement helped doctors implement change in their practices that lead to improved results.
Doctor's Office
5
RESULTS MADE PUBLIC
MN Health Scores website publicly reports local performance on depression remission.
MINNESOTA HealthScores
5%
7%
33%
18%
12%
25%
6
NATIONAL CONSENSUS STANDARD
NQF endorsed the measure as a national consensus standard.
USA
MN
7
ELECTRONIC HEALTH RECORDS
MN Community Measurement retooled the measure for use in electronic health records.
Jane Smith
Age: 47 0085974
Date of Last
PHQ-9: 12/1/11
8
HIT PAYMENT QUALIFICATION
Depression improvement at 6 months was suggested for inclusion in CMS' Meaningful Use HIT payment program by an NQF convened group, eventually leading to more widespread adoption and improvement in patient care.
IMPROVE

IV. MAP Structure

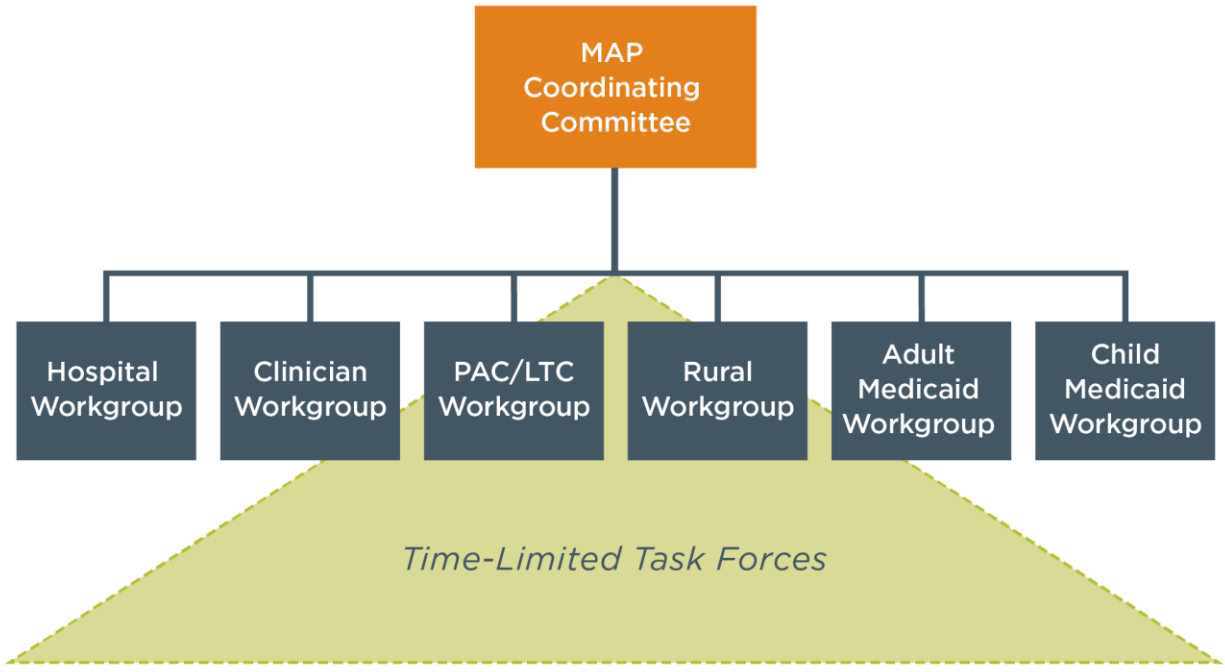
How is MAP structured?

MAP operates under a two-tiered structure consisting of a Coordinating Committee along with multiple workgroups and time-limited task forces convened as needed.

- The MAP Coordinating Committee provides strategic direction to MAP workgroups and task forces, and it reviews and provides final approval of the products, recommendations, and guidance developed by the different workgroups and task forces.
- MAP workgroups advise the Coordinating Committee on measures needed for specific care settings, care providers, and patient populations.
- MAP task forces are time-limited bodies that consider specific topics, such as core sets or families of measures, and provides analyses of those topics to the Coordinating Committee and workgroups. Their members are drawn from the MAP Coordinating Committee and workgroups.

The three setting-specific workgroups (Hospital, Clinician, and PAC/LTC) provide input to the pre-rulemaking process created by the ACA. The Adult and Child Medicaid workgroups provide input on the Medicaid Core Sets. The Rural Health Workgroup provides input on issues affecting healthcare quality in rural populations. While only the three setting specific Workgroups vote during the pre-rulemaking process, NQF seeks input from the Medicaid and Rural Health workgroups to ensure a focus on issues affecting those populations.

The MAP structure is depicted below:



Coordinating Committee

The Coordinating Committee serves as the governing body and makes all final recommendations regarding the inclusion of measures in federal programs. The six workgroups and ad hoc task forces provide input to the MAP Coordinating Committee designed to offer in-depth analyses of the measures proposed for program use. As noted above, the Coordinating Committee approves all MAP recommendations. The Coordinating Committee has the authority to reverse a Workgroup decision.

Hospital Workgroup

The Hospital Workgroup provides input to the Coordinating Committee on matters related to the selection and coordination of measures for hospitals, including inpatient acute, outpatient, cancer, and psychiatric hospitals. The Hospital Workgroup provides annual pre-rulemaking input on the following programs:

- Hospital Inpatient Quality Reporting and Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs
- Hospital Value-Based Purchasing
- Hospital Outpatient Quality Reporting
- Prospective Payment System Exempt Cancer Hospital Quality Reporting
- Inpatient Psychiatric Facility Quality Reporting
- Hospital Readmission Reduction Program
- Hospital-Acquired Condition Reduction Program
- Ambulatory Surgical Center Quality Reporting
- End-Stage Renal Disease Quality Incentive Program

Clinician Workgroup

The Clinician Workgroup provides recommendations for coordinating clinician performance measurement across federal programs. This is achieved by ensuring the alignment of measures and data sources to reduce duplication and burden, identifying the characteristics of an ideal measure set to promote common goals across programs, and implementing standardized data elements. The Clinician Workgroup provides annual pre-rulemaking input on the following programs:

- Merit-Based Incentive Payment System (MIPS)
- Medicare Shared Savings Program (MSSP)

Post-Acute Care/Long-Term Care (PAC/LTC) Workgroup

The PAC/LTC Workgroup reviews measures for post-acute and long-term care programs. Its aim is to establish performance measurement alignment across PAC/LTC settings while emphasizing that alignment must be balanced with consideration for the heterogeneity of patient needs across settings.

This is achieved by acknowledging the distinct types of care and levels of care across post-acute care and long-term care settings and identifying measures that can address these types and levels of care, while also taking into account the multiple provider types with varying payment structures (particularly differing requirements between Medicare and Medicaid). The workgroup also strives to standardize measure concepts across these settings while recognizing the need for measures to address the unique qualities of each setting. The PAC/LTC Workgroup provides annual pre-rulemaking input on the following programs:

- Home Health Quality Reporting Program
- Skilled Nursing Facility Quality Reporting Program
- Inpatient Rehabilitation Facility Quality Reporting Program
- Long-Term Care Hospital Quality Reporting Program
- Hospice Quality Reporting Program
- Skilled Nursing Facility Value-Based Purchasing Program

Adult and Child Medicaid Workgroups

In 2017-2018 the MAP Medicaid Adult and Child committees will convene as Workgroups rather than time-limited task forces. Historically, MAP Medicaid members convened as time-limited Task Forces and seated individuals based on MAP membership (e.g. pre-established Coordinating Committee and/or Hospital, Clinician, PAC/LTC Workgroups). The 2017-2018 Workgroup members will be seated through a formal nominations process. Workgroup members do not need to be existing members of MAP or NQF members.

The Medicaid Child and Adult Workgroups provide recommendations to revise, strengthen, and improve the Core Set of Health Care Quality Measures for adults enrolled in Medicaid (Medicaid Adult Core Set) and children enrolled in Medicaid and CHIP (Medicaid Child Core Set). The Workgroups also identify high-priority measure gaps specific to the Medicaid adult and child populations. The Adult Workgroup provides annual input on measures relevant to adults ages 18 and over. The Child Workgroup provides annual input on measures relevant to children ages 0-18 as well as pregnant women, in order to address pre-natal and post-partum quality of care issues. Both Workgroups give consideration to provider and state level burden of reporting and potential for alignment across state and federal quality reporting programs.

Rural Health Workgroup

Under contract with the Department of Health and Human Services (HHS), NQF will convene a new Rural Health Workgroup to advise HHS on the selection of rural-relevant measures most applicable for rural America. This workgroup will be comprised of up to 25 members with expertise in the areas of rural health, program implementation, and quality measurement. The Coordinating Committee will review and finalize the input of the Rural Health Workgroup.

During this 12-month period of performance, the Rural Health Workgroup will:

- develop a set of criteria for selecting measures and measure concepts;
- identify a set of the best available core set of (i.e., "rural relevant") measures to address the needs of the rural population (i.e., measures that potentially are applicable to CMS's hospital inpatient and outpatient quality reporting programs and its clinician-focused quality reporting programs);
- identify rural-relevant gaps in measurement,
- provide recommendations regarding alignment and coordination of measurements efforts across programs, care settings, specialties, and sectors (both public and private); and
- address a measurement topic relevant to vulnerable individuals in rural areas.

NQF will also work with the Rural Health Workgroup to provide input to the pre-rulemaking process. NQF staff will collaborate with the Rural Health Workgroup to highlight measures under consideration that may be particularly relevant to issues in the rural population. NQF will also brief the Rural Health Workgroup on the pre-rulemaking work.

MAP Task Forces

MAP has previously convened a number of taskforces. To better promote alignment around measures assessing key healthcare priorities, MAP convened a set of time-limited task forces to develop families of measures. Before 2017-2018, MAP convened Adult and Child Medicaid Taskforces to provide recommendations on the Medicaid Adult Core Set and Medicaid Child Core Set. Other prior task forces include the Health Insurance Exchange Task Force, the Measure Selection Criteria and Impact Task Force, and the Strategy Task Force. There are currently no active MAP taskforces.

IV. MAP Membership

NQF continually strives to improve its measure selection process so as to remain responsive to its stakeholders' needs. Volunteer, multistakeholder committees are the central component to this process, and the success of NQF's MAP work is due in large part to the participation of its members.

Composition of MAP Coordinating Committee and Workgroups

Each MAP group represents a variety of stakeholders, including consumers and patients, purchasers, providers, health professionals, health plans, suppliers and industry, community and public health, and healthcare quality experts. Because NQF attempts to represent a diversity of stakeholder perspectives on committees, a limited number of individuals from each of these stakeholder groups can be seated. MAP members do not need to be members of NQF.

MAP includes organizational members, individual subject-matter experts, and nonvoting federal liaisons. Organizational members represent the views of their entire constituency. Individual subject-matter experts represent themselves. Only organizational members may send a substitute to a MAP meeting to represent their perspective, provided that the substitute is identified in advance. All MAP members are encouraged to engage colleagues and solicit input from their stakeholder networks throughout the process.

MAP Member Terms

MAP members are appointed for three-year terms, with approximately one-third of the members eligible for reappointment or turnover each year. There are no term limits for MAP at this time.

MAP Expectations and Time Commitment

Participation in MAP requires a significant time commitment. Over the course of the member's term, several in-person meetings, web meetings, and teleconferences will be scheduled. MAP participation includes many activities that could include:

- Review meeting materials prior to each scheduled web or in-person meeting
- Participate in an annual web meeting to begin the pre-rulemaking cycle
- Attend scheduled in-person meetings of a workgroup or Coordinating Committee (1-2 annually, for up to 2 full days in Washington, DC)
- Participate in additional calls or web meetings as necessary
- Complete all surveys, pre-meeting assignments, and evaluations
- Consider serving on a MAP Task Force when invited.

If a member has poor attendance or participation, the NQF staff will contact the member asking if he/she would like to forego their MAP membership. Organizations may replace their representatives on MAP as they choose in order to ensure consistent participation. The total length of the organization's term would not change. If individual subject matter experts are unable to fulfill their terms (for any

reason), their seats would be removed during the annual nominations process and potentially given to other experts. An incoming expert would serve a full three-year term.

MAP Member Disclosure of Interest

Per the NQF Disclosure of Interest Policy for MAP, each nominee will be asked to complete a general disclosure of interest (DOI) form prior to being seated. The DOI form for each nominee is reviewed in the context of the programmatic areas in which MAP will be reviewing measures. Disclosures must be updated a minimum of annually, prior to any measure and programmatic review.

MAP Nomination Requirements

MAP's membership is recalibrated annually. The MAP Coordinating Committee and workgroup members have staggered terms, with approximately one-third of the combined organizational and subject matter expert seats up for consideration each year. To strengthen the pool of nominees, NQF staff broadly publicizes nominations, MAP membership, and NQF membership when the annual nominations process is open. In addition, staff will contact MAP members whose terms are expiring to explore interest in reappointment, but reappointment is not guaranteed.

To be considered for appointment to MAP, one must submit the following information:

- A completed online nomination form, including:
    - A brief statement of interest
    - A brief description of nominee expertise highlighting experience relevant to the committee
    - A short biography (maximum 100 words), highlighting experience/knowledge relevant to the expertise described above and involvement in candidate measure development
    - Curriculum vitae or list of relevant experience (e.g., publications) *up to 20 pages*
- A completed electronic disclosure of interest form. This will be requested upon your submission of the nominations form for Committees actively seeking nominees
- Confirmation of availability to participate in currently scheduled calls and meeting dates

Materials should be submitted through the NQF website. Self-nominations are welcome. Third-party nominations must indicate that the organization or individual has been contacted and is willing to serve. NQF's principles of transparency require a public call for nominations and the opportunity for the public to comment on the members selected for the multistakeholder groups.

MAP Member Responsibilities

- Strong commitment to advancing the performance measurement and accountability purposes of MAP.
- Willingness to work collaboratively with other MAP members, respect differing views, and reach agreement on recommendations. Input should not be limited to specific interests,

though sharing of interests is expected. Impact of decisions on all healthcare populations should be considered. Input should be analysis and solution-oriented— not reactionary.

- Ability to volunteer time and expertise as necessary to accomplish the work of MAP, including meeting preparation, attendance and active participation at meetings, completion of assignments, and service on task forces and ad hoc groups.
- Organizational MAP members will be responsible for identifying an individual to represent them.
- Commitment to attending meetings. Organizational representatives may request to send a substitute in exceptional circumstances and with advance notice; individual subject matter members will not be allowed to send substitutes to meetings.
- At the beginning of the pre-rulemaking cycle, NQF staff will contact each organizational member's leadership and ask the organization to designate potential substitutes for the pre-rulemaking cycle.
- Proxy voting, in which an organizational member votes on behalf of another organizational member, is not allowed under any circumstances. This is different from substitutes, in which the organization designates a different representative to represent its views at a particular meeting.
- If an organizational representative is repeatedly absent, the chair may ask the organization to designate a different representative.
- Demonstration of respect for the MAP decision-making process by not making public statements about issues under consideration until MAP has completed its deliberations.
- Acceptance of NQF's conflict of interest policy. Members will be required to publicly disclose their interests and any changes in their interests over time.

Role of the Co-Chairs and Chairs

Two Coordinating Committee members are selected to serve as co-chairs. Each workgroup is also led by two co-chairs. If a task force is convened then a chair or co-chairs will be appointed as well. The co-chairs' responsibilities are to:

- facilitate MAP meetings and teleconferences;
- work with NQF staff to achieve the goals of the project;
- assist NQF staff in anticipating questions and identifying additional information that may be useful to the Workgroup, Task Forces and/or Coordinating Committee during deliberations;
- participate as full voting members of MAP; and
- For workgroup/task force chairs, representing the perspective of the entire workgroup at Coordinating Committee meetings or teleconferences.

Guidelines for Participation in MAP Meetings

The following principles apply to all MAP meetings:

- **Disclosure of Interests** – Once a year, at the start of the pre-rulemaking process or other initiative, each MAP member is asked to disclose any potential conflicts of interest as identified on submitted Disclosure of Interest forms.
- **Open attendance** – Web and in-person meetings are open to the public. Participants can join the meeting in person at the NQF offices or remotely via web streaming and/or phone. Information about each meeting is available on the NQF website, including the meeting's agenda and materials.
- **Transparency** –All proceedings are recorded and transcribed. Recordings and/or summaries are posted on NQF's website.
- **Commenting** – NQF members and the public are provided opportunities to comment at designated times during the meeting.
- **Mutual respect** – As a multistakeholder group, MAP brings together varied perspectives, values, and priorities to the discussion. Respect for differences of opinion and collegial interactions with other MAP members and participants are critical. Members must avoid dominating a conversation and allow others to contribute their perspectives.
- **Efficiency in deliberations** – Meeting agendas are typically full. All MAP members are responsible for ensuring that the work of the meeting is completed during the time allotted. MAP members should be prepared for discussion, having reviewed the material before the meeting. Comments should be concise, focused, and relevant to the matter at hand. Members should remember to indicate agreement without repeating what has already been said.

SharePoint Site

- MAP members will receive the access link and password for the project SharePoint site.
- All project documents will be housed on SharePoint to provide ready access for all members.
- If you have difficulty accessing the SharePoint site, please contact the NQF project staff.

V. MAP's Annual Pre-Rulemaking Review of Measures Under Consideration

Overview

During the pre-rulemaking review cycle, the federal government looks to MAP, a public-private partnership convened by NQF, to advise on the selection of measures for CMS quality initiative and value-based purchasing programs. Under statute, HHS is required to publish annually by December 1st a list of measures under consideration for future federal rulemaking and to consider MAP's recommendations about the measures during the rulemaking process. The annual pre-rulemaking process affords MAP the opportunity to review the measures under consideration for federal rulemaking and provide upstream input to HHS in a global and strategic manner. Over the course of the review process, MAP promotes alignment across HHS programs and with private sector efforts, incorporates measure use and performance information into MAP decision-making, and provides specific recommendations about the best use of available measures and filling measure gaps.

Measures Under Consideration by HHS

Each year, HHS releases a list of measures being considered for use in a range of federal public-reporting, performance-based payment, and other programs. This list must be made available by December 1 annually. It is commonly abbreviated as the MUC list, short for "measures under consideration." The list of measures forms the basis of MAP's pre-rulemaking review.

MAP Measure Selection Criteria

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

To determine whether a measure should be considered for a specified program, the MAP evaluates the measures under consideration against the MSC. Additionally, the MSC serve as the basis for the preliminary analysis algorithm. MAP members are expected to familiarize themselves with the criteria and use them to indicate their support for a measure under consideration.

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

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

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

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

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

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

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

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

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

Subcriterion 2.3 Affordable care

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

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

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

Subcriterion 3.2 Measure sets for public reporting programs should be meaningful for consumers and purchasers

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

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

Subcriterion 3.5 Emphasize inclusion of endorsed measures that have eMeasure specifications available

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

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

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

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

Subcriterion 4.3 Payment program measure sets should include outcome measures linked to cost measures to capture value

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

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

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

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

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

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

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

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

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

7. Program measure set promotes parsimony and alignment

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

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

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

VI. MAP Evaluation Approach

The approach to the analysis and recommendation of measures is a five-step process:

1. **Develop Program Measure Set Framework**. Using CMS critical program objectives and NQF measure selection criteria, NQF staff will organize each program's finalized measure set. These frameworks will be used to better understand the current measures in the program as well as how well any new measures might fit into the program by allowing workgroup members to quickly and visually identify gaps and other areas of needs.
2. Conduct preliminary assessment of measures under consideration MAP uses the Measure Selection Criteria and a defined decision algorithm to determine whether the measures under consideration will enhance the program measure sets. Staff perform a preliminary analysis based on the algorithm
3. **Review preliminary recommendations**, MAP workgroups discuss the preliminary for each measure under consideration during December in-person meetings and make an initial recommendation to the Coordinating Committee for each measure under consideration. After a public commenting period, the Coordinating Committee meets to review the Workgroup recommendations and finalize the input to HHS.
4. **Identify and prioritize gaps for programs and settings.** MAP continues to identify gaps in measures within each program and provide measure ideas to spur development. MAP also considers the gaps across settings, prioritizing by importance and feasibility of addressing the gap when possible.
5. **Release reports of MAP's recommendations**. MAP issues a series of reports detailing its recommendations. On or before February 1, MAP issues a list each measure and MAP's resulting recommendation. On or before February 15, MAP issues its guidance for hospital and PAC/LTC programs. On or before March 15, MAP issues its guidance for clinician programs.

MAP's Standard Decision Categories

MAP reaches a decision about every measure under consideration. The decisions are standardized for consistency. Table 1 outlines the decision categories and the evaluation criteria used for each category. Each decision is also accompanied by one or more statements of rationale that explain why each decision was reached.

Table 1: MAP Decision Categories

Decision Category	Evaluation Criteria
Support for Rulemaking	The measure is fully developed and tested in the setting where it will be applied and meets assessments 1-6 of the MAP Preliminary Analysis Algorithm listed below. If the measure is in current use, it also meets assessment 7.
Conditional Support for Rulemaking	The measure is fully developed and tested and meets assessments 1-6. MAP will provide a rationale that outlines the conditions (e.g., NQF endorsement) based on assessments 4-7 (reference Table 2 below) that should be met. Ideally the conditions specified by MAP would be met before the measure is proposed for use. However, the Secretary retains policy discretion to propose the measure. CMS may address the MAP-specified conditions without resubmitting the measure to MAP prior to rulemaking.
Refine and Resubmit for Rulemaking	The measure meets assessments 1-3, but needs modifications. A designation of this decision category assumes at least one assessment 4-7 is not met. MAP will provide a rationale that outlines each suggested refinement (e.g., measure is not fully developed and tested OR there are opportunities for improvement under evaluation). Ideally, the modifications suggested by MAP would be made before the measure is proposed for use. However, the Secretary retains policy discretion to propose the measure. CMS may address the MAP-specified refinements without resubmitting the measure to the MAP prior to rulemaking. CMS may informally, without deliberations and voting, review these refinements via the "feedback loop" with the MAP. These updates may occur during the web meetings of the MAP workgroups scheduled annually in the fall.
Do Not Support for Rulemaking	The measure under consideration does not meet one or more of assessments 1-3.

Please note that measures receiving a designation of refine and resubmit may not be resubmitted to the MUC list. The feedback loop process was created to address MAP members' desire for more information about the development of a measure and how MAP's input was addressed. The feedback loop process takes place at the workgroups' fall web meetings.

Preliminary Analysis of Measures

To facilitate MAP's consent calendar voting process, NQF staff conduct a preliminary analysis of each measure under consideration. The preliminary analysis is intended to provide MAP members with a succinct profile of each measure and to serve as a starting point for MAP discussions. Staff use an algorithm developed from the MAP Measure Selection Criteria to evaluate each measure in light of MAP's previous guidance. The preliminary analysis algorithm will use a series of assessments to determine if a measure receives a recommendation of support for rulemaking, conditional support for rulemaking, refine and resubmit prior to rulemaking, or do not support.

Table 2: MAP Pre-Rulemaking Preliminary Analysis Algorithm

Assessment	Definition	Outcome
1) The measure addresses a critical quality objective not adequately addressed by the measures in the program set.	• The measure addresses the broad aims and one or more of the six National Quality Strategy priorities; or • The measure is responsive to specific program goals and statutory or regulatory requirements; or • The measure can distinguish differences in quality, is meaningful to patients/consumers and providers, and/or addresses a high-impact area or health condition.	Yes: Review can continue. No: Measure will receive a Do Not Support. MAP will provide a rationale for the decision to not support or make suggestions on how to improve the measure for a future support categorization.
2) The measure is evidence-based and is either strongly linked to outcomes or an outcome measure.	• For process and structural measures: The measure has a strong scientific evidence-base to demonstrate that when implemented can lead to the desired outcome(s). • For outcome measures: The measure has a scientific evidence-base and a rationale for how the outcome is influenced by healthcare processes or structures.	Yes: Review can continue No: Measure will receive a Do Not Support MAP will provide a rationale for the decision to not support or make suggestions on how to improve the measure for a future support categorization.
3) The measure addresses a quality challenge.	• The measure addresses a topic with a performance gap or addresses a serious reportable event (i.e. a safety event that should never happen); or	Yes: Review can continue No: Measure will receive a Do Not Support. MAP will provide a rationale for the decision to not support or

Assessment	Definition	Outcome
	• The measure addresses unwarranted or significant variation in care that is evidence of a quality challenge.	make suggestions on how to improve the measure for a future support categorization.
4) The measure contributes to efficient use of measurement resources and/or supports alignment of measurement across programs.	• The measure is either not duplicative of an existing measure or measure under consideration in the program or is a superior measure to an existing measure in the program; or • The measure captures a broad population; or • The measure contributes to alignment between measures in a particular program set (e.g. the measure could be used across programs or is included in a MAP "family of measures") or • The value to patients/consumers outweighs any burden of implementation.	Yes: Review can continue No: Highest rating can be refine and resubmit. MAP will provide a rationale for the decision to not support or make suggestions on how to improve the measure for a future support categorization.
5) The measure can be feasibly reported.	• The measure can be operationalized (e.g. the measure is fully specified, specifications use data found in structured data fields, and data are captured before, during, or after the course of care.)	Yes: Review can continue No: Highest rating can be Refine and Resubmit. MAP will provide a rationale for the decision to not support or make suggestions on how to improve the measure for a future support categorization.
6) The measure is reliable and valid for the level of analysis, program, and/or setting(s) for which it is being considered	• The measure is NQF-endorsed; or • The measure is fully developed and full specifications are provided; and • Measure testing has demonstrated reliability and validity for the level of analysis, program, and/or setting(s) for which it is being considered.	Yes: Measure could be supported or conditionally supported. No: Highest rating can be refine and resubmit. MAP will provide a rationale for the decision to not support or make suggestions on how to

Assessment	Definition	Outcome
		improve the measure for a future support categorization.
7) If a measure is in current use, no unreasonable implementation issues that outweigh the benefits of the measure have been identified.	• Feedback from end users has not identified any unreasonable implementation issues that outweigh the benefits of the measure; or • Feedback from implementers or end users has not identified any negative unintended consequences (e.g., premature discharges, overuse or inappropriate use of care or treatment, limiting access to care); and • Feedback is supported by empirical evidence.	If no implementation issues have been identified: Measure can be supported or conditionally supported. If implementation issues are identified: The highest rating can be Conditional Support. MAP can also choose to not support the measure, or request it be revised and resubmitted. MAP will provide a rationale for the decision to not support or make suggestions on how to improve the measure for a future support

NQF Member and Public Comment Periods

A major priority is to ensure broad input into the deliberations on measures. To encourage early input, NQF staff has formalized a process in which stakeholders can provide feedback on individual measures immediately after HHS provides the list of measures under consideration for the year. These public comments will be provided to MAP workgroups when reviewing the measures under consideration in December. Then, there will be another opportunity for public comment in which stakeholders can provide feedback on the individual workgroup decisions and broader measurement guidance for federal programs. These comments will be considered by the MAP Coordinating Committee when it approves the final decisions on measures and strategic input to the programs. Furthermore, during the workgroup and Coordinating Committee in-person meetings, the general public will have frequent opportunities to comment. The public will have an opportunity to comment on the *preliminary analysis* before each major discussion (by program or group of measures.).

When a comment period opens, a notification is posted on the NQF website and will be available through the event calendar and on the specific project page. NQF also sends out an email notification to NQF members and members of the public who have signed up for these notifications. Both NQF members and interested members of the public can submit comments on the list of measures under consideration, individual workgroup decisions, broader measurement guidance for federal programs, and Medicaid final reports. NQF members and nonmembers value the opportunity to weigh in on the

deliberations, often offering constructive criticism, alternative viewpoints, or support for the Committee's recommendations. As part of NQF's commitment to transparency, all submitted comments will be posted on the NQF website, where anyone can review them.

Workgroup Review of Measures under Consideration

The Hospital, Clinician, and PAC/LTC workgroups meet in-person each December to evaluate measures under consideration and make recommendations about their potential use in federal programs. These recommendations are then reviewed by the MAP Coordinating Committee in January. In preparation for in-person meetings, MAP members receive detailed materials, typically four to seven days before the meeting. The timeframe depends on how soon CMS makes the MUC list public. Familiarizing oneself with the content prior to the meeting is critical.

Although they do not vote during the pre-rulemaking process, NQF staff work with the Medicaid and Rural Health Workgroups to get input on how the measures under consideration could affect those populations and incorporate that input into the deliberations of the other workgroups and Coordinating Committee.

Coordinating Committee Review

The Coordinating Committee is charged with setting the strategic direction for MAP, reviewing the process MAP uses to make its recommendations, and finalizing all input to HHS. The MAP Coordinating Committee meets prior to the in-person meetings of the MAP workgroups. This meeting is focused on reviewing the process the Workgroups will use to make their initial guidance and providing upstream guidance on strategic issues. By reviewing the decision-making framework used by the workgroups, the Coordinating Committee will provide strategic guidance on key issues, such as defining measure impact, the goals of alignment, and filling measure gaps.

As noted above, the Coordinating Committee meets again after the winter in-person workgroup meetings to finalize MAP recommendations to HHS, and identify cross cutting themes across the workgroup deliberations. The Coordinating Committee considers the Workgroup recommendations, public and NQF member comments. The Coordinating Committee has the authority to reverse a Workgroup decision. The Coordinating Committee can choose to revisit a measure under consideration, have additional discussion, and vote for a different decision.

VII. MAP Voting Procedures

The voting procedures for the pre-rulemaking process have been updated for 2017-2018. The updates reflect the Coordinating Committee's guidance to remove the process to tally votes for more supportive categories with those of less supportive categories to achieve consensus. The Coordinating Committee noted that this process could give too much weight to a small number of votes. The new procedure asks for a separate vote on each proposed decision category.

Pre-Rulemaking Voting Procedure

Key Principles

The procedure described below is intended to allow MAP to move quickly through its decision-making process for straightforward and noncontroversial measures, reserving valuable discussion time for consensus-building on sensitive issues.

- MAP has established a consensus threshold of greater than 60 percent of participants.
    - Multiple stakeholder groups would need to agree to reach this threshold.
    - Abstentions do not count in the denominator.
- Every measure under consideration receive a decision, either individually or as part of a slate of measures.
- Workgroups and will be expected to reach a decision on every measure under consideration. There will not be a category of "split decisions" that would mean the Coordinating Committee decides on that measure. However, the Coordinating Committee may decide to continue discussion on a particularly important matter of program policy or strategy.
- Staff will provide an overview of the process for establishing consensus through voting at the start of each in-person meeting.
- After additional introductory presentations from staff and the chair to give context to each programmatic discussion, voting will begin.
- The in-person meeting Discussion Guide will organize content as follows:
    - Measures under consideration will be divided into a series of related groups for the purposes of discussion and voting. The groups are likely to be organized around programs (Hospital and PAC/LTC) or condition categories (Clinician/Medicaid/CHIP).
- Each measure under consideration will have been subject to a preliminary staff analysis based on a decision algorithm approved by the Coordinating Committee.
    - The discussion guide will note the result of the preliminary analysis (i.e., support, do not support, or conditional support, refine and resubmit) and provide rationale to support how that conclusion was reached.

Voting Procedure

The Workgroups and Coordinating Committee will use the same voting procedures.

- Step 1. Staff will review a Preliminary Analysis Consent Calendar
    - Staff will present the consent calendar reflecting the result of the preliminary analysis using MAP selection criteria and programmatic objectives.
- Step 2. MUCs can be pulled from the Consent Calendar and become regular agenda items

- The co-chairs will ask the Workgroup members to identify any MUCs they would like to pull off the consent calendar. Any Workgroup member can ask that one or more MUCs on the consent calendar be removed for individual discussion. Workgroup members are asked to identify any MUCs to be pulled off for individual discussion prior to the in-person meeting, if possible.
- Workgroup members should clarify if they are pulling a measure for discussion only or if they disagree with the preliminary analysis and would like to vote on a new motion.
- Measures pulled for discussion will focus on resolving clarifying questions.
    - If during the course of discussion, a workgroup member determines the discussion has shown the need for a new vote a workgroup member can put forward a motion.
- Measures pulled for a vote should meet one of the following criteria:
    - Disagreement with the preliminary analysis
    - New information is available that would change the results of the algorithm
- Once all measures that the Workgroup would like to discuss are removed from the consent calendar, the co-chair will ask if there is any objection to accepting the preliminary analysis and recommendation of the MUCs remaining on the consent calendar
- If no objections are made for the remaining measures, the consent calendar and the associated recommendations will be accepted (no vote will occur at this time)

- Step 3. Discussion and Voting on Measures Identified for a New Motion
    - Workgroup member(s) who identified the need for discussion describe their perspective on the use of the measure and how it differs from the preliminary recommendation in the discussion guide.
        - If a motion is for conditional support or refine and resubmit the member making the making should clarify and announce the conditions or suggested refinements.
    - Workgroup member(s) assigned as lead discussant(s) for the relevant group of measures will be asked to respond to the individual(s) who requested discussion. Lead discussant(s) should state their own point of view, whether or not it is in agreement with the preliminary recommendation or the divergent opinion.
    - The co-chair will then open for discussion among the Workgroup. Other workgroup members should participate in the discussion to make their opinions known. However, one should refrain from repeating points already presented by others in the interest of time.
    - After the discussion, the Workgroup member who made the motion has the option to withdraw the motion. Otherwise, the Workgroup will be asked to vote on the motion.
        - If the motion is for conditional support or refine and resubmit the chair can accept additional conditions or suggested refinement based on the Workgroup's discussion.
        - If the named conditions or refinements directly contradict each other, the chair should ask for a separate motion after the original motion has been subject to a vote.
- Step 4: Tallying the Votes:

- If the motion put forward by the workgroup member receives greater than 60% of the votes, the motion will pass and the measure will receive that decision.
- If the motion does not receive greater than 60% of the votes, the co-Chairs will resume discussion to develop another motion. After the conclusion of discussion, the co-Chairs will put forward another motion. If that motion receives greater than 60% of the votes, the motion will pass. If not, discussion will resume.
- If a no motion put forward by the Workgroup achieves greater than 60% the preliminary analysis decision will stand.

VIII. MAP Pre-Rulemaking Reports

In addition to deliberating about specific measures, MAP identifies broader issues for each program, such as whether current metrics help the program achieve its goals, implementation challenges, and unintended consequences. By reviewing over 15 programs, MAP is also able to identify cross-cutting challenges and opportunities, such as opportunities for alignment across programs, areas for potential alignment between public and private programs, and progress in filling critical measurement gaps. This synthesis across programs is one of the ways in which MAP adds strategic value and captures the expertise of the multistakeholder group.

The final deliverables for the MAP pre-rulemaking activities will be separated into three distinct categories with different time frames. Separating the programmatic and individual measure analysis will make it easier for the report's readers to find the information most applicable to them. Staging their release also allows the reports to be more inclusive as it will provide longer commenting and review opportunities.

- *Stage 1: Recommendations on individual measures on the MUC list (February 1).* This deliverable, in spreadsheet format, gives feedback on each measure under consideration along with limited explanatory text. The spreadsheet is organized into a standardized format. This product would be released on February 1 to meet the statutory deadline.
- *Stage 2: Guidance for Hospital and PAC/LTC programs (February 15)*. This deliverable includes strategic guidance on the federal health programs focused on hospital and post-acute care/long-term care settings, as these programs generally have earlier timelines for proposed rules. This document highlights the key strategic issues that programs for that setting should consider, such as whether current metrics address program goals, gaps in current program measures, ongoing measure implementation challenges, unintended consequences, strategies for improving alignment with other public and private programs, and filling critical gaps.
- *Stage 3: Guidance for clinician and special programs (March 15).* This deliverable includes strategic guidance on clinician programs and special programs, such as the Medicare Shared Savings Plan. The content and format is similar to the stage 2 deliverable.

IX. MAP Medicaid Workgroups' Annual Review of Measures

Overview

As required by legislation, the Affordable Care Act (ACA) and the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), CMS annually publishes recommended changes to revise, strengthen, and improve the Medicaid Adult Core Set and Child Core Set, respectively. MAP has been charged with providing input on the use of performance measures to assess and improve the quality of care delivered to adults and children who are enrolled in Medicaid and CHIP. MAP considers the states' experiences voluntarily implementing the Core Sets when making recommendations. The annual process has allowed for a critical and practical review and understanding of the measures in use and how states engage with the program. HHS uses MAP's findings, including the state perspectives, to inform the statutorily required annual update of the Adult and Child Core Sets.

This work takes place annually in the spring and summer. NQF also seeks input to from the Medicaid Workgroups and identifies measures under consideration that may be especially relevant to the Medicaid population to ensure integration across MAP's work and to drive improvements in quality for vulnerable populations.

Approach

1. **Evaluate measures and the potential benefit of adding them to the Core Sets.** Guided by MAP's Measure Selection Criteria (MSC), a defined decision algorithm and feedback from the most recent year of state implementation, MAP reviews measures in the current Core Sets. Using the decision algorithm, NQF staff and Workgroup members review measures in the gap areas identified during the previous year's review and compile and present measures they judge to be a good fit. MAP discuss these measures largely based on their specification and the feasibility of implementing them for statewide quality improvement.
2. **Identify and prioritize gaps for programs and settings.** MAP identifies gap areas using state feedback, review of state reporting, and data on prevalent conditions affecting the Medicaid and CHIP populations. The list of measure gaps is used as a starting point for future discussions.

MAP Medicaid's Standard Decision Categories

MAP reaches a decision and votes on measures discussed by the workgroups. The decisions are standardized for consistency. Each decision is accompanied by one or more statements of rationale as to how and why each decision was reached. The table below provides the decision categories and sample rationales used for each category.

MAP Decision Categories and Example Rationales

MAP Decision Category	Rationale (Examples
Support	• Addresses a previously identified measure gap • Measures that are ready for immediate use • Promotes alignment across programs and settings

Conditional Support	• Pending endorsement by NQF • Pending CMS confirmation of feasibility • MAP can express the condition. It is open-ended.
Do Not Support	• Unlikely to come up in the Medicaid review but it would be how MAP signal a measure was inappropriate or a bad fit for use in the Core Sets

Preliminary Analysis of Medicaid Measures

As an enhancement to the process for recommending measures for the Medicaid Adult and Child Core Sets, MAP developed a preliminary analysis algorithm to support the staff review of potential measures. The Coordinating Committee reviewed and approved this algorithm during its January 2016 meeting. The algorithm developed to review measures in the Core Sets is also intended to provide MAP members with a succinct profile of each measure and to serve as a starting point for MAP discussions. The algorithm has been tweaked slightly to emphasis considerations such as alignment and feasibility.

Assessment	Definition	Outcome
1) The measure addresses a critical quality objective not adequately addressed by the measures in the program set.	• The measure addresses the broad aims and one or more of the six National Quality Strategy priorities; or • The measure is responsive to specific program goals and statutory or regulatory requirements; or • The measure can distinguish differences in quality, is meaningful to patients and providers, and/or addresses a high-impact area or health condition. • Focus on high impact areas and health conditions along with gap areas for Medicaid adult and child populations	Yes: Review can continue. Conditional Support: Task Force will provide a rationale for the decision to conditionally support or make suggestions on how to improve the measure or a future support categorization. No: Measure will receive a Do Not Support
2) The measure is evidence-based and is either strongly linked to outcomes or an outcome measure.	• For process and structural measures: The measure has a strong scientific evidence-base to demonstrate that when implemented can lead to the desired outcome(s). • For outcome measures: The measure has a scientific evidence-base and a rationale for how the outcome is	Yes: Review can continue Conditional Support: Task Force will provide a rationale for the decision to conditionally support or make suggestions on how to improve the measure for a future support categorization.

	influenced by healthcare processes or structures.	No: Measure will receive a Do Not Support
3) The measure addresses a quality challenge.	• The measure addresses a topic with a performance gap or addresses a serious reportable event (i.e. a safety event that should never happen); or • The measure addresses unwarranted or significant variation in care that is evidence of a quality challenge.	Yes: Review can continue Conditional Support: Task Force will provide a rationale for the decision to conditionally support or make suggestions on how to improve the measure for a future support categorization. No: Measure will receive a Do Not Support
4) The measure contributes to efficient use of measurement resources and/or supports alignment of measurement across programs.	• The measure is either not duplicative of an existing measure or measure under consideration in the program or is a superior measure to an existing measure in the program; or • The measure captures a broad population; or • The measure contributes to alignment between measures in a particular program set (e.g. the measure could be used across programs or is included in. a MAP "family of measures") or • The value to patients/consumers outweighs any burden of implementation. • Alignment across various non-Medicaid quality related Core Sets is facilitated, such as CMS Quality Collaborative Core Set-Adult Set.	Yes: Review can continue Conditional Support: Task Force will provide a rationale for the decision to conditionally support or make suggestions on how to improve the measure for a future support categorization. No: Measure will receive a Do Not Support

5) The measure can be feasibly reported.	• The measure can be operationalized (e.g. the measure is fully specified, specifications use data found in structured data fields, and data are captured before, during, or after the course of care.) • The can be feasibly implemented at the state Medicaid level. • Data for the measure can be collected easily. • The measure does not pose undue resource constrains on the state. • Medicaid agencies at the state level can implement measure without tweaking it and or changing the level of analysis.	Yes: Review can continue Conditional Support: Task Force will provide a rationale for the decision to conditionally support or make suggestions on how to improve the measure for a future support categorization. No: Measure will receive a Do Not Support
6) The measure is reliable and valid for the level of analysis, program, and/or setting(s) for which it is being considered	• The measure is NQF-endorsed; or • The measure is fully developed and full specifications are provided; and • Measure testing has demonstrated reliability and validity for the level of analysis, program, and/or setting(s) for which it is being considered.	Yes: Support measure. Conditional Support: Task Force will provide a rationale for the decision to conditionally support or make suggestions on how to improve the measure for a future support categorization. No: Measure will receive a Do Not Support
7) If a measure is in current use, no unreasonable implementation issues that outweigh the benefits of the measure have been identified.	• Feedback from end users has not identified any unreasonable implementation issues that outweigh the benefits of the measure; or • Feedback from implementers or end users has not identified any negative unintended consequences (e.g., premature discharges, overuse or inappropriate use of care or treatment, limiting access to care); and • Feedback is supported by empirical evidence.	Yes: Support measure. Conditional Support: Task Force will provide a rationale for the decision to conditionally support or make suggestions on how to improve the measure for a future support categorization.

		No: Measure will receive a Do Not Support

Review of Medicaid Measures During In-Person Meetings

MAP Medicaid Workgroups meet in-person each May to evaluate measures and make recommendations about their potential addition or removal from the Medicaid Core Sets. These recommendations are then reviewed by the MAP Coordinating Committee in August. In preparation for the web and in-person meetings, MAP members receive detailed materials, typically four to seven days before the meeting. Familiarizing oneself with the content prior to the meeting is critical.

Medicaid Workgroup Voting Procedure

- Step 1. Staff compile measures that address identified high-priority gap areas in the Core Sets.
    - Staff save the measures in a measure summary worksheet and present them to the workgroup members before the in-person meeting.
- Step 2. Measures can be suggested for review by workgroup members and become a measure for consideration during the in-person meeting
    - Workgroup members identify measures they would like to discuss from the measure summary worksheet compiled by staff or other sources. Any workgroup member can make a recommendation.
    - Measures recommended by workgroup member are judged to be a good fit based on the algorithm and preliminary analysis using MAP selection criteria and programmatic objectives
- Step 3. Voting on Measures
    - Workgroup members who recommend measures for discussion will be assigned as lead discussants. Lead discussants should state their own point of view, describe the measure specifications, how the measure addresses prevalent and/or high impact health conditions affecting the Medicaid and CHIP populations, and the feasibility of implementing the measure for statewide use.
    - Other workgroup members should participate in the discussion to make their opinions known. However, one should refrain from repeating points already presented by others in the interest of time.
    - After discussion of each measure, the Workgroup will vote on the measure with three options:
        - Support
        - Support with conditions
        - Do not support

Tallying the votes:

- If a measure receives > 60% for Support -- the recommendation is Support
- If a measure receives > 60% for Conditional Support – the recommendation is Conditional Support

- Otherwise the recommendation is "Do not support"
- Abstentions are discouraged and do not count in the denominator.

Public Comment

To ensure that there is broad input into the deliberations of the Medicaid Core Set measures, there are frequent opportunities for public comment during the web and in-person meetings. NQF members and public stakeholders can provide feedback on MAP's measure-specific recommendations to fill high-priority gaps in the Core Sets and strategic issues related to the programmatic context for the Adult Core Set and its relationship to the Child Core Sets and vice versa. Furthermore, NQF members and public stakeholders are invited to comment during a 30-day comment period on the Medicaid final reports. The final reports provide MAP's annual recommendations on the Adult and Child Core Sets.

Coordinating Committee Review

The Coordinating Committee meets after the Adult and Child Medicaid Workgroups to finalize MAP recommendations to HHS, and identify cross cutting themes across the workgroup deliberations. This usually occurs via web meeting in August.

Deliverables

MAP will issue two reports by August 31 each year covering Adult and Child Medicaid Core Sets. The Medicaid reports include recommendations on individual measures for addition or removal from the Medicaid Core Sets. All measure specific recommendations are focused on filling and addressing high-priority gaps. The Medicaid reports also summarize selected states' feedback on collecting and reporting measures. These reports cover cross-cutting strategic issues that span both the Adult and Child Core Sets, such as opportunities for alignment, ongoing measure implementation challenges, and filling critical gaps.

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[i] President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. *Advisory Commission's Final Report*. 1998. Available at: https://archive.ahrq.gov/hcqual/.