NATIONAL QUALITY FORUM
Driving measurable health improvements together

Measure Applications Partnership

MAP Member Guidebook

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Contents

National Quality Forum

Who is NQF?

The National Quality Forum (NQF), established in 1999, is a nonprofit, nonpartisan, membership-based organization. NQF is recognized and funded in part by the Centers for Medicare & Medicaid Services (CMS) and entrusted with an important public service responsibility of bringing together various public- and private-sector organizations to reach consensus on how to measure quality in healthcare as the nation works 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*.[a] In its final report, published in 1998, the Commission concluded that an organization such as 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 300 organizational fee-based members who give generously of their time and expertise. The NQF Board of Directors, which is composed of key public- and private-sector leaders who represent major stakeholders in America's healthcare system, governs the organization. Consumers and those who purchase healthcare hold a simple majority of the at-large seats. NQF's membership spans all those interested in healthcare. Consumers and those who purchase healthcare sit side-by-side with those who provide care and others in the healthcare industry.

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. NQF also provides public input to CMS on optimal, aligned measure use via its convening of the Measure Applications Partnership (MAP). Additionally, NQF convenes multistakeholder groups to explore and make recommendations for diverse measurement science topics, thus informing the quality measurement enterprise.

Who benefits from this work?

Both public and private payers use measures for a variety of accountability purposes, including public reporting and pay-for-performance. Measures are an essential part of making quality and cost of healthcare more transparent to all, which is important for those who receive care or help to 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 more information about NQF and endorsed measures?

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. The Quality Positioning System (QPS) is a web-based tool that helps you

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

find NQF-endorsed measures. This system allows users to search by measure title or NQF number, as well as by condition, care setting, measure steward, or several other characteristics.

Measure Applications Partnership Overview

What is the MAP?

MAP was created by section 3014 of the Patient Protection and Affordable Care Act (ACA) 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. NQF created MAP, contracted and funded by CMS, to fulfill a statutory requirement to convene multistakeholder groups to provide input to HHS on measures for use in public reporting, performance-based payment, and other programs.

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 MAP are as follows:

- Improve outcomes in high-leverage areas for patients and their families
- Align performance measurement across programs to provide consistent and meaningful information that supports provider/clinician improvement, informs consumer choice, and enables purchasers and payers to buy on value
- 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, it 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 multistakeholder 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.

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. 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 (U.S.)—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 charges its Standing

Committees with reviewing measures to determine whether they meet NQF's criteria to gain endorsement.

Types of High-Priority Measures

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 (PROs), seek to determine whether the desired results are achieved. Measuring performance on outcomes encourages a "systems approach" to providing and improving care.

Electronic clinical quality measures (eCQMs) and health information technology (IT)—NQF is committed to improving healthcare quality through the use of health IT. Care can be safer, more affordable, and better coordinated when electronic health records (EHRs) and other clinical IT systems capture the data needed to measure performance and when those data are easily shared between IT systems. NQF's health IT initiatives, which have 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.

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 person-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 align 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. The MAP Health Equity Advisory Group provides input and advice on healthcare disparities as part of the measure review process.

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 or patient populations somewhat differently. Such duplicative measures and those with similar but nonidentical specifications may increase data collection burden and create confusion or inaccuracy in interpreting performance results for those who implement and use performance measures. Recognizing its need to serve in a facilitator role while accounting for the needs of measure developers, NQF has proposed a revised process to foster harmonization, to ensure competing measures issues are adequately addressed, and to provide adequate time for measure developers to resolve questions on how to bring measure specifications into alignment.

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.

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 (IOM), such measures can enhance the performance measurement enterprise and provide a potentially deeper view of the reliability of the care system.

MAP Structure

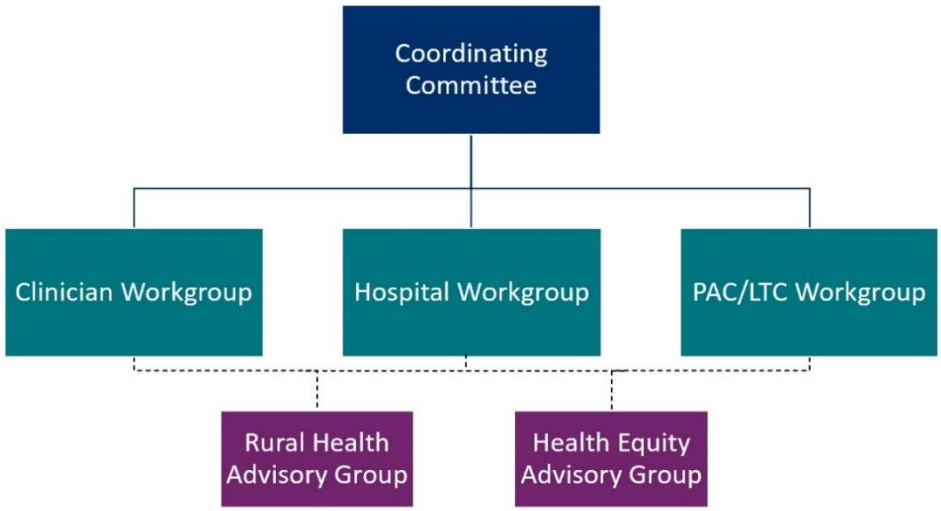
The Three Tiers of MAP

MAP operates under a three-tiered structure consisting of a Coordinating Committee along with three setting-specific Workgroups and two Advisory Groups.

- The MAP Coordinating Committee provides strategic direction to MAP Workgroups and provides final approval of the recommendations and guidance developed by the different Workgroups and Advisory Groups.
- MAP Workgroups advise the Coordinating Committee on measures needed for specific care settings, care providers, and patient populations.
- MAP Advisory Groups provide perspectives of stakeholders most affected by, and most knowledgeable about, quality challenges and potential solutions for rural communities and measurement issues affecting health disparities and the 1,000+ U.S. critical access hospitals to the Coordinating Committee and Workgroups.

The three setting-specific Workgroups (i.e., Hospital, Clinician, and Post-Acute Care/Long-Term Care [PAC/LTC]) provide input to the pre-rulemaking process created by the ACA. The Rural Health Advisory Group provides input on access, cost, or quality issues encountered by rural residents, data collection and/or reporting challenges, and potential unintended consequences for rural providers when reviewing proposed measures. The Health Equity Advisory Group provides input on measures under consideration (MUCs) with the goal to reduce health differences closely linked with social, economic, or environmental disadvantages. While only the three setting-specific Workgroups and the Coordinating Committee vote during the pre-rulemaking process, the Workgroups receive input from the Rural Health Advisory Group and the Health Equity Advisory Group to ensure a focus on issues affecting rural populations and health disparities.

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 three Workgroups and two Advisory Groups 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 and 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:

- Ambulatory Surgical Center Quality Reporting Program (ASCQR)
- End-Stage Renal Disease Quality Incentive Program (ESRD QIP)
- Hospital-Acquired Condition Reduction Program (HACRP)
- Hospital Inpatient Quality Reporting Program (Hospital IQR)
- Hospital Outpatient Quality Reporting Program (Hospital OQR)
- Hospital Readmissions Reduction Program (HRRP)
- Hospital Value-Based Purchasing Program (HVBP)
- Inpatient Psychiatric Facility Quality Reporting Program (IPFQR)
- Medicare Promoting Interoperability Program for Eligible Hospitals and Critical Access Hospitals (Medicare Promoting Interoperability Program)
- Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting Program (PCHQRP)

- Rural Emergency Hospital Quality Reporting Program (REHQRP)

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 Part C and D Star Ratings
- Medicare Shared Savings Program (Shared Savings Program)

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

The PAC/LTC Workgroup provides input on measures for post-acute care (PAC) and long-term care (LTC) 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 PAC and LTC settings and identifying measures that can address these types and levels of care while also considering the multiple provider types with varying payment structures (particularly differing requirements between Medicare and Medicaid). This 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 (HH QRP)
- Hospice Quality Reporting Program (HQRP)
- Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)
- Long-Term Care Hospital Quality Reporting Program (LTCH QRP)
- Skilled Nursing Facility Quality Reporting Program (SNF QRP)
- Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP)

Rural Health Advisory Group

NQF also works with the Rural Health Advisory Group to provide input to the pre-rulemaking process. The Rural Health Advisory Group highlights MUCs that may be particularly relevant to issues in the rural population (e.g., access, costs, or quality issues encountered by rural residents, data collection and/or reporting challenges, and potential unintended consequences for rural providers). The Rural Health Advisory Group helps to accomplish the following tasks:

- Provide input on measurement issues to MAP Workgroups and Coordinating Committee during the pre-rulemaking process and provide rural health perspectives on the selection of quality measures in MAP
- Identify rural-relevant gaps in measurement
- Provide input to help address priority rural health issues, including the challenge of low case-volume and access

Health Equity Advisory Group

Achieving health equity, eliminating disparities, and improving the health of all groups are commonly held goals across the U.S. healthcare system. Established for the 2021-2022 MAP cycle, NQF has convened a Health Equity Advisory Group to provide input on MUCs to HHS with a lens to measurement issues affecting health disparities and the 1,000+ U.S. critical access hospitals. The Health Equity Advisory Group provides input on MUCs with the goal to reduce health differences closely linked with social, economic, or environmental disadvantages. The Health Equity Advisory Group helps to accomplish the following tasks:

- Provide input to MAP Workgroups and Coordinating Committee during the pre-rulemaking process on measurement issues impacting health disparities and critical access hospitals
- Identify health disparity gaps in measurement
- Provide input to reduce health differences that are closely linked to social determinants of health

MAP Cycle

MAP's process for providing input to HHS on the selection of performance measures for public reporting and performance-based payment programs consists of a series of meetings that include planning meetings, orientations, preparation meetings, and review meetings. CMS' pre-rulemaking process includes public release of the MUC list. MAP's pre-rulemaking work is conducted by the Coordinating Committee, the Clinician Workgroup, the Hospital Workgroup, the PAC/LTC Workgroup, the Rural Health Advisory Group, and the Health Equity Advisory Group.

MAP Membership

Volunteer, multistakeholder groups are the central component of this process, and the success of NQF's MAP work is due in large part to the participation of its members.

Composition of MAP Groups

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. Due to the importance of representing diverse stakeholder perspectives within MAP groups, 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 (SMEs), and non-voting federal liaisons. Organizational members represent the views of their entire constituency. Individual SMEs 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. In some years, the desired staggering may not be achieved due to changes in the size of the MAP body. If the desired staggering is not achieved, NQF staff may take specific actions, such as reducing the number of seats appointed or appointing members for a shorter term (such as one or two years), during a specific annual nominations cycle. An exception is the new Health Equity Advisory Group, which had initial appointments consisting of two-year or three-year terms to minimize the risk of disruptive turnover. There are no member term limits for MAP.

MAP Expectations and Time Commitment

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

- Reviewing meeting materials prior to each scheduled web meeting
- Participating in an annual web meeting to begin the pre-rulemaking cycle
- Attending scheduled meetings of an Advisory Group, Workgroup or Coordinating Committee (one to two annually)
- Participating in additional calls or web meetings as necessary
- Completing all surveys, pre-meeting assignments, and evaluations

If a member has poor attendance or participation, NQF staff will contact the member and ask whether they 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 SMEs 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 NQF's Disclosure of Interest (DOI) Policy for MAP, each nominee will be asked to complete a general 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, Workgroup, and Advisory Group members have staggered terms, with approximately one-third of the combined organizational and SME 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. MAP members whose terms are expiring are welcome to submit a nomination once their term expires; however, reappointment is not guaranteed.

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

- A completed online nomination form, including the following:
    - 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 DOI form. This will be requested upon your submission of the nominations form for MAP groups actively seeking nominees
- Confirmation of availability to participate in currently scheduled calls and meeting dates

Materials should be submitted via 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, although sharing of interests is expected. The impact of decisions on all healthcare populations should be considered. Input should be analysis and solution oriented.
- 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 organization's identified contact 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 MAP's 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, including public disclosure of interests and any changes in interests over time.

Role of the Co-chairs

All MAP Committees, Workgroups, and Advisory Groups are led by two co-chairs. The co-chairs are selected by NQF staff. The co-chairs' responsibilities are as follows:

- 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 Advisory Group, Workgroup, or Coordinating Committee during deliberations
- Participate as full SME-voting members of MAP

All MAP co-chairs are appointed as individuals and should be, and should be perceived as, a neutral expert. Co-chairs are appointed to two-year terms and may serve up to two terms (four years total) as co-chairs. Co-chair terms will be staggered whenever possible to allow for overlap in terms for co-chair continuity and smooth transitions.

If an individual representing an organizational member is appointed as co-chair of a MAP group, the organizational member cannot appoint another individual as its representative. The organizational member seat is suspended (i.e., the organizational member does not lose any time on their term while serving as a co-chair); in other words, the organizational member may not appoint another individual to serve as its representative. If the co-chair steps down, the individual may resume their role as the organizational member representative, or the organizational member may appoint a different representative.

Guidelines for Participation in MAP Meetings

The following principles apply to all MAP meetings:

- **Disclosure of interests (DOI)** – Once a year, at the start of the pre-rulemaking process or other initiatives, each MAP member is asked to disclose any potential conflicts of interest as identified on submitted DOI forms.
- **Open attendance** – Web meetings are open to the public. Participants can join the meeting 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 Review Meetings are recorded. 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.

Measure Set Review (MSR)

Overview

For the 2021-2022 MAP cycle, NQF collaborated with CMS and the MAP Coordinating Committee to define a pilot process for Measure Set Review (MSR). In 2022, NQF expanded Measure Set Review to include both Advisory Groups, all three setting-specific Workgroups, and the Coordinating Committee. For more information, see the MAP Member Guidebook Appendix: Measure Set Review.

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

Overview

During the pre-rulemaking review cycle, CMS looks to MAP to advise on the selection of measures for CMS quality initiatives and VBP programs. Under statute, HHS is required to publish annually (by December 1) a list of measures under consideration (MUCs) for future federal rulemaking and to contract with a consensus-based entity (currently NQF) for the pre-rulemaking process to receive input on these measures. The annual pre-rulemaking process affords MAP, funded by CMS, the opportunity to review the MUCs 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, 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 CMS

Each year, CMS releases a list of measures being considered for use in a range of federal public-reporting and performance-based payment programs. It is commonly abbreviated as the MUC List. The list of measures forms the basis of MAP's pre-rulemaking review.

MAP Measure Selection Criteria (MSC)

MAP uses its measure selection criteria (MSC) to guide the review of the MUCs. The MSC are intended to assist MAP members 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. The central focus should be on the selection of high-quality measures that address key national healthcare priorities. Preferences for measure selection include evaluating the relative strengths and weaknesses of a program measure set and how the addition of an individual measure would contribute to the set.

To determine whether a measure should be considered for a specified program, MAP evaluates the MUCs 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 an MUC.

1. NQF-endorsed measures are preferred for program measure sets. Measures are based on scientific evidence and meet the requirements for validity, feasibility, reliability, and use.

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 uses impactful measures, which significantly advance healthcare outcomes for high-priority areas in which there is a demonstrated performance gap or variation.

Demonstrated by a program measure set that promotes improvement in key national healthcare priorities, such as CMS' Meaningful Measures Framework; emerging public health concerns; and ensuring that the set addresses key improvement priorities for all providers.

3. Program measure set is responsive to specific program goals and requirements, including all statutory 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 electronic clinical quality measure (eCQM) specifications available.*

4. Program measure set may include a mix of measure types; however, the highest priority is given to measures which are digital, or patient centered/patient-reported outcomes, and/or support equity. Process measures must have a direct and proven relationship to improved outcomes in a high-impact area in which there are no outcome, or intermediate outcome, measures.

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 and cost measures to capture value.*

5. Program measure set enables measurement of person- and family-centered care and services AND are meaningful to patients and useful in making best-care choices.

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 supports healthcare equity; helps identify gaps and disparities in care; and promotes accessible, culturally sensitive, and unbiased care for all.

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 versus 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 sets are aligned across programs and settings as appropriate and possible.

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 parsimony and 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 promote alignment and can be used across multiple programs or applications.*

MAP Evaluation Approach

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

1. **Conduct a preliminary assessment of measures under consideration.** MAP uses the MSC and a defined-decision algorithm to determine whether the MUCs will enhance the program measure sets. NQF staff perform a preliminary analysis for each MUC based on the algorithm.
2. **Review preliminary recommendations.** MAP Advisory Groups provide input about the rural perspective (i.e., Rural Health Advisory Group) and measurement issues affecting health disparities and critical access hospitals (i.e., Health Equity Advisory Group) for the MUCs. MAP Workgroups discuss the preliminary analysis for each MUC during December meetings and make an initial recommendation to the Coordinating Committee for each MUC. After a public commenting period ends, the Coordinating Committee meets to review the Workgroup recommendations and finalize the input to HHS.
3. **Identify and prioritize gaps for programs and settings.** Time permitting, 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.
4. **Release reports of MAP's recommendations.** MAP issues a series of reports detailing its recommendations. On or before February 1, MAP issues a list of measures with MAP's corresponding recommendations. 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.

Preliminary Analysis of Measures

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. NQF staff use an algorithm developed from MAP's MSC to evaluate each measure. This algorithm was approved by the MAP Coordinating Committee. As shown in **Table 1**, the preliminary analysis algorithm will use a series of assessments to determine whether a measure receives a recommendation of support for rulemaking, conditional support for rulemaking, do not support for rulemaking with potential for mitigation, or do not support.

Table 1. 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 key healthcare improvement 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 for Rulemaking." 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, it 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 for Rulemaking." 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 serious reportable event (i.e., a safety event that should never happen); or • The measure addresses unwarranted or significant variation or a gap in care that is evidence of a quality challenge.	Yes: Review can continue No: Measure will receive a "Do Not Support for Rulemaking." 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.

Assessment	Definition	Outcome
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 MUC 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 • The value to patients/consumers outweighs any burden of implementation.	Yes: Review can continue No: Highest rating can be "Do Not Support with Potential for Mitigation." 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 "Do Not Support with Potential for Mitigation." 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 applicable to and appropriately specified for the program's intended care setting(s), level(s) of analysis, and population(s).	• The measure is NQF endorsed; or • The measure is fully developed, and full specifications are provided; and • Measure specifications are provided 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 "Conditional Support for Rulemaking." 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.

Assessment	Definition	Outcome
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, and 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 for Rulemaking." MAP can also choose to not support the measure, with or without the potential for mitigation. 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.

MAP's Standard Decision Categories

MAP reaches a decision about every MUC. The decisions are standardized for consistency. **Table 2** 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 2. MAP Decision Categories

Decision Category	Definition	Evaluation Criteria
Support for Rulemaking	MAP supports implementation of the measure as specified and has not identified any conditions that should be met prior to implementation.	The measure is fully developed and tested in the setting where it will be applied, and it meets assessments #1-6 of the MAP preliminary analysis algorithm. If the measure is in current use, it also meets assessment #7.
Conditional Support for Rulemaking	MAP supports implementation of the measure as specified but has identified certain conditions or modifications that would ideally be addressed prior to implementation.	The measure meets assessments #1-3 but may need modifications. A designation of this decision category assumes at least one assessment from #4-7 is not met. MAP will provide a rationale that outlines each suggested condition (e.g., measure requires NQF review or endorsement 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 MAP prior to rulemaking.
Do Not Support for Rulemaking With Potential for Mitigation	MAP does not support implementation of the measure as specified. However, MAP agrees with the importance of the measure concept and has suggested modifications be required for potential support in the future. Such a modification would be considered a material change to the measure. A material change is defined as any modification to the measure specifications that significantly affects the measure result.	The measure meets assessments #1-3 but cannot be supported as currently specified. A designation of this decision category assumes at least one assessment from #4-7 is not met.
Do Not Support for Rulemaking	MAP does not support the measure.	The MUC does not meet one or more of assessments #1-3.

MAP members have expressed a desire to understand how their input has been addressed. The feedback loop process was created to address MAP members' request for more information about the development of a measure and how MAP's input was addressed. CMS may informally, without deliberations and voting, review these modifications via the "feedback loop" with MAP. These updates may occur during the web meetings of the MAP Workgroups scheduled annually in the fall.

NQF Member and Public Comment Periods

It is a priority to ensure broad input into the deliberations on measures. To garner early input, a process has been established so that stakeholders can provide feedback on individual measures immediately after HHS provides the MUC List for the year. These public comments will be provided to MAP Workgroups when reviewing the MUCs 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. The MAP Coordinating Committee will consider these comments when it approves the final decisions on measures and strategic input to the programs. Furthermore, during the Advisory Group, Workgroup, and Coordinating Committee 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 as well as 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 MUC List, individual Workgroup decisions, and broader measurement guidance for federal programs. 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. To ensure transparency, all submitted comments will be posted on the NQF website for public review as part of the meeting materials for the Workgroup and Coordinating Committee Review Meetings.

Workgroup and Advisory Group Review of Measures Under Consideration

The Hospital, Clinician, and PAC/LTC Workgroups meet each December to evaluate MUCs 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 the December meetings, MAP members receive detailed materials, typically five days before the Review Meeting. The time frame depends on how soon CMS publicizes the MUC List. Familiarizing oneself with the content prior to the meeting is critical.

Although they do not vote during the pre-rulemaking process, the Rural Health Advisory Group and the Health Equity Advisory Group convene to provide input on how the MUCs could affect the rural population and health disparities and incorporate that input into the deliberations of the 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. NQF works with the Coordinating Committee and the co-chairs to update the MAP processes, as needed, each cycle.

As noted above, the Coordinating Committee meets after the December Workgroup meetings to finalize MAP recommendations to HHS and time permitting, identify cross-cutting themes across the Workgroup deliberations. The Coordinating Committee considers the Workgroup recommendations and public and NQF member comments. The Coordinating Committee has the authority to reverse a Workgroup decision. The Coordinating Committee can choose to revisit a MUC, have additional discussion, and vote for a different decision.

MAP Voting Procedures

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, thus reserving valuable discussion time for consensus building on sensitive issues.

- Quorum is defined as 66 percent of the voting members of the Committee or Workgroup present virtually for live voting to take place.
    - Quorum must be established prior to voting. The process to establish quorum is composed of the following steps: (1) taking roll call and (2) determining whether a quorum is present. At this time, only if a member of the Committee or Workgroup questions the presence of a quorum is it necessary to reassess the presence of the quorum.
- If quorum is not established during the meeting, MAP will vote via electronic ballot after the meeting concludes.
- Virtual voting will occur via Poll Everywhere. Voting MAP members will be provided with a link to the poll prior to the meeting and will be instructed to follow the link in order to cast their vote during meetings.
- MAP has established a consensus threshold of greater than or equal to 60 percent of voting participants voting positively AND a minimum of 60 percent of the quorum figure voting positively.
    - Abstentions do not count in the denominator.
- Every MUC will receive a decision.
- Staff will provide an overview of the process for establishing consensus through voting at the start of each Review Meeting.
- After additional introductory presentations from staff and the co-chairs to give context to each programmatic discussion, voting will begin.
- The Review Meeting agenda will organize content as follows:
    - MUCs will be divided into a series of related groups for the purposes of discussion and voting.
- Each MUC will have been subject to a preliminary staff analysis based on a decision algorithm approved by the Coordinating Committee.
- MAP seated members will receive a copy of the detailed preliminary analysis and staff decisions (i.e., support, do not support, or conditional support) and rationale to support how that conclusion was reached.

- The Coordinating Committee will use a consent calendar for its Review Meeting. The purpose of the consent calendar is to focus the Coordinating Committee discussion on measures that elicited strong differences of opinion among workgroup members, measures that did not reach consensus, and measures for which new information emerged during public comment. Committee members will have an opportunity to pull measures for discussion during the public comment period.
    - NQF staff will put measures onto the consent calendar if a measure meets all of the following criteria:
        - 80 percent or greater of voting Workgroup members vote for the same decision category.
        - No process concern(s) is identified that may have affected the recommendation of a measure.
        - No new information is received through public comment that was not available or discussed during the Workgroup's measure Review Meeting, which is conflicting to the Workgroup's recommendation(s).
        - The measure was not pulled for discussion by the Coordinating Committee.

Advisory Group Discussion Procedure

- MAP Rural Health Advisory Group
    - MAP Rural Health Advisory Group will review/discuss and provide feedback on the impact each categorized measure group has on the following topics:
        - Better care for rural residents in terms of access, cost, or quality
        - Data collection and/or reporting challenges for rural providers
        - Methodological problems of calculating performance measures for small rural facilities
        - Potential unintended consequences for rural health providers or rural health populations
    - For those measures in which the group topics discussed do not apply, the MAP Rural Health Advisory Group will provide individual measure feedback
- MAP Health Equity Advisory Group
    - MAP Health Equity Advisory Group will review/discuss and provide feedback on the impact each categorized measure group has on the following topics:
        - Advancing health equity
        - Critical access hospitals (CAHs)
        - Data collection and/or reporting challenges related to health disparities
        - Methodological problems of calculating measure performance after adjusting for health disparities
        - Potential unintended consequences related to health disparities
    - For those measures in which the group topics discussed do not apply, the MAP Health Equity Advisory Group will provide individual measure feedback

Workgroup Voting Steps

- Step 1. NQF staff will review the preliminary analysis for each MUC using the MAP selection criteria, including summarizing the Advisory Group discussions, public comment, and programmatic objectives.

- Step 2. A CMS representative will present a brief overview and/or contextual background on the MUC.
- Step 3. Lead discussants will review and present their findings.
    - Workgroup member(s) will be assigned as lead discussant(s) based on knowledge and experience with measure topics while balancing the opportunity to serve as a lead discussant to as many members as possible. Lead discussants are asked to review their assigned measures in advance of the meeting and will be asked during the meeting to respond to the staff's preliminary assessment for the measure. 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.
- Step 4. The co-chairs 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.
    - Measure developers will respond to the clarifying questions and concerns on the specifications of the measure.
    - NQF staff will respond to clarifying questions and concerns on the preliminary analysis.
- Step 5. The Workgroup will vote on acceptance of the preliminary analysis decision.
    - After discussion ends, the co-chairs will open the floor for a vote on accepting the preliminary analysis assessment. This vote will be framed as a yes-or-no vote to accept the result.
    - If greater than or equal to 60 percent of the Workgroup members vote to accept the preliminary analysis assessment, then the preliminary analysis assessment will become the Workgroup recommendation. If less than 60 percent of the Workgroup votes to accept the preliminary analysis assessment, discussion will continue on the measure.
- Step 6. Discussion and voting on the MUC will take place if less than 60 percent accept the preliminary analysis assessment.
    - After discussion ends, the co-chairs will open the MUC for a vote.
        - Co-chairs will summarize the major themes of the Workgroup's discussion.
        - The co-chairs will determine what decision category will be put to a vote first based on potential consensus emerging from the discussions. If the co-chairs do not feel there is a consensus position to use to begin voting, the Workgroup will take a vote on each potential decision category one at a time. The first vote will be on support, then conditional support, then do not support with the potential for mitigation, and lastly do not support.
- Step 7: NQF staff will tally the votes.
    - If a decision category put forward by the co-chairs receives greater than or equal to 60 percent of the votes, the motion will pass, and the measure will receive that decision.
    - If no decision category achieves greater than 60 percent to overturn the preliminary analysis, the preliminary analysis decision will stand. This will be marked by staff and noted for the Coordinating Committee's consideration.

Coordinating Committee Voting Steps

Prior to the Coordinating Committee Review Meeting, Committee members have the opportunity to request to pull measures off the consent calendar. Members should provide a clear and concise rationale for why they are requesting to pull a measure.

- Step 1. For measures that are not on the consent calendar, NQF staff will review the Workgroup decision for each MUC, including summarizing the Advisory Group discussions, public comment, and programmatic objectives.
    - Workgroup co-chairs will be invited to attend the Coordinating Committee review meeting. If in attendance, Workgroup co-chairs may respond to questions on the Workgroup's decision.
- Step 2. A CMS representative will present a brief overview and/or contextual background on the MUC.
- Step 3. Lead discussants will review and present their findings.
    - Coordinating Committee member(s) will be assigned as lead discussant(s) based on knowledge and experience with measure topics while balancing the opportunity to serve a lead discussant to as many members as possible. Lead discussants are asked to review their assigned measures in advance of the meeting and will be asked during the meeting to respond to the Workgroup's decision for the measure. 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.
    - If a member requests to pull a measure from the consent calendar, they will serve as the lead discussant for that measure.
- Step 4. The co-chairs will then open the floor for discussion among the Coordinating Committee. Other Committee 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.
    - Measure developers will respond to the clarifying questions on the specifications of the measure.
    - Workgroup co-chairs and/or NQF staff will respond to clarifying questions or expressed concerns on the Workgroup's decision.
- Step 5. The Committee will vote on acceptance of the Workgroup's decision.
    - After discussion ends, the co-chairs will open for a vote on accepting the Workgroup's decision. This vote will be framed as a "yes" or "no" vote to accept the result.
    - If greater than or equal to 60 percent of the Committee members vote to accept the Workgroup's decision, then the Workgroup's recommendation will become MAP's recommendation. If less than 60 percent of the Committee votes to accept the Workgroup's decision, discussion will continue on the measure.
- Step 6. Discussion and voting on the MUC will take place if less than 60 percent accept the Workgroup decision.
    - After the discussion ends, the co-chairs will open the MUC for a vote.
        - Co-chairs will summarize the major themes of the Committee's discussion.
        - The co-chairs will determine what decision category will be put to a vote first based on the potential consensus emerging from the discussions. If the co-chairs do not feel there is a consensus position to use to begin voting, the Committee will take a vote on each potential decision category one at a time. The first vote will be on support, then conditional support, then do not support with potential for mitigation, and lastly do not support.
- Step 7: NQF staff will tally the votes.

- If a decision category put forward by the co-chairs receives greater than or equal to 60 percent of the votes, the motion will pass, and the measure will receive that decision.
- If no decision category achieves greater than 60 percent to overturn the Workgroup's decision, the Workgroup's decision will stand.

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 to achieve its goals, implementation challenges, and unintended consequences. By reviewing multiple federal quality and performance 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. NQF will summarize these themes in the Review Meeting summaries.

As the final deliverable for the MAP pre-rulemaking activities NQF provides:

- *Recommendations on individual measures on the MUC List.* This deliverable, in spreadsheet format, gives feedback on each MUC along with limited explanatory text, including a rationale for the measure recommendation. The spreadsheet is organized into a standardized format. This product would be released on February 1 to meet the statutory deadline.