MEASURE APPLICATIONS PARTNERSHIP

Input on the Quality Rating System for Qualified Health Plans in the Health Insurance Marketplaces

FINAL REPORT

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NATIONAL QUALITY FORUM

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EXECUTIVE SUMMARY

The new health insurance marketplaces, also known as exchanges, provide an opportunity for many Americans to choose health plans that meet standards of coverage, cost, and quality. To date, much attention has been given to insurance expansions, minimum benefits, and enrollment; however, success of the marketplaces is dependent on the creation of markets that are driven by information and incentives to improve care. The Quality Rating System (QRS) is the mechanism for making performance information transparent.

In this report, the Measure Applications Partnership (MAP) provides input to the Department of Health and Human Services (HHS) on the performance measures proposed by HHS for use in the initial implementation of the QRS. While the purpose of the QRS is two-fold, enabling consumer choice and supporting regulatory oversight, MAP's input focuses on identifying performance measures that will best inform consumer selection of health plans in the marketplaces.

Recognizing that the initial implementation of the QRS will be limited to existing measures, MAP set a vision for the QRS. MAP identified four primary steps to achieve this vision over the next five years:

- First, HHS should immediately begin to address measure gaps in the QRS, specifically, out-of-pocket costs and shared-decisionmaking.
- Second, HHS should thoroughly test all aspects of the QRS with the diverse marketplace populations without delaying implementation and monitor on an ongoing basis.
- Third, HHS should include provider-level quality information within three years after initial implementation for comprehensive support of consumer decisionmaking.
- Fourth, HHS should add functionality to the QRS within five years of initial implementation that allows consumers to customize and prioritize information to assist in their unique decisionmaking processes.

MAP considered HHS' proposed measures and structure that will be implemented in 2016 in of the context of this broader vision. MAP supported 28 out of 42 measures proposed for the family core set and 19 out of 25 measures proposed for the child core set. Additionally, MAP conditionally supported eight measures for the family core set and four for the child core set, and did not support six measures for the family core set and two for the child core set. Recognizing that the proposed measures are limited to those currently available, MAP identified three measures to address gap areas, and prioritized gap areas for measure development.

INTRODUCTION

The Measure Applications Partnership (MAP) is a public-private partnership convened by the National Quality Forum (NQF) to provide input to the Department of Health and Human Services (HHS) on the selection of performance measures for public reporting, performance-based payment programs, and other purposes. MAP is designed to facilitate alignment of public- and private-sector uses of performance measures to further the National Quality Strategy's (NQS) three-part aim of creating better, more affordable care and healthier people (see MAP Background—Appendix A). MAP's careful balance of interests—across consumers, businesses and purchasers, labor, health plans, clinicians, providers, communities and states, and suppliers—ensures that HHS will receive varied and thoughtful input on performance measure selection.

The Affordable Care Act (ACA) calls for the first national infrastructure to offer citizens health insurance through Affordable Insurance Exchanges, also known as Health Insurance Marketplaces. ACA also requires HHS to develop a Quality Rating System (QRS) for Qualified Health Plans (QHP) offered through the marketplaces.[1] The purpose of the QRS is to enable consumer selection of QHPs and regulatory oversight by providing quality and relative cost information. MAP has been tasked with providing input on the hierarchical structure, organization, and measures proposed for the Marketplaces QRS.

MAP convened a time-limited Health Insurance Exchange–Quality Rating System (HIX-QRS) Task Force, drawn from the membership of the MAP Coordinating Committee and workgroups, to advise the MAP Coordinating Committee on recommendations for the QRS (see MAP Coordinating Committee and HIX-QRS Task Force Rosters—Appendix B). The 26-member HIX-QRS Task Force convened via three web meetings and one two-day, in-person meeting to develop its input to the Coordinating Committee. A draft report was available for a two-week public comment period in December 2013. The MAP Coordinating Committee reviewed the comments received (see Public Comments—Appendix H) and finalized MAP's recommendations on the QRS during their January 2014 meeting. All MAP meetings are open to members of the public; the agendas and materials for the task force and Coordinating Committee meetings can be found on the **NQF website**.

On November 19, 2013, HHS released its proposed rule for the QRS: **Notice with Comment on the Patient Protection and Affordable Care Act; Exchanges and Qualified Health Plans, Quality Rating System (QRS), Framework Measures and Methodology**. HHS provided MAP with **supporting documentation** on the proposed QRS hierarchical structure, organization, and measures for the family and child core sets.

In this report, MAP defines a vision for the QRS, delineating MAP's recommended structure and types of measures that should be used. With MAP's recommended vision established, MAP then provides input on HHS' proposed structure and measures for the QRS.

VISION FOR ENABLING CONSUMER CHOICE IN THE HEALTH INSURANCE MARKETPLACES

MAP defined its vision for the Quality Rating System for the Health Insurance Marketplaces taking into consideration the characteristics of the marketplace population. Of the more than 47 million uninsured nonelderly people in the US (ages 0-64), 30 million are anticipated to be eligible for health insurance coverage under the ACA marketplaces. Individuals gaining coverage or newly insured through the marketplaces will be a combination of those who do not have insurance and those who purchase insurance in the individual market. Additionally, more than 50 percent of the marketplace population is expected to be unmarried adults, with a median age of 33 (see Population Profile—Appendix C).

A primary focus of the QRS is to enable consumer choice of health plans; therefore, MAP's vision articulates how information can be most accessible to consumers (i.e., how information is structured in the QRS), what information is most meaningful to consumers (i.e., the performance measures that support consumer decisionmaking), and how the QRS should be implemented over time. MAP's Quality Rating System Guiding Principles summarize MAP's vision and serve as its basis for providing input on HHS' proposed structure and measures for the QRS.

Making Information Accessible to Consumers

Recognizing the diverse population that will enter the Marketplaces, the QRS should be interactive and customizable, allowing consumers to prioritize what is most important to them. For example, consumers with a chronic condition should be able to easily access quality information for that condition. Current consumer reporting tools (e.g., **Consumers' CHECKBOOK**) serve as models for providing customizable information to consumers. In addition to providing options for customizing information, the QRS should be accessible, providing information in consumer-friendly terms and summarizing information so that it can be viewed at-a-glance.

The QRS represents a unique opportunity to educate the public on quality of care and how this information can inform healthcare decisions, as many consumers entering the marketplaces will have minimal experience with the healthcare system. Accordingly, the QRS should use plain language to explain quality information and provide consumer decision-support tools. Public commenters emphasized the need for consumer friendly information. To ensure that information can be easily digested, the QRS should provide an overall score and summary scores of meaningful topic areas for each QHP, and the ability to drill down to performance scores for individual measures. Performance information should be based on statistically significant differences in plan quality. Additionally, information in the QRS should be displayed at levels that are meaningful to consumers, such as by region, by market, or by plan medal level. Finally, information on the QRS should be monitored and tested on an ongoing basis for health literacy and numeracy across diverse populations to ensure that consumers using the QRS will understand information as intended.

Recognizing that consumers will become more accustomed to using quality information over time, MAP recommends that the QRS include feedback loops—systematic mechanisms for collecting information on the use and usefulness of information used in the QRS. As the QRS offers plans of different medal levels, which are defined by cost, it will be important to monitor how

measure information impacts plan selection when plans are segmented by cost. This information would provide insight into new strategies for reporting quality information in increasingly meaningful ways. Improvements to the QRS should be timely and responsive to the information gleaned through feedback loops.

Making Information Meaningful for Consumers

In considering the measure information needed to enable consumer choice, MAP looked to its Measure Selection Criteria (see Appendix D), which define the characteristics of an ideal measure set.

Measures in the QRS should focus on experience, cost, and quality outcomes

In considering the information consumers desire, MAP identified and prioritized high-leverage opportunities for measurement and determined how best to organize the opportunities. The high-leverage opportunities represent areas of consumer interest and improvement gaps, and areas of greatest cost and prevalence. MAP defined the five highest priority measurement areas as: (1) patient and family experience or satisfaction, (2) cost (including total out-of-pocket costs, costs for specific medical services and prescription medications, shared financial responsibility, and affordability), (3) care coordination and case management, (4) medication management, and (5) quality of providers in the health plan. Similarly, when considering how best to organize information in the QRS, MAP identified three overarching categories that are most important to consumers—experience, cost, and quality. Public commenters generally agreed with focusing on experience, cost, and quality outcomes and noted that this information should be displayed in a manner that will allow consumers to consider all three aspects and their interrelationships when selecting health plans.

Measures in the QRS should address both plan and provider performance

MAP recognizes that consumers seek information on both plans and providers. When identifying high-leverage opportunities, MAP reviewed the functions of plans (e.g., network maintenance, benefit design, managing costs) and the services rendered by providers, considering the overlaps and distinctions between plan and provider functions and which should be primarily accountable for various functions. Notably, MAP members had divergent perspectives on how the QRS should address plan and provider performance. Consumer and purchaser representatives asserted that plans should be held accountable for all care provided by providers in plans' networks, thus information that can be attributed to providers should also be attributed to plans. In contrast, plan representatives noted that they have limited ability to control provider behavior and providers contract with multiple plans, thus variation in provider performance cannot be solely attributed to a single plan. Public commenters reiterated these disparate views; consumer commenters noted that provider-level information is highly valuable for decisionmaking, while plan commenters noted that provider-level information will increase data collection burden and that other avenues exist for accessing provider-level information. In light of these differing views, additional work is needed to determine the best approach for including provider performance in the QRS. For example, would a summary of the performance of all providers in a network be sufficient or is performance information for individual providers needed?

Regardless of the approach for including provider performance, MAP noted that the experience and quality high-leverage opportunities for measurement are similar for plans and providers; however, the specific measures to assess these high-leverage opportunities may vary. Ideally, MAP envisions aligned measurement across plans

and providers. For example, a care coordination measure for health plans may assess plans' efforts to provide patient information to multiple providers; whereas, a care coordination measure for providers may assess providers' timeliness in transferring information to the plan or other sites of care. Regarding cost, MAP emphasized that cost should be addressed from the consumer's perspective—providing relevant information on out-of-pocket cost of services, prescription costs, and premiums.

Phased Approach to Implementation

MAP recognizes that many aspects of its vision for the QRS might not be feasible for initial implementation in 2016. Initial implementation may be limited to health plans reporting on existing quality measures, so MAP sought to define the structure and types of measures that are feasible in the initial years of implementation. MAP's recommended initial structure (see Appendix E) presents high-leverage opportunities for measurement organized by experience, cost, and quality. MAP recommends phasing in other aspects of its vision over time.

MAP considers alignment among measurement activities as a critical aspect of phased implementation of MAP's vision for the QRS. Accordingly, MAP strongly supports alignment among federal, state, and private sector reporting efforts. Achieving broad alignment will avoid data collection burden and send consistent messages to consumers.

To promote measure alignment, MAP recommends that measurement opportunities for the QRS align with ACA and QHP reporting requirements, synchronizing data collection and reporting. Specifically, QHPs are required to be accredited or become accredited. Accreditation includes assessment of local plan performance on clinical quality measures, experience, and other plan functions such as access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information. Some information required by QHPs in ACA provisions or accreditation may be useful and meaningful to consumers and should be publicly reported. For example, high-leverage opportunities such as member access to information and cultural competency may be best assessed through accreditation standards, and the results of the assessment should be made publicly available on the QRS.

Public commenters emphasized the importance of aligning measurement requirements and suggested using additional data sources, such as clinical data registries, to support alignment and build on existing data collection and reporting strategies.

MAP Guiding Principles for the Quality Rating System

MAP's Quality Rating System Guiding Principles summarize MAP's vision and serve as its basis for providing input on HHS' proposed structure and measures for the QRS. The principles are not absolute rules; rather, they are meant to guide measure selection decisions. The principles are intended to complement the statutory requirements for QHPs in the ACA and the MAP Measure Selection Criteria (Appendix D). Public commenters generally supported MAP's guiding principles.

- QRS structure should focus on consumer needs by providing information that is:
  - Usable and of interest to consumers in comparing plan performance
  - Accessible and can be easily and quickly interpreted by consumers
  - Interactive and customizable, allowing consumers to emphasize their values
- Measures within the QRS should:
  - Focus on cost, experience, clinical quality outcomes, and patient-reported outcomes

- Address core plan functions, including quality of providers, managing costs, and additional benefits
- Drive improvement for plans and providers by measuring quality at the proper level of accountability (i.e., attributable and actionable by plans, attributable and actionable by providers)
- Be NQF-endorsed®, or build on existing structural information
- Be aligned and parsimonious, taking into consideration existing plan reporting requirements

- A phased approach to implementation is needed:
  - Initially limited to existing information
    - Time is needed for meaningful comparisons as new plans entering the market will require time to become established
    - Begin with few categories of measures (e.g., roll-ups aligned with the NQS triple aim)
    - Over time, expand beyond existing health plan-level quality measures

INPUT ON PROPOSED MARKETPLACES QRS

Hierarchical Structure for the Quality Rating System

HHS' proposed family and child QRS hierarchical structure aligns closely with MAP's recommended structure; the differences highlight areas for future enhancement of the QRS. A side-by-side comparison of MAP's recommended structure and HHS' proposed structure is included in Appendix F. Generally, MAP supports the use of an overall summary score and a hierarchical structure that allows consumers to view high-level summaries of health plan quality and obtain more detailed performance results in the QRS. As previously mentioned, the QRS should be tested with consumers to ensure that the information is presented in a consumer-friendly manner.

The first tiers of both the proposed and recommended structures address experience, cost, and quality. For the experience and quality tiers, MAP recommends including information on both plan performance and provider performance. Provider information should be included in the QRS over time; MAP recognizes that the initial years of the QRS will be limited to health plan information, given the aforementioned issues with expanding to provider-level information at this time. Provider information should include all providers in the care team and not be limited to physicians. For the cost tier, MAP recommends expanding beyond plan efficiency to include information on affordability that consumers find most valuable such as out-of-pocket costs.

MAP recommends enhancements to HHS' proposed structure for the QRS, specifically:

- The proposed structure included member experience with health plan as a component of plan efficiency and affordability. MAP recommends placing this information in the experience tier.
- The proposed structure subcomponents within clinical quality management are care coordination, clinical effectiveness, patient safety, and prevention. MAP recommends slightly altering these components by incorporating safety into care coordination and renaming clinical effectiveness "living with chronic illness."
- The proposed structure combines several measures into composites, whereas MAP's recommendation includes subdomains. MAP agrees with the use of composite measures within the QRS; however, those composites should be tested and endorsed as composite measures.

Measures for the Quality Rating System

Throughout its work, MAP uses its Measure Selection Criteria to assess the adequacy of program measure sets. Overall, the measure sets that HHS proposed for the family and child QRS address most of the criteria. The measures in the proposed family and child QRS core sets are mostly NQF-endorsed® and are a balance of process and outcome measures, including patient experience outcome measures. The proposed sets align with measures in a variety of federal, state, and private performance measurement programs. The sets primarily address the NQS aims of better care and prevention and well-being, while affordable care is a significant gap.

MAP reviewed 42 measures HHS proposed for inclusion in the family core set and 25 measures proposed for inclusion in the child core set. For

each proposed measure MAP provided a rationale for one of the following recommendations:

- Support: Indicates measures under consideration that should be added to the QRS.
- Conditional Support: Indicates measures, measure concepts, or measure ideas that should be phased into the QRS over time, subject to contingent factor(s).
- Do Not Support: Indicates measures that are not recommended for inclusion in the QRS.

Overall, MAP supported the use of most of the measures in HHS' proposed family and child core sets for the QRS (28 for the family core set and 19 for the child core set). MAP conditionally supported measures that were found to be not ready for implementation and in need of further experience or testing before being added to the QRS (8 for the family core set and 4 for the child core set). Additionally, MAP conditionally supported measures where HHS proposed a single rate within an NQF-endorsed measure, preferring use of complete endorsed measures instead. MAP did not support certain measures for the QRS that should be assessed at the provider level of analysis or could be better addressed by other measures (6 for the family core set and 2 for the child core set). See Appendix G for individual measure recommendations.

Recognizing that HHS' proposed core sets were limited to currently available measures specified for the health plan level of analysis, MAP suggests that the measure set be expanded as soon as possible. MAP reviewed NQF-endorsed measures specified for use in health plans that could potentially address gaps in the QRS measure set. MAP identified one measure that HHS should consider adding to the measure set, NQF #0541 Proportion of Days Covered (PDC): 5 Rates by Therapeutic Category. One public commenter supported inclusion of this measure because it addresses a high-leverage opportunity for measurement and aligns with measures used in other programs. MAP also identified two additional measures that could be phased into the program over time, NQF #1560 Relative Resource Use for People with Asthma and NQF #1561 Relative Resource Use for People with COPD, once additional experience has been gained with similar resource use measures (for cardiovascular conditions and diabetes) that HHS proposed and MAP supported for the QRS. Additionally, MAP noted that the anticipated Marketplace populations are expected to be different than current, privately insured populations. MAP encourages testing the proposed measures for disparities sensitivity, reliability and validity, and performance in the Marketplaces prior to public reporting.

MAP's recommended reorganization of the proposed structure is demonstrated in Table 1. In addition, the table includes the measures that HHS proposed for the QRS and that MAP supports or conditionally supports. The measures are listed below the relevant high-leverage opportunity; measure gaps, where no measures are available for a high-leverage opportunity, are marked with an asterisk and italicized.

TABLE 1. MAP'S RECOMMENDATION FOR THE QRS STRUCTURE: Organization of High-Leverage Opportunities and Supported Proposed Measures

Experience

Summary Indicator	Domain	Subdomain	High-Leverage Opportunity/Proposed Measures Supported by MAP
Experience	Plan Experience	Experience with Health Plan	• Patient and Family Experience/Satisfaction – CAHPS – Customer Service – CAHPS – Global Rating of Health Plan • *Shared Decisionmaking** • *Quality of Providers** • *Member Complaints and Grievances**
		Access to Plan Resources	• Member Access to Information – CAHPS – Plan Information on Costs • *Member Education** • Cultural Competency – CAHPS – Cultural Competency • *Access to Health Plan Resources, Medical Records**
		Access to Care	• Access to Care, Specialists, Mental Health and Substance Use Services, and Network Adequacy – CAHPS – Getting Care Quickly – CAHPS – Getting Needed Care – Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life – Well-Child Visits in the First 15 Months of Life (Child Core Set Only) – Children and Adolescents' Access to Primary Care Practitioners (Child Core Set Only) • *Covered Services/Benefits**
	Provider Experience	Provider Experience	• Patient and Family Experience/Satisfaction – CAHPS – Rating of All Health Care – CAHPS – Rating of Personal Doctor – CAHPS – Rating of Specialist Seen Most Often • *Shared Decisionmaking** • *Access to Medical Records**

Cost

Summary Indicator	Domain	Subdomain	High-Leverage Opportunity/Proposed Measures Supported by MAP
Cost	Cost	Cost	• Out-of-Pocket Costs • Efficient Resource Use – Appropriate Testing for Children With Pharyngitis – Appropriate Treatment for Children with Upper Respiratory Infection – Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (Family Core Set Only) – Relative Resource Use for People with Cardiovascular Conditions – Inpatient Facility Index (Family Core Set Only) – Relative Resource Use for People with Diabetes – Inpatient Facility Index (Family Core Set Only) – Use of Imaging Studies for Low Back Pain (Family Core Set Only)

Health Plan Quality

Summary Indicator	Domain	Subdomain	High-Leverage Opportunity/Proposed Measures Supported by MAP
Quality	Health Plan Quality	Staying Healthy	• Maternal Health – Prenatal and Postpartum Care: Postpartum Care (Family Core Set Only) – Prenatal and Postpartum Care: Timeliness of Prenatal Care (Family Core Set Only) • Well-Infant, Child, Adolescent Care – Childhood Immunization Status – Immunizations for Adolescents • Behavioral/Mental Health – Antidepressant Medication Management (Family Core Set Only) – Follow-Up After Hospitalization for Mental Illness: 7 days (Family Core Set Only) – Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase – Follow-Up Care for Children Prescribed ADHD Medication: Continuation Phase (Child Core Set Only) • Tobacco, Alcohol, and Substance Use – CAHPS – Medical Assistance With Smoking and Tobacco Use Cessation (Family Core Set Only) • Screening, Immunization, and Treatment of Infectious Disease – CAHPS – Flu Shots for Adults (Family Core Set Only) – Chlamydia Screening in Women (Ages 16-20) (Child Core Set Only) – HPV Vaccination for Female Adolescents (Child Core Set Only) • Cancer Screening – Breast Cancer Screening (Family Core Set Only) – Cervical Cancer Screening (Family Core Set Only) – Colorectal Cancer Screening (Family Core Set Only) • Weight Management and Wellness Counseling – Weight Assessment and Counseling for Nutrition and Physical Activity Children and Adolescents: BMI Percentile Documentation • Dental and Vision Care – Annual Dental Visit
		Living with Chronic Illness	• Cardiovascular Care – Controlling High Blood Pressure (Family Core Set Only) • Diabetes Care – Diabetes Care: Eye Exam (Retinal) Performed Screening (Family Core Set Only) – Diabetes Care: Hemoglobin A1c (HbA1c) Control <8.0% Screening (Family Core Set Only) • Asthma and Respiratory Care – Medication Management for People with Asthma • *Cancer Treatment**
		Coordination	• Care Coordination and Case Management – CAHPS – Coordination of Members' Health Care Services • Medication Management – Annual Monitoring for Patients on Persistent Medications (Family Core Set Only) • *Advanced Illness Care** • *Care for Older Adults** • Readmissions – Plan All-Cause Readmissions (Family Core Set Only)

Provider Quality

Summary Indicator	Domain	Subdomain	High-Leverage Opportunity/Proposed Measures Supported by MAP
Quality	Provider Quality	Staying Healthy	• *Maternal Health** • *Well-Infant, Child, Adolescent Care** • *Behavioral/Mental Health** • *Tobacco, Alcohol, and Substance Use** • *Screening, Immunization, and Treatment of Infectious Disease** • *Weight Management and Wellness Counseling** • *Dental and Vision Care**
		Living with Chronic Illness	• *Cardiovascular Care** • *Diabetes Care** • *Asthma and Respiratory Care** • *Cancer Screening and Treatment**
		Coordination	• *Care Coordination and Case Management* • *Medication Management** • *Advanced Illness Care** • *Care for Older Adults** • *Readmissions**

PATH FORWARD

The QRS for the new Health Insurance Marketplaces is an opportunity to engage consumers across the country in innovative and dynamic ways. MAP encourages continual progression in the QRS and has identified several opportunities for its enhancement. Some public commenters noted that MAP's recommendations are complex and burdensome to implement in the timeline MAP proposes, while other commenters indicated work should begin now to implement MAP's recommendations. Specifically, MAP recommends that HHS:

Begin addressing measure gaps in the QRS immediately. Significant gaps remain in health plan-level performance measurement. Available measures do not fill the gaps completely, may assess only a portion of the issue, or may not be relevant to consumers. Over time, MAP encourages additional measure development and submission for NQF endorsement at the health plan-level of analysis and for the purpose of enabling consumer decisionmaking. The highest priority gaps include measures of shared decisionmaking and total out-of-pocket cost.

Test the QRS with consumers prior to initial implementation. Although the existing measures have been previously used in public reporting systems, the structure and measures may not resonate with the anticipated Marketplace population. Additionally, testing across the diverse marketplace population(s) can help refine consumer-friendly language, explanations, and displays needed throughout the QRS. Testing should be done on an ongoing basis and not delay the implementation of the QRS.

Include provider level quality information in the QRS within three years of initial implementation. As indicated in MAP's vision, the QRS should provide information about provider performance. As a starting place, HHS could include provider registries for all plans, enabling customers to identify a provider of their choice while selecting plans.

Provide functionality for consumers to customize information in the QRS within five years of initial implementation. MAP's vision articulates that the QRS should include functionality for consumers to access the information most important to them.

ENDNOTES

1 U.S. Congress. *Patient and Affordable Care Act Health- Portions of the Health Care and Education Reconciliation Act of 2010*. Washington, DC; Government Printing Office; 2010; Sec.1311(c)(3) . Available at http://housedocs.house.gov/energycommerce/ppacacon.pdf. Last accessed December 2013.

APPENDIX A:
MAP Background

Purpose

The Measure Applications Partnership (MAP) is a public-private partnership convened by the National Quality Forum (NQF) for providing input to the Department of Health and Human Services (HHS) on selecting performance measures for public reporting, performance-based payment, and other programs. The statutory authority for MAP is the Affordable Care Act (ACA), which requires HHS to contract with NQF (as the consensus-based entity) to “convene multi-stakeholder groups to provide input on the selection of quality measures” for various uses.[1]

MAP’s careful balance of interests—across consumers, businesses and purchasers, labor, health plans, clinicians, providers, communities and states, and suppliers—ensures HHS will receive varied and thoughtful input on performance measure selection. In particular, the ACA-mandated annual publication of measures under consideration for future federal rulemaking allows MAP to evaluate and provide upstream input to HHS in a more global and strategic way.

MAP is designed to facilitate progress on the aims, priorities, and goals of the National Quality Strategy (NQS)—the national blueprint for providing better care, improving health for people and communities, and making care more affordable.[2] Accordingly, MAP informs the selection of performance measures to achieve the goal of **improvement, transparency, and value for all**.

MAP’s objectives are to:

1. **Improve outcomes in high-leverage areas for patients and their families**. MAP encourages the use of the best available measures that are high-impact, relevant, and actionable. MAP has adopted a person-centered approach to measure selection, promoting broader use of patient-reported outcomes, experience, and shared decisionmaking.
2. **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**. MAP promotes the use of measures that are aligned across programs and between public- and private-sectors to provide a comprehensive picture of quality for all parts of the healthcare system.
3. **Coordinate measurement efforts to accelerate improvement, enhance system efficiency, and reduce provider data collection burden**. MAP encourages the use of measures that help transform fragmented healthcare delivery into a more integrated system with standardized mechanisms for data collection and transmission.

Coordination with Other Quality Efforts

MAP activities are designed to coordinate with and reinforce other efforts for improving health outcomes and healthcare quality. Key strategies for reforming healthcare delivery and financing include publicly reporting performance results for transparency and healthcare decisionmaking, aligning payment with value, rewarding providers and professionals for using health information technology (health IT) to improve patient care, and providing knowledge and tools to healthcare providers and professionals to help them improve performance. Many public- and private-sector organizations have important responsibilities in implementing these strategies, including federal and state agencies, private purchasers,

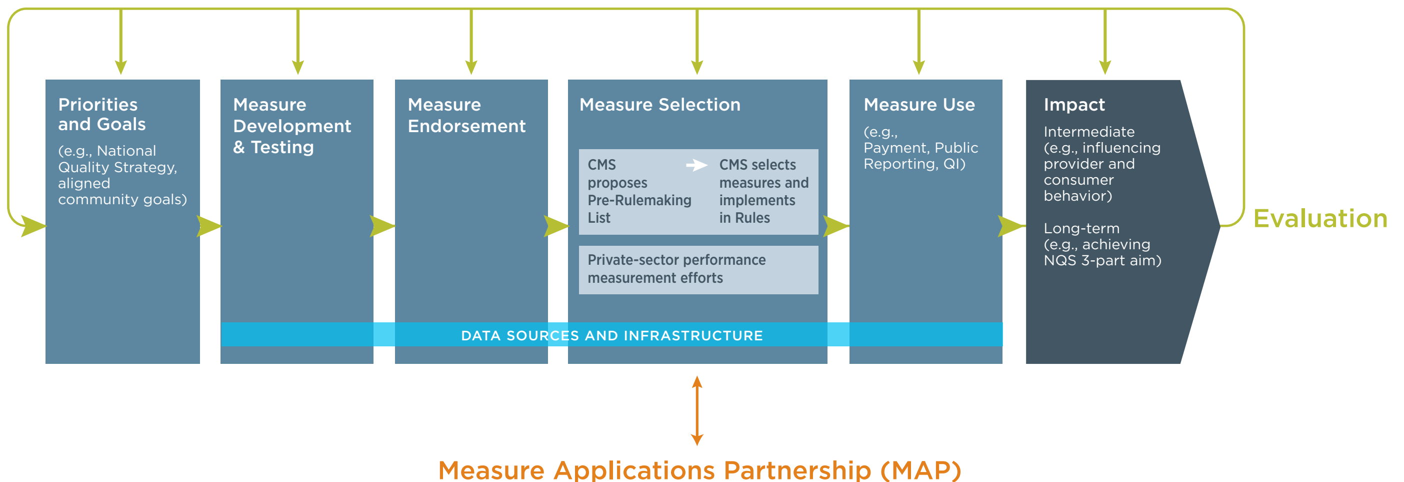
measure developers, groups convened by NQF, accreditation and certification entities, various quality alliances at the national and community levels, as well as the professionals and providers of healthcare.

Foundational to the success of all of these efforts is a robust Quality Enterprise (see Figure A1) that includes:

- **Setting priorities and goals.** The work of the Measure Applications Partnership is predicated on the National Quality Strategy and its three aims of better care, affordable care, and healthy people/healthy communities. The NQS aims and six priorities provide a guiding framework for the work of the MAP, in addition to helping align it with other quality efforts.
- **Developing and testing measures.** Using the established NQS priorities and goals as a guide, various entities develop and test measures (e.g., PCPI, NCQA, The Joint Commission, medical specialty societies).
- **Endorsing measures.** NQF uses its 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.
- **Measure selection and measure use.** Measures are selected for use in a variety of performance measurement initiatives conducted by federal, state, and local agencies; regional collaboratives; and private sector entities. MAP's role within the Quality Enterprise is to consider and recommend measures for public reporting, performance-based payment, and other programs. Through strategic selection, MAP facilitates measure alignment of public- and private-sector uses of performance measures.
- **Impact.** Performance measures are important tools to monitor and encourage progress on closing performance gaps. Determining the intermediate and long-term impact of performance measures will elucidate if measures are having their intended impact and are driving improvement, transparency, and value.
- **Evaluation.** Evaluation and feedback loops for each of the functions of the Quality Enterprise ensure that each of the various activities is driving desired improvements.

MAP seeks to engage in bi-directional exchange (i.e., feedback loops) with key stakeholders involved in each of the functions of the Quality Enterprise.

FIGURE A1. FUNCTIONS OF THE QUALITY ENTERPRISE.



Structure

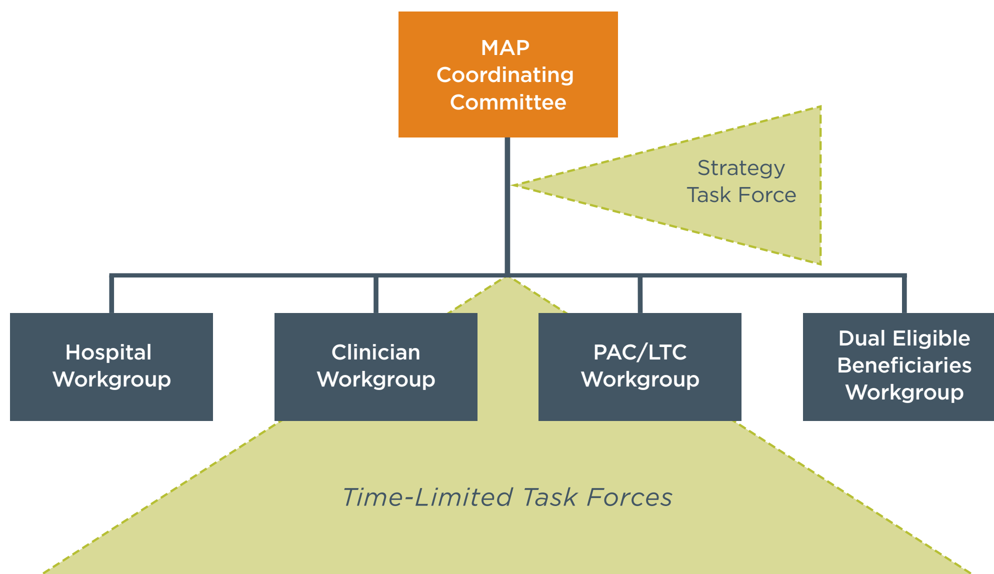
MAP operates through a two-tiered structure (see Figure A2). The MAP Coordinating Committee provides direction to the MAP workgroups and task forces and final input to HHS. MAP workgroups advise the Coordinating Committee on measures needed for specific care settings, care providers, and patient populations. Time-limited task forces charged with developing "families of measures"—related measures that cross settings and populations—and a multi-year strategic plan, provide further information to the MAP Coordinating Committee and workgroups. Each multi-stakeholder group includes representatives from public- and private-sector organizations particularly affected by the work and individuals with content expertise.

The NQF Board of Directors oversees MAP. The Board will review any procedural questions and periodically evaluate MAP's structure, function, and effectiveness, but will not review the Coordinating Committee's input to HHS. The Board selected the Coordinating Committee and workgroups based on Board-adopted selection criteria. Balance among stakeholder groups was paramount. Because MAP's tasks are so complex, including individual subject matter experts in the groups also was imperative.

All MAP activities are conducted in an open and transparent manner. The appointment process includes open nominations and a public comment period. MAP meetings are broadcast, materials and summaries are posted on the NQF website, and public comments are solicited on recommendations.

MAP decisionmaking is based on a foundation of established guiding frameworks. The NQS is the primary basis for the overall MAP strategy. Additional frameworks the NQF-endorsed® Patient-Focused Episodes of Care framework,[3] the HHS Partnership for Patients safety initiative,[4] the HHS Prevention and Health Promotion Strategy,[5] the HHS Disparities Strategy,[6] and the HHS Multiple Chronic Conditions framework.[7]

FIGURE A2. MAP 2013 STRUCTURE



Additionally, the MAP Coordinating Committee has developed Measure Selection Criteria (MSC) to help guide MAP decisionmaking. The MAP Measure Selection Criteria are intended to build on, not duplicate, the NQF endorsement criteria. In 2013, MAP updated the MSC to incorporate lessons learned from the previous pre-rulemaking cycles and to incorporate the Guiding Principles that the Clinician and Hospital Workgroups had developed during their 2012-2013 pre-rulemaking input.

The Measure Selection Criteria provide decisionmaking guidance for MAP members as they are considering the appropriateness of measures for specific programs. They call attention to aspects of the measure such as endorsement status, alignment with an NQS aim or priority, alignment with other programs (if applicable), whether it is disparities sensitive, and other important considerations. The criteria are intended to act as guidance, rather than absolute rules.

Timeline and Deliverables

MAP convenes each winter to fulfill its statutory requirement of providing input to HHS on measures under consideration for use in federal programs. MAP workgroups and Coordinating Committee meet in December and January to provide program-specific recommendations to HHS by February 1. (MAP 2013 Pre-Rulemaking Report, submitted to HHS February 1, 2013).

Additionally, MAP engages in strategic activities throughout the spring, summer, and fall to inform MAP's pre-rulemaking input. To date MAP has:

- Engaged in **Strategic Planning** to establish MAP's goal and objectives. This process identified strategies and tactics that will enhance MAP's input.
  - MAP Approach to the Strategic Plan, submitted to HHS on June 1, 2012
  - MAP Strategic Plan, submitted to HHS on October 1, 2012
- Identified **Families of Measures**—sets of related available measures and measure gaps that span programs, care settings, levels of analysis, and populations for specific topic areas related to the NQS priorities and high-impact conditions—to facilitate coordination of measurement efforts.
  - MAP Families of Measures: Safety, Care Coordination, Cardiovascular Conditions, Diabetes, submitted to HHS on October 1, 2012
- Provided a measurement strategy and best available measures for evaluating the quality of care provided to Medicare/Medicaid **Dual Eligible Beneficiaries**, including high-need groups.
  - Measuring Healthcare Quality for the Dual Eligible Beneficiary Population, submitted to HHS on June 1, 2012)
  - Further Exploration of Healthcare Quality Measurement for the Dual Eligible Beneficiary Population, submitted to HHS on December 21, 2012
- Provided input on **program considerations and specific measures** for federal programs that are not included in MAP's annual pre-rulemaking review.
  - MAP Expedited Review of the Initial Core Set of Measures for Medicaid-Eligible Adults, submitted to HHS on October 15, 2014
- Developed **Coordination Strategies** intended to elucidate opportunities for public and private stakeholders to accelerate improvement and synchronize measurement initiatives. Each coordination strategy addresses measures, gaps, and measurement issues; data sources and health information technology implications; alignment across settings and across public- and private-sector programs; special considerations for dual-eligible

beneficiaries; and path forward for improving measure application.

- Coordination Strategy for Clinician Performance Measurement, submitted to HHS on October 1, 2011
- Readmissions and Healthcare-Acquired Conditions Performance Measurement Strategy Across Public and Private Payers, submitted to HHS on October 1, 2011
- MAP Coordination Strategy for Post-Acute Care and Long-Term Care Performance Measurement, submitted to HHS on February 1, 2012
- Performance Measurement Coordination Strategy for PPS-Exempt Cancer Hospitals, submitted to HHS on June 1, 2012
- Performance Measurement Coordination Strategy for Hospice and Palliative Care, submitted to HHS on June 1, 2012

ENDNOTES

1 U.S. Government Printing Office (GPO). Patient Protection and Affordable Care Act (ACA), PL 111-148 Sec. 3014. Washington, DC: GPO; 2010, p.260. Available at http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf. Last accessed January 2013.

2 National Quality Strategy: 2012 Annual Progress Report. Available at http://www.healthcare.gov/news/factsheets/2012/04/national-quality-strategy04302012a.html. Last accessed January 2013.

3 NQF, Measurement Framework: Evaluating Efficiency Across Patient-Focused Episodes of Care. Washington DC: NQF; 2010. Available at http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=25912 Last accessed January 2013.

4 Department of Health and Human Services (HHS), Partnership for Patients: Better Care, Lower Costs. Washington, DC: HHS; 2011. Available at www.healthcare.gov/center/programs/partnership. Last accessed January 2013.

5 HHS, National Prevention, Health Promotion and Public Health Council (National Prevention Council). Washington, DC: HHS; 2011. Available at www.healthcare.gov/center/councils/nphpphc/index.html. Last accessed January 2013.

6 HHS, National Partnership for Action to End Health Disparities, Washington, DC: HHS; 2011. Available at http://minorityhealth.hhs.gov/npa/. Last accessed January 2013.

7 HHS, HHS Initiative on Multiple Chronic Conditions, Washington, DC: HHS: 2011. Available at www.hhs.gov/ash/initiatives/mcc/. Last accessed January 2013.

APPENDIX B:
Measure Applications Partnership Rosters

Roster for the MAP Coordinating Committee

CO-CHAIRS (VOTING)
George Isham, MD, MS
Elizabeth McGlynn, PhD, MPP

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVES
AARP	Joyce Dubow, MUP
Academy of Managed Care Pharmacy	Marissa Schlaifer, RPh, MS
AdvaMed	Steven Brotman, MD, JD
AFL-CIO	Gerry Shea
America's Health Insurance Plans	Aparna Higgins, MA
American College of Physicians	David Baker, MD, MPH, FACP
American College of Surgeons	Frank Opelka, MD, FACS
American Hospital Association	Rhonda Anderson, RN, DNSc, FAAN
American Medical Association	Carl Sirio, MD
American Medical Group Association	Sam Lin, MD, PhD, MBA
American Nurses Association	Marla Weston, PhD, RN
Catalyst for Payment Reform	Suzanne Delbanco, PhD
Consumers Union	Lisa McGiffert
Federation of American Hospitals	Chip Kahn
LeadingAge (formerly AAHSA)	Cheryl Phillips, MD, AGSF
Maine Health Management Coalition	Elizabeth Mitchell
National Alliance for Caregiving	Gail Hunt
National Association of Medicaid Directors	Foster Gesten, MD, FACP
National Business Group on Health	Shari Davidson
National Partnership for Women and Families	Alison Shippy
Pacific Business Group on Health	William Kramer, MBA
Pharmaceutical Research and Manufacturers of America (PhRMA)	Christopher Dezii, RN, MBA,CPHQ

EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Child Health	Richard Antonelli, MD, MS
Population Health	Bobbie Berkowitz, PhD, RN, CNAA, FAAN
Disparities	Marshall Chin, MD, MPH, FACP
Rural Health	Ira Moscovice, PhD
Mental Health	Harold Pincus, MD
Post-Acute Care/ Home Health/ Hospice	Carol Raphael, MPA

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVES
Agency for Healthcare Research and Quality (AHRQ)	Nancy Wilson, MD, MPH
Centers for Disease Control and Prevention (CDC)	Gail Janes, PhD, MS
Centers for Medicare & Medicaid Services (CMS)	Patrick Conway, MD, MSc
Health Resources and Services Administration (HRSA)	John Snyder, MD, MS, MPH (FACP)
Office of Personnel Management/FEHBP (OPM)	Edward Lennard, PharmD, MBA
Office of the National Coordinator for HIT (ONC)	Kevin Larsen, MD, FACP

ACCREDITATION/CERTIFICATION LIAISONS (NON-VOTING)	REPRESENTATIVES
American Board of Medical Specialties	Lois Nora, MD, JD, MBA
National Committee for Quality Assurance	Peggy O'Kane, MHS
The Joint Commission	Mark Chassin, MD, FACP, MPP, MPH

Roster for the MAP Health Insurance Exchange–Quality Rating System Task Force

CHAIR (VOTING)
Elizabeth Mitchell

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVES
Academy of Managed Care Pharmacy	Marissa Schlaifer, RPh, MS
AdvaMed	Steve Brotman, MD, JD
Aetna	Andrew Baskin, MD
America's Essential Hospitals	David Engler, MD
America's Health Insurance Plans	Aparna Higgins, MA
American Association of Retired Persons	Joyce Dubow, MUP
American Board of Medical Specialties	Lois Nora, MD, JD, MBA
American Medical Group Association	Samuel Lin, MD, PhD, MBA, MPA, MS
Center for Patient Partnerships	Rachel Grob, PhD
CIGNA	David Ferriss, MD, MPH
Consumers' CHECKBOOK	Robert Krughoff, JD
Humana, Inc.	George Andrews, MD, MBA, CPE, FACP
Iowa Healthcare Collaborative	Lance Roberts, PhD
March of Dimes	Cynthia Pellegrini
Memphis Business Group on Health	Christie Upshaw Travis, MSHA
National Business Coalition on Health	Colleen Bruce, JD
National Partnership for Women and Families	Emma Kopleff, MPH
SNP Alliance	Chandra Torgerson, MS, RN, BSN
The Brookings Institution	Mark McClellan, MD, PhD

EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
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Health IT	Thomas von Sternberg, MD
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Medicaid ACO	Ruth Perry, MD
Nursing	Gail Stuart, PhD, RN

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Health Resources and Services Administration (HRSA)	Terry Adirim, MD, MPH

MAP COORDINATING COMMITTEE CO-CHAIRS (NON-VOTING, EX OFFICIO)
George Isham, MD, MS
Elizabeth McGlynn, PhD, MPP

APPENDIX C:
Health Insurance Marketplace Population Profile

Of the more than 47 million uninsured nonelderly people in the United States (ages 0-64), 30 million are anticipated to be eligible for health insurance coverage under the Affordable Care Act (ACA) through Health Insurance Marketplaces, also known as exchanges. Individuals gaining coverage or newly insured through the marketplaces will be a combination of those who do not have insurance and those who purchase insurance in the individual market.

- Approximately 17 million people will be newly insured in 2014.[1]
- 90 percent of individual marketplace enrollees will receive federal subsidies.
- The total marketplace population is projected to reach 29 million in 2021 (25 million in the individual marketplace and 4 million through the SHOP marketplace).[2]
- More than 50 percent of the marketplace population is expected to be unmarried adults, with a median age of 33.

Geography

Americans throughout the country will make up the marketplace population.

- Individuals in the South and West regions of the United States are most likely to be uninsured.
- Approximately 40 percent of the expected individual marketplace enrollees will come from five states: California, Texas, Florida, New York, and Illinois.[3,4]

Race and Ethnicity

The marketplace population is anticipated to be more ethnically diverse than the currently insured population.

- Currently, individuals of ethnic minority (Black, Asian, or Hispanic) make up the majority of uninsured individuals in the United States: 66.4 percent in 2011.
- African American, Asian, Native American, and multiracial individuals are estimated to make up to 25 percent of the new insurance marketplaces, compared to 21 percent of the currently insured population.
- Insurance coverage among ethnically diverse groups is estimated to increase by 32.3 percent.
- Over 30 percent of the expected marketplace population will speak a language other than English in the home compared to only 12 percent of the currently insured market.

Family Status

The newly insured are more likely to be unmarried adults.

- The current insurance market is made up of 40 percent married and 29 percent single adults, and 31 percent children.
- The proportion of the newly insured that is made up of single adults is expected to be 52 percent.

Children are currently the least likely to be uninsured because they are more likely to qualify for Medicaid or the Children's Health Insurance Program (CHIP).[5]

- 90 percent of children in the U.S. have either public or private health insurance coverage.
- Children enrolled in Medicaid and CHIP are more likely to have a usual source of care, to have had a well-child visit in the past year, and to have been seen by a specialist in the past

year, and they are less likely to have had their medical care delayed than uninsured children.[6]

- Rates of young adults without insurance have recently decreased due to early ACA provisions allowing them to remain on a parent's private health plan until age 26, but the uninsured rates continue to remain high compared to other age groups.

Education

Individuals who do not have a high school degree are less likely to be currently insured and will make up a majority of the newly insured population.

- 32 percent of the currently insured population is made up of people with high school education or less, compared to the expected 61 percent of the newly insured population.
- 37 percent of the currently insured population has a college degree, compared to only 14 percent of the newly insured population.

Employment

Individuals with full-time employment are currently more likely to have insurance than those who do not have full-time employment.

- The anticipated marketplace population has a median income of 166 percent of the federal poverty level (FPL), compared to the currently insured population medium income of 333 percent of the FPL.[7]
- 59 percent of individuals in the current insurance market have full-time employment, compared to 42 percent of the newly insured.
- Across industries, more than 80 percent of uninsured workers are in blue-collar jobs; the gap in rates of coverage between blue- and white-collar workers is two-fold or greater.
- More than 50 percent of currently uninsured individuals have at least one full-time worker in their family, and only 15 percent have only part-time workers in their family.
- Most uninsured workers are either self-employed or work for small firms less likely to offer health benefits.[8]
- Partially employed individuals are expected to cycle coverage between Medicaid and the marketplaces, a phenomenon known as "churn."

Health Status

The marketplace population is less likely to report excellent or very good health than the traditional market.[9]

- 26 percent of the newly insured population is estimated to report being in excellent health, and 29 percent is estimated to report being in very good health, compared to 37 percent and 33 percent of the currently insured population, respectively.
- 16 percent of people with a disability in the U.S. are estimated to be uninsured.
- Leading causes of death in the U.S. for nonelderly adults include malignant neoplasms, diseases of the heart, unintentional injuries, suicide, chronic lower respiratory diseases, chronic liver disease, diabetes mellitus, and homicide.[10]
- Lack of insurance increases mortality rate by 25 percent. Risk of death from some preventable and treatable diseases (including heart disease and certain types of cancer) is also higher for people without health insurance.[11]

Access to Care

In 2011, 75 percent of the nonelderly uninsured population was without insurance for more than a year, during which 43 percent report having no healthcare visits within the past 12 months, compared to 12 percent of the continuously insured population who report having no healthcare visits.

- More than 25 percent of uninsured adults forgo needed care each year, and they are less likely than those with insurance to receive preventative care and services for major health conditions and chronic conditions.[12]

ENDNOTES

1 Congressional Budget Office (CBO). *CBO's May 2013 Estimate of the Effects of the Affordable Care Act on Health IInsurance Coverage*. Washington, DC: CBO;2013. Availbable at http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf. Last accessed December 2013.

2 PricewaterhouseCoopers LLP website. Available at http://www.pwc.com/us/healthexchanges Last accessed January 2014.

3 Congressional Budget Office (CBO). Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision. Washington, DC: CBO; July 2012. Available at http://cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf. Last accessed December 2013.

4 U.S. Census Bureau. Health Insurance Historical Tables – HIB Series. Washington, DC: Census Bureau; 2011. Available at http://www.census.gov/hhes/www/hlthins/data/historical/HIB_tables.html. Last accessed December 2013.

5 Medicaid and CHIP currently restrict eligibility for many lawfully residing immigrants during their first five years in the US, though nearly 20 percent of the uninsured are noncitizens (both lawfully present and undocumented immigrants). Some states are taking up recent federal options to eliminate this waiting period for children and pregnant women. Undocumented workers are ineligible for Medicaid and CHIP coverage.

6 Hess C, Basini LO, Plaza CL. *Keeping Children's Coverage Strong in the Context of the Affordable Care Act: Perspectives from State Children's Health Insurance Leaders*. Washington, DC: National Academy for State Health Policy.; May 2012. Available at http://www.nashp.org/sites/default/files/keeping.children's.coverage.strong.pdf. Last accessed December 2013.

7 ACA originally required the expansion of Medicaid to 138 percent of federal poverty level (FPL) in all states, or $11·490 for an individual and $23·550 for a family of four in 2013. However, the Supreme Court ruling in June 2012 made this expansion optional. The result is that some individuals could fall between the cracks of Medicaid eligibility levels in states that do not expand Medicaid and limits for exchange subsidies, leaving them uninsured.

8 Kaiser Commission on Key Facts. *Medicaid and the Uninsured*. Washington, DC: Henry H. Kaiser Family Foundation, 2012. Available at http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7806-05.pdf. Last accessed December 2013.

9 PwC Health Research Institute. Health Insurance Exchanges: Long on options, short on time. Washington, DC:Pricewaterhouse Coopers;2012 Available at http://www.cchfreedom.org/files/files/HIX%20pwc-report%2037%20states%20not%20ready%20Sept%202012(1).pdf. Last accessed December 2013.

10 Centers for Disease Control (CDC), National Center for Health Statistics (NCHS). *National Vital Statistics System*,. Atlanta, GA: CDC, NCHS;2012.

11 Dorn S. *Uninsured and Dying Because of It: Updating the Institute of Medicine Analysis on the Impact of Uninsurance on Mortality*. Washington, DC: Urban Institute, 2008. Available at http://www.urban.org/UploadedPDF/411588_uninsured_dying.pdf. Last accessed December 2013.

12 CDC, NCHS. *National Vital Statistics System*. 2012.

APPENDIX D:
MAP Measure Selection Criteria

The Measure Selection Criteria (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.

Criteria

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.

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

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

Sub-criterion 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:

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

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

Sub-criterion 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.

Sub-criterion 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)

Sub-criterion 3.2 Measure sets for public reporting programs should be meaningful for consumers and purchasers

Sub-criterion 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)

Sub-criterion 3.4 Avoid selection of measures that are likely to create significant adverse consequences when used in a specific program.

Sub-criterion 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.

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

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

Sub-criterion 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.

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

Sub-criterion 5.2 Measure set addresses shared decisionmaking, such as for care and service planning and establishing advance directives

Sub-criterion 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).

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

Sub-criterion 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.

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

Sub-criterion 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)

APPENDIX E:
MAP's Recommended Structure for the QRS and High-Leverage Opportunities for Measurement

Summary Indicator	Domain	Subdomain	High-Leverage Opportunity
Experience	Plan Experience	Experience with Health Plan	• Patient and Family Experience/Satisfaction • Shared Decisionmaking • Quality of Providers • Member Complaints and Grievances
		Access to Plan Resources	• Member Access to Information • Member Education • Cultural Competency • Access to Health Plan Resources, Medical Records
		Access to Care	• Access to Care, Specialists, and Network Adequacy • Covered Services/Benefits
	Provider Experience	Provider	• Patient and Family Experience/Satisfaction • Shared Decisionmaking • Access to Medical Records
Cost	Cost	Cost	• Out of pocket costs • Premiums • Efficient Resource Use
Quality	Health Plan Quality	Staying Healthy	• Maternal Health • Well-Infant, Child, Adolescent Care • Behavioral/Mental Health • Screening, Immunization, and Treatment of Infectious Disease • Tobacco, Alcohol, and Substance Use • Weight Management and Wellness Counseling • Dental and Vision Care
		Living with Chronic Illness	• Cardiovascular Care • Diabetes Care • Asthma and Respiratory Care • Cancer Screening and Treatment
		Coordination	• Care Coordination and Case Management • Medication Management • Advanced Illness Care • Care for Older Adults • Readmissions
	Provider Quality	Staying Healthy	• Maternal Health • Well-Infant, Child, Adolescent Care • Behavioral/Mental Health • Screening, Immunization, and Treatment of Infectious Disease • Tobacco, Alcohol, and Substance Use • Weight Management and Wellness Counseling • Dental and Vision Care
		Living with Chronic Illness	• Cardiovascular Care • Diabetes Care • Asthma and Respiratory Care • Cancer Screening and Treatment
		Coordination	• Care Coordination and Case Management • Medication Management • Advanced Illness Care • Care for Older Adults • Readmissions

APPENDIX F:

MAP's Recommended and HHS' Proposed Structure — Side by Side Comparison

Experience

Tier 1	Proposed QRS Indicator	Tier 2	Proposed QRS Domain	Subdomain/High-Leverage Opportunity	Proposed QRS Composite
Experience	Member Experience	Plan Experience	Access	**Access to Care** • Access to Care, Specialists, Mental Health and Substance Use Services, and Network Adequacy • Covered Services/Benefits **Access to Plan Resources** • Member Access to Information • Member Education • Cultural Competency • Access to Health Plan Resources, Medical Records **Experience with Health Plan** • Patient and Family Experience/ Satisfaction • Shared Decisionmaking • Quality of Providers	**Access to Care** • CAHPS – Getting Care Quickly • CAHPS – Getting Needed Care **Access Preventive Visits** • Adolescent Well-Care Visits • Adults' Access to Preventive and Ambulatory Health Services • Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
		Provider Experience	Doctor and Care	• Patient and Family Experience/ Satisfaction • Shared Decisionmaking • Access to Medical Records	**Doctor and Care** • CAHPS – Cultural Competency • CAHPS – Rating of All Health Care • CAHPS – Rating of Personal Doctor • CAHPS – Rating of Specialist Seen Most Often

Cost

Tier 1	Proposed QRS Indicator	Tier 2	Proposed QRS Domain	High-Leverage Opportunity	Proposed QRS Composite
Cost	Plan Efficiency, Affordability and Management	Cost	Plan Service	**Cost** MAP members further defined the cost to include: • Efficient Resource Use • Out of pocket costs • Premiums • Covered Services/Benefits	**Member Experience with Health Plan** • CAHPS – Customer Service • CAHPS – Global Rating of Health Plan • CAHPS – Plan Information on Costs
			Efficiency and Affordability		**Efficient Care** • Appropriate Testing for Children With Pharyngitis • Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis • Relative Resource Use for People with Cardiovascular Conditions – Inpatient Facility Index • Relative Resource Use for People with Diabetes – Inpatient Facility Index • Use of Imaging Studies for Low Back Pain

Quality – Health Plan Quality

Tier 1	Proposed QRS Indicator	Tier 2	Proposed QRS Domain	High-Leverage Opportunity	Proposed QRS Composite
Quality	Clinical Quality Management	Health Plan Quality (Identical HLOs to Provider Quality)	Care Coordination	**Coordination** • Care Coordination and Case Management • Medication Management • Advanced Illness Care • Readmissions	**No Composite** • CAHPS – Coordination of Members' Health Care Services
			Patient Safety (Not on Child Structure)		**No Composite** • Annual Monitoring for Patients on Persistent Medications • Plan All-Cause Readmissions
			Prevention	**Prevention/Staying Healthy** • Maternal Health • Well-Infant, Child, Adolescent Care • Behavioral/Mental Health • Screening, Immunization, and Treatment of Infectious Disease • Tobacco, Alcohol, and Substance Use • Weight Management and Wellness Counseling • Dental and Vision Care **Chronic Management** • Cardiovascular Care • Diabetes Care • Asthma and Respiratory Care • Cancer Screening and Treatment	**Checking for Cancer** (Not on Child Structure) • Breast Cancer Screening • Cervical Cancer Screening • Colorectal Cancer Screening **Maternal Health** (Not on Child Structure) • Prenatal and Postpartum Care: Postpartum Care • Prenatal and Postpartum Care: Timeliness of Prenatal Care **Staying Healthy Adult** (Not on Child Structure) • Adult BMI Assessment • CAHPS – Aspirin Use and Discussion • CAHPS – Flu Shots for Adults • CAHPS – Medical Assistance With Smoking and Tobacco Use Cessation **Staying Healthy Child** • Annual Dental Visit • Childhood Immunization Status • Immunizations for Adolescents • Weight Assessment and Counseling for Nutrition and Physical Activity Children and Adolescents: BMI Percentile Documentation
			Clinical Effectiveness		**Behavioral Health** • Antidepressant Medication Management • Follow-Up After Hospitalization for Mental Illness: 7 days • Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase **Cardiovascular Care** (Not on Child Structure) • Cholesterol Management for Patients With Cardiovascular Conditions: LDL-C Control (<100 mg/Dl) • Cholesterol Management for Patients With Cardiovascular Conditions: LDL-C Screening • Controlling High Blood Pressure **Diabetes Care** (Not on Child Structure) • Diabetes Care: Eye Exam (Retinal) Performed • Diabetes Care: Hemoglobin A1c (HbA1c) Control <8.0% **No Composite** • Medication Management for Asthma

Quality – Provider Quality

Tier 1	Proposed QRS Indicator	Tier 2	Proposed QRS Domain	High-Leverage Opportunity	Proposed QRS Composite
Quality	Clinical Quality Management	Provider Quality (Identical HLOs to Health Plan Quality)	Care Coordination	**Coordination** • Care Coordination and Case Management • Medication Management • Advanced Illness Care • Readmissions	**No composite** • CAHPS – Coordination of Members' Health Care Services
			Patient Safety (Not on Child Structure)		**No Composite** • Annual Monitoring for Patients on Persistent Medications • Plan All-Cause Readmissions
			Prevention	**Prevention/Staying Healthy** • Maternal Health • Well-Infant, Child, Adolescent Care • Behavioral/Mental Health • Screening, Immunization, and Treatment of Infectious Disease • Tobacco, Alcohol, and Substance Use • Weight Management and Wellness Counseling • Dental and Vision Care Chronic Management • Cardiovascular Care • Diabetes Care • Asthma and Respiratory Care • Cancer Screening and Treatment	**Checking for Cancer** (Not on Child Structure) • Breast Cancer Screening • Cervical Cancer Screening • Colorectal Cancer Screening **Maternal Health** (Not on Child Structure) • Prenatal and Postpartum Care: Postpartum Care • Prenatal and Postpartum Care: Timeliness of Prenatal Care **Staying Healthy Adult** (Not on Child Structure) • Adult BMI Assessment • CAHPS – Aspirin Use and Discussion • CAHPS – Flu Shots for Adults • CAHPS – Medical Assistance With Smoking and Tobacco Use Cessation **Staying Healthy Child** • Annual Dental Visit • Childhood Immunization Status • Immunizations for Adolescents • Weight Assessment and Counseling for Nutrition and Physical Activity Children and Adolescents: BMI Percentile Documentation
			Clinical Effectiveness		**Behavioral Health** • Antidepressant Medication Management • Follow-Up After Hospitalization for Mental Illness: 7 days • Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase **Cardiovascular Care** (Not on Child Structure) • Cholesterol Management for Patients With Cardiovascular Conditions: LDL-C Control (<100 mg/Dl) • Cholesterol Management for Patients With Cardiovascular Conditions: LDL-C Screening • Controlling High Blood Pressure **Diabetes Care** (Not on Child Structure) • Diabetes Care: Eye Exam (Retinal) Performed • Diabetes Care: Hemoglobin A1c (HbA1c) Control <8.0% **No Composite** • Medication Management for Asthma

APPENDIX G:
MAP's Recommendations and Rationale on HHS' Proposed Family and Child QRS Measures

Proposed QRS Set	Measure # and NQF Status	Measure Title	MAP Recommendation and Rationale	MAP Additional Findings
Family and Child Core Sets	0006 *Endorsed*	CAHPS – Customer Service	**Support** NQF-endorsed® measure Addresses program goals/ requirements Promotes alignment across programs, settings, and public- and private-sector efforts	
Family and Child Core Sets	0006 *Endorsed*	CAHPS – Global Rating of Health Plan	**Support** NQF-endorsed measure Addresses program goals/ requirements Promotes alignment across programs, settings, and public- and private-sector efforts	MAP recommends continued study of this measure to identify what factors, such as cost, drive performance on this measure.
Family and Child Core Sets	0006 *Endorsed*	CAHPS – Plan Information on Costs	**Support** NQF-endorsed measure Addresses program goals/ requirements Promotes alignment across programs, settings, and public- and private-sector efforts	
Family and Child Core Sets	*Not Endorsed*	CAHPS – Cultural Competency	**Conditional Support** Not ready for implementation; measure needs further experience or testing before being used in the program	MAP expressed concerns that this measure assesses provider performance rather than health plan performance. AOA supports MAP's conclusion.
Family and Child Core Sets	0006 *Endorsed*	CAHPS – Getting Care Quickly	**Support** NQF-endorsed measure Addresses program goals/ requirements Promotes alignment across programs, settings, and public- and private-sector efforts	

Proposed QRS Set	Measure # and NQF Status	Measure Title	MAP Recommendation and Rationale	MAP Additional Findings
Family and Child Core Sets	0006 *Endorsed*	CAHPS – Getting Needed Care	**Support** NQF-endorsed measure Promotes alignment across programs, settings, and public- and private-sector efforts Promotes person- and family-centered care	
Family and Child Core Sets	*Not Endorsed*	Adolescent Well-Care Visits	**Do Not Support** Measure does not adequately address any current needs of the program	This measure assesses if adolescents have an annual visit; however, evidence does not exist to support annual visits for adolescents. AHIP supports MAP's conclusion.
Family and Child Core Sets	1516 *Endorsed*	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	**Support** NQF-endorsed measure Addresses National Quality Strategy aim or priority not adequately addressed in program measure set Promotes alignment across programs, settings, and public- and private-sector efforts	
Child Core Set	1392 *Endorsed*	Well-Child Visits in the First 15 Months of Life	**Support** NQF-endorsed measure Addresses National Quality Strategy aim or priority not adequately addressed in program measure set Addresses program goals/ requirements	
Family Core Set	*Not Endorsed*	Adults' Access to Preventive and Ambulatory Health Services	**Do Not Support** Measure does not adequately address any current needs of the program	This measure assesses if adults over 20 have an annual visit; however, evidence does not exist to support annual visits for adults. AHIP supports MAP's conclusion.

Proposed QRS Set	Measure # and NQF Status	Measure Title	MAP Recommendation and Rationale	MAP Additional Findings
Child Core Set	*Not Endorsed*	Children and Adolescents' Access to Primary Care Practitioners	**Do Not Support** Measure does not adequately address any current needs of the program A 'Supported' measure under consideration addresses a similar topic and better addresses the needs of the program	MAP prefers NQF# 1516 Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life. This measure assesses if children had any visit with a primary care practitioner—evidence supports PCP visits for children under 6, that care will be captured in NQF# 1516. AHIP supports MAP's conclusion.
Family and Child Core Sets	0006 *Endorsed*	CAHPS – Rating of All Health Care	**Support** NQF-endorsed measure Addresses program goals/ requirements Promotes alignment across programs, settings, and public- and private-sector efforts	
Family and Child Core Sets	0006 *Endorsed*	CAHPS – Rating of Personal Doctor	**Support** NQF-endorsed measure Promotes alignment across programs, settings, and public- and private-sector efforts Promotes person- and family-centered care	MAP suggested that the measure be revised to account for the entire healthcare team, rather than just the doctor.
Family and Child Core Sets	0006 *Endorsed*	CAHPS – Rating of Specialist Seen Most Often	**Support** NQF-endorsed measure Promotes alignment across programs, settings, and public- and private-sector efforts Promotes person- and family-centered care	

Proposed QRS Set	Measure # and NQF Status	Measure Title	MAP Recommendation and Rationale	MAP Additional Findings
Family and Child Core Sets	0002 *Endorsed*	Appropriate Testing for Children With Pharyngitis	**Support** NQF-endorsed measure Addresses National Quality Strategy aim or priority not adequately addressed in program measure set Promotes alignment across programs, settings, and public- and private-sector efforts	
Child Core Set	0069 *Endorsed*	Appropriate Treatment for Children with Upper Respiratory Infection	**Support** NQF-endorsed measure Addresses National Quality Strategy aim or priority not adequately addressed in program measure set Addresses a measure type not adequately represented in the program measure set	
Family Core Set	0058 *Endorsed*	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	**Support** NQF-endorsed measure Addresses National Quality Strategy aim or priority not adequately addressed in program measure set Promotes alignment across programs, settings, and public- and private-sector efforts	
Family Core Set	1558 *Endorsed*	Relative Resource Use for People with Cardiovascular Conditions – Inpatient Facility Index	**Conditional Support** Use complete NQF-endorsed measure	The measure should be used as endorsed; the measure cannot be reported without considering outpatient costs. MAP expressed caution about using this measure for consumer decisionmaking; consumer education is needed so that consumers can interpret resource use measures. AHIP does not support MAP's conclusion.

Proposed QRS Set	Measure # and NQF Status	Measure Title	MAP Recommendation and Rationale	MAP Additional Findings
Family Core Set	1557 *Endorsed*	Relative Resource Use for People with Diabetes – Inpatient Facility Index	**Conditional Support** Use complete NQF-endorsed measure	The measure should be used as endorsed; the measure cannot be reported without considering outpatient costs. MAP expressed caution about using this measure for consumer decisionmaking; consumer education is needed so that consumers can interpret resource use measures. AHIP does not support MAP's conclusion.
Family Core Set	0052 *Endorsed*	Use of Imaging Studies for Low Back Pain	**Support** NQF-endorsed measure Addresses National Quality Strategy aim or priority not adequately addressed in program measure set Promotes alignment across programs, settings, and public- and private-sector efforts	
Family Core Set	1517 *Endorsed*	Prenatal and Postpartum Care: Timeliness of Prenatal Care	**Support** NQF-endorsed measure Addresses National Quality Strategy aim or priority not adequately addressed in program measure set Promotes alignment across programs, settings, and public- and private-sector efforts	
Family Core Set	1517 *Endorsed*	Prenatal and Postpartum Care: Postpartum Care	**Support** NQF-endorsed measure Addresses National Quality Strategy aim or priority not adequately addressed in program measure set Promotes alignment across programs, settings, and public- and private-sector efforts	

Proposed QRS Set	Measure # and NQF Status	Measure Title	MAP Recommendation and Rationale	MAP Additional Findings
Family and Child Core Sets	0038 *Endorsed*	Childhood Immunization Status	**Support** NQF-endorsed measure Addresses National Quality Strategy aim or priority not adequately addressed in program measure set Promotes alignment across programs, settings, and public- and private-sector efforts	
Family and Child Core Sets	1407 *Endorsed*	Immunizations for Adolescents	**Support** NQF-endorsed measure Addresses National Quality Strategy aim or priority not adequately addressed in program measure set Promotes alignment across programs, settings, and public- and private-sector efforts	
Family Core Set	0105 *Endorsed*	Antidepressant Medication Management	**Support** NQF-endorsed measure Addresses National Quality Strategy aim or priority not adequately addressed in program measure set Promotes alignment across programs, settings, and public- and private-sector efforts	
Family Core Set	0576 *Endorsed*	Follow-Up After Hospitalization for Mental Illness: 7 days	**Support** NQF-endorsed measure Addresses National Quality Strategy aim or priority not adequately addressed in program measure set Included in a MAP family of measures	
Family and Child Core Sets	0108 *Endorsed*	Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	**Conditional Support** Use complete NQF-endorsed measure	The measure should be used as endorsed, including the rate that assesses continuation and management. In the family core set.

Proposed QRS Set	Measure # and NQF Status	Measure Title	MAP Recommendation and Rationale	MAP Additional Findings
Child Core Set	0108 *Endorsed*	Follow-Up Care for Children Prescribed ADHD Medication: Continuation Phase	**Conditional Support** Use complete NQF-endorsed measure	
Family Core Set	0039 *Endorsed*	CAHPS – Flu Shots for Adults	**Support** NQF-endorsed measure Addresses program goals/ requirements Promotes alignment across programs, settings, and public- and private-sector efforts	MAP recommended that the denominator population be expanded; flu shots are recommended for all age groups.
Child Core Set	0033 *Endorsed*	Chlamydia Screening in Women (Ages 16-20)	**Support** NQF-endorsed measure Addresses National Quality Strategy aim or priority not adequately addressed in program measure set Addresses program goals/ requirements	
Child Core Set	1959 *Endorsed*	HPV Vaccination for Female Adolescents	**Support** NQF-endorsed measure Addresses National Quality Strategy aim or priority not adequately addressed in program measure set Addresses program goals/ requirements	
Family Core Set	0031 *Not Endorsed*	Breast Cancer Screening	**Conditional Support** Not ready for implementation; should be submitted for and receive NQF endorsement	The measure is being updated to reflect guideline changes; implementation should be delayed until the measure is endorsed.
Family Core Set	0032 *Endorsed*	Cervical Cancer Screening	**Conditional Support** Not ready for implementation; should be submitted for and receive NQF endorsement	The measure is being updated to reflect guideline changes; implementation should be delayed until the measure is endorsed.

Proposed QRS Set	Measure # and NQF Status	Measure Title	MAP Recommendation and Rationale	MAP Additional Findings
Family Core Set	0034 *Endorsed*	Colorectal Cancer Screening	**Support** NQF-endorsed measure Addresses National Quality Strategy aim or priority not adequately addressed in program measure set Promotes alignment across programs, settings, and public- and private-sector efforts	
Family Core Set	0027 *Endorsed*	CAHPS – Medical Assistance With Smoking and Tobacco Use Cessation	**Support** NQF-endorsed measure Addresses program goals/ requirements Promotes alignment across programs, settings, and public- and private-sector efforts	
Family and Child Core Sets	0024 *Endorsed*	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents: BMI Percentile Documentation	**Conditional Support** Use complete NQF-endorsed measure	The measure should be used as endorsed, including the rate that assesses follow-up.
Family Core Set	*Not Endorsed*	Adult BMI Assessment	**Do Not Support** Measure does not adequately address any current needs of the program Measure previously submitted for endorsement and was not endorsed	Documentation of BMI assessment is insufficient; measurement should include evidence-based intervention and outcome.
Family and Child Core Sets	1388 *Endorsed*	Annual Dental Visit	**Support** NQF-endorsed measure Addresses National Quality Strategy aim or priority not adequately addressed in program measure set Promotes alignment across programs, settings, and public- and private-sector efforts	

Proposed QRS Set	Measure # and NQF Status	Measure Title	MAP Recommendation and Rationale	MAP Additional Findings
Family Core Set	*Not Endorsed*	Controlling High Blood Pressure	**Support** NQF-endorsed measure Addresses National Quality Strategy aim or priority not adequately addressed in program measure set Promotes alignment across programs, settings, and public- and private-sector efforts	The measure is undergoing updates to address current guidelines.
Family Core Set	*Not Endorsed*	CAHPS – Aspirin Use and Discussion	**Do Not Support** Measure does not adequately address any current needs of the program	The measure does not address recent guideline changes and does not have a method for determining if respondents are clinically indicated for aspirin.
Family Core Set	*Not Endorsed*	Cholesterol Management for Patients With Cardiovascular Conditions: LDL-C Control (<100 mg/Dl)	**Do Not Support** Measure does not adequately address any current needs of the program	The measure is undergoing updates to address recent guideline changes; implementation should be delayed until the measure is endorsed.
Family Core Set	*Not Endorsed*	Cholesterol Management for Patients With Cardiovascular Conditions: LDL-C Screening	**Do Not Support** Measure does not adequately address any current needs of the program	The measure is undergoing updates to address recent guideline changes; implementation should be delayed until the measure is endorsed.
Family Core Set	0055 *Endorsed*	Diabetes Care: Eye Exam (Retinal) Performed	**Support** NQF-endorsed measure Addresses National Quality Strategy aim or priority not adequately addressed in program measure set Promotes alignment across programs, settings, and public- and private-sector efforts	

Proposed QRS Set	Measure # and NQF Status	Measure Title	MAP Recommendation and Rationale	MAP Additional Findings
Family Core Set	0575 *Endorsed*	Diabetes Care: Hemoglobin A1c (HbA1c) Control <8.0%	**Support** NQF-endorsed measure Addresses National Quality Strategy aim or priority not adequately addressed in program measure set Promotes alignment across programs, settings, and public- and private-sector efforts	
Family and Child Core Sets	*1799 Endorsed*	Medication Management for People With Asthma	**Support** NQF-endorsed measure Addresses National Quality Strategy aim or priority not adequately addressed in program measure set Promotes alignment across programs, settings, and public- and private-sector efforts	
Family and Child Core Sets	*Not Endorsed*	CAHPS – Coordination of Members' Health Care Services	**Support** Addresses program goals/ requirements Promotes alignment across programs, settings, and public- and private-sector efforts Addresses National Quality Strategy aim or priority not adequately addressed in program measure set	
Family Core Set	D0021 *Endorsement Withdrawn*	Annual Monitoring for Patients on Persistent Medications	**Conditional Support** Not ready for implementation; should be submitted for and receive NQF endorsement	The measure is undergoing updates and will be submitted for endorsement; implementation should be delayed until the measure is endorsed.

Proposed QRS Set	Measure # and NQF Status	Measure Title	MAP Recommendation and Rationale	MAP Additional Findings
Family Core Set	1768 *Endorsed*	Plan All-Cause Readmissions	**Support** NQF-endorsed measure Addresses National Quality Strategy aim or priority not adequately addressed in program measure set Promotes alignment across programs, settings, and public- and private-sector efforts	

APPENDIX H:
Public Comments

Section 1: General Comments on the Report

America's Health Insurance Plans

Carmella Bocchino

Measures used must represent the best available assessment of performance within each domain.

We believe there is value in multiple sources of data for quality measurement and support the exploration of additional data sources, such as registries that collect patient-reported outcomes.

Federation of American Hospitals

Jayne Chambers

The FAH is a long-time supporter of efforts to coordinate quality improvement across settings and commends the report for creating a framework that builds upon existing quality reporting. However, the FAH believes the report could be stronger by clearly outlining an underlying set of principles. The FAH recommends the following principles in establishing a national approach to the development of a Quality Rating System (QRS) for Qualified Health Plan (QHPs).

The QRS should build on the quality standards already employed in existing quality measurement programs. We believe that building on current methodologies and measures will result in more efficient, consistent and understandable quality measures for enrollees, providers and Exchanges. As such, FAH recommends that the report emphasize that QRS should begin with existing national quality and efficiency measures used by CMS in the various hospital, physician, pharmaceutical, home health (to name a few) quality programs. All of these programs provide a rich basis from which to draw measures to address many different patient populations.

Tapping into the infrastructure of these federal quality reporting programs provides ready access to the collection and reporting systems that support these programs. Using existing systems will permit providers and QHPs alike to maintain their focus on patient care and quality improvement and to avoid the increased costs of creating new quality measures and infrastructures for data collection and validation.

Secondly, the FAH recommends that any of the quality measures used in a QRS comparison or evaluation program: (1) support the goals of the National Quality Strategy (NQS); (2) be endorsed by the National Quality Forum ("NQF"); and, (3) recommended for use in specific settings by the Measure Applications Partnership ("MAP").

Florida Blue

Josh Fraum

1. Challenges to Implementation

We are concerned that as an entirely new quality rating system, the proposed Health Insurance Exchange QRS is too comprehensive, too complex, and too administratively burdensome for Health Plans to implement in the near term. We firmly agree with MAP's assessment that "many aspects of the vision for the QRS might not be feasible for implementation in 2016," stating that Health Plans would have a difficult time reporting on new measures in addition to those already reported by Plans.

At a time when the cost of health care reform is at its highest, the health care industry should be cautious of indirectly increasing Health Plan and provider spending. Vendor services necessary for a QRS comprised of over 60 measures is a massive financial expense. We estimate that the current cost of vendor-related services for the QRS to be about $10 million per 500,000 members or about $20 per member per year. Furthermore, each Health Plan would have additional and significant expenses generated by the need to hire new analytical and clinical staff, major IT projects, new measure-related manual processes, and other QRS-related

expenditures. Moreover, for Medical Loss Ratio purposes, QRS-related spending would inflate the administrative expenses of Health Plans, which if not a qualifying "quality improvement expenditure," may lead to higher premiums.

In terms of cost, we are concerned about comparing the QRS to the Medicare Star Ratings program. The consumer market is a far more price-sensitive market than the Medicare Advantage market. The cost per member for a Medicare Advantage beneficiary is several times more expensive and the Medicare Advantage market has a greater capacity to offset significant costs by changing benefit structures. In the consumer market, these significant costs could push a young adult deciding to buy a bronze plan to go without coverage. The consumer market cannot absorb these price increases, especially since some QHP enrollees only purchase QHPs to avoid the tax penalty. The consumer market population is generally healthier, utilizes services less frequently, and more likely to view being uninsured as an alternative. An effective QRS does not need to mirror the cost or complexities of the Medicare Star Ratings System.

(continued on next comment)

Florida Blue

Josh Fraum

(continued from previous comment)

2. Phased Approach to Implementation

We also agree with MAP that the QRS needs to have a phased approach to implementation. If CMS takes the approach to ease into implementation, by controlling Health Plan costs and limiting the QRS to measures already reported by Health Plans, the chances for the success of the QRS would be considerably higher. We stress the importance of simplification in the early years. An incremental approach, starting with no more than 20 essential quality measures would be tolerable for Health Plans. In subsequent years, new measures should be added, but limited only to NQF-endorsed measures. Careful consideration of the utility, effectiveness, and meaningfulness of the initial measure set, as well as the impact to Health Plans, should be taken into account before moving on to the next phase of implementation.

3. Incentivize Broad Provider Networks and Participation in All Counties in a Given State

As a Health Plan, one of our key concerns with the proposed QRS is that it may create perverse incentives for Health Plans to only focus in populous counties within a given state and limit the provider network in those counties. The smaller the geographic area a Health Plan has to focus on, the easier it will be for that Plan to raise its quality rating. Furthermore, this could lead to some Health Plans only including providers in their networks that optimize their provider coding to get the best quality scores. We firmly believe that participation in more counties in a given state should be incentivized by any Health Plan quality rating system. There should also be additional incentives to have broader provider networks and participate in rural counties.

In terms of methodology on this issue, we are again concerned about comparing the QRS to the Medicare Star Ratings program. Medicare Advantage Organizations that offer products in many rural areas and that have inclusive networks are at a disadvantage when it comes to the Medicare Star Ratings System. Using Medicare Stars for the proposed Marketplace QRS would incentivize cherry-picking, limiting access to providers, and limiting coverage options in rural areas. The proposed methodology would inadvertently incentivize Health Plans to focus on select metropolitan areas and offer narrow provider networks to ensure better quality ratings.

Memphis Business Group on Health

Cristie Travis

Regarding The Path Forward section, Memphis Business Group on Health supports phasing in additional measures and functionality in the QRS. We do believe that the proposed timeline of adding provider-level performance within three years following initial implementation and functionality for customized information within five years following initial implementation are too far into the future. With initial implementation scheduled for 2016, provider-level performance would not be available until 2019 and the improved functionality would not be available until 2021. The ability to add these aspects to the QRS exists today. Development and

implementation work needed to add these aspects could begin now resulting int he ability to add them to QRS more quickly. These aspects should be prioritized for implementation so consumers can use this information and functionality to select plans and policies that meet their specific needs.

Section 2: Vision for Enabling Consumer Choice in the Health Insurance Marketplaces

American Optometric Association

Kara Webb

The American Optometric Association (AOA) supports the NQF recommendation to make the QRS interactive and customizable. For the QRS to be successful it must be meaningful to consumers. Giving consumers the option to emphasize the information that is most important to them is critical to ensuring the value of the QRS. Additionally, as the MAP has indicated, QRS information must be provided in consumer friendly terms. Including feedback loops whereby consumers can provide information on the usefulness of the QRS data would also be helpful.

With regard to provider performance, the MAP has indicated that additional work is needed to determine the best approach for including this type of data in the QRS. The AOA concurs. The provider performance measures currently available have significant limitations. Before including provider performance information in the QRS we must ensure that the measures used are valid and reliable.

America's Health Insurance Plans

Carmella Bocchino

We agree that information presented to consumers should be accessible and meaningful. To achieve this goal, reporting should be conducted at a level that results in reliable information and avoids issues associated with small numbers, such as reporting at the product (e.g., HMO or PPO) level.

The report's recommendation that the QRS include provider level quality information within three years would accentuate the challenges associated with small numbers. While we are supportive of performance measurement at the provider level, we do not believe that the QRS is the most suitable tool for this level of reporting as other avenues for provider performance reporting that are based on data from all payers would result in more reliable, and thus more meaningful, information on provider performance.

We agree that a quality rating system should present information on the three components of clinical quality, patient experience, and cost. Each of these three components should be displayed separately to consumers, yet displayed so that consumers are encouraged to consider all three during plan selection. Additionally, quality ratings should be displayed and compared at the level that is most useful for consumer decision making; namely, at the regional or market levels rather than at the national level.

A QHP-specific quality rating system should build on existing rating methodology of other rating systems, such as MA Stars or NCQA Health Plan Rankings, while addressing their limitations. For example, NCQA's Health Plan Rankings have shown large differences in plan ratings (from one accreditation category to another) that are based on very small differences in quality scores. To address limitations within the current rating systems, a QHP-specific quality rating system should ensure that quality distinctions made among health plans are based on statistically significant differences in plan quality data so that the ratings are meaningful and useful to consumers.

While both the QRS for health plans offered through the Federally Facilitated Exchange and the QRS framework for state-based exchanges should use existing rating methodologies as a base, states should have some flexibility to supplement their QRS frameworks for state-based exchanges to reflect the specific needs and priorities of the states.

Memphis Business Group on Health

Cristie Travis

Thank you for the very comprehensive and accurate discussion of the alternative views on addressing both health plan and provider performance in the

QRS. Memphis Business Group on Health believes it is essential for the QRS to provide meaningful performance measures at the provider level. For some of the health plan policies offered in the marketplace, care may only be covered if it is provided by in-network providers. For other policies, the out-of-network deductibles and out-of-pocket maximums are often significantly higher (sometimes twice as high for deductibles and three times as high for out-of-pocket) than in-network deductibles and maximums. Such differences are meant to steer people to use in-network providers. Many will not be able to afford the out-of-network financial requirements and will, therefore, be limited to using only in-network providers. Health plans are selling a package of services that includes both health plan services and provider services. Health plans should be held accountable for the quality of the providers they select for their networks. For many people, these in-network provides will be the only providers they can afford to visit.

Section 3: Input on Proposed Marketplaces QRS: Hierarchical Structure

American Optometric Association

Kara Webb

The American Optometric Association (AOA) strongly supports the MAP recommendation to include in the QRS hierarchical structure information related to vision care. Given that pediatric vision services were recognized as an essential health benefit in the Affordable Care Act (ACA), the AOA is especially concerned with ensuring that QHPs are appropriately monitored to confirm that statutorily mandated services are covered and accessible to beneficiaries. The fact that vision care services were not included in the HHS proposed QRS hierarchical structure is a significant omission. The AOA appreciates the MAP recognition of this oversight.

Section 4: Input on Proposed Marketplaces QRS: Measures

American Optometric Association

Kara Webb

The MAP has indicated that they conditionally support the inclusion of the CAHPS-Cultural Competency measure in the QRS and indicated that the task force expressed concerns that this measure assesses provider performance rather than health plan performance. The American Optometric Association (AOA) shares the task force's concerns and does not support the inclusion of this measure in the QRS.

The MAP has recommended the inclusion of the diabetes care eye examination measure in the QRS. The AOA fully supports the MAP's recommendation. Inclusion of this measure in the QRS is an important indicator of the quality of diabetic care coverage offered by health plans and will be helpful to consumers. The AOA also believes that the MAP should recommend that the QRS include a measure related to the essential benefit for pediatric eye care. The AOA recommends that for the essential benefit related to pediatric eye care, which includes an eye exam in every state and eyeglasses in nearly every state, CMS should use the current Annual Dental Visit measure (NQF 1388) as a model. The pediatric eye care measure could capture the percentage of members 0-19 who had at least one billable visit to an eye care professional (optometrist or ophthalmologist) during the measurement year. The numerator statement would read, "had at least one eye care professional visit during the measurement year" and the denominator statement would read, "members 0-19 years of age. Report six age stratifications and a total rate: 0-3 years, 4-6 years, 7-10 years, 11-14 years, 15-19 years and Total." Using the Annual Dental Visit measure as a model for a new measure would allow CMS to gather information regarding pediatric eye care services. This would give consumers valuable information regarding QHP success in providing access to needed health care services for children. The AOA also intends to bring this recommendation to the National Committee for Quality Assurance (NCQA), the measure steward for the Annual Dental Visit measure, to develop the

comparable measure for annual eye examinations for children.

America's Health Insurance Plans

Carmella Bocchino

Visit frequency measures, such as the proposed Adolescent Well-Care Visits measure, are not meaningful measures of access. Moreover, access is thoroughly assessed during the accreditation process and additional measurement would be redundant.

RRU measures, such as the Relative Resource Use for People with Cardiovascular Conditions and the Relative Resource Use for People with Diabetes Inpatient Facility Index measures, are not meaningful measures for consumers to use in assessing efficiency as they don't directly address affordability for consumers, particularly given the proposal to only use the inpatient utilization portion of the measures. NCQA has decided to eliminate RRU measures from its formulation of health plan rankings.

CMS should look at broader measures of efficiency, such as total cost of care, for use in reporting in future years.

Consumers' Checkbook

Robert Krughoff

Appendix G of the report says that the task force recommended making the Global Rating of Health Plan measure conditional and delaying its use to allow further study of the measure. I don't remember that decision and I believe a substantial plurality of task force members supported the measure.

A question was raised as to whether respondents to this global rating CAHPS question might be giving too much weight to cost. I agree that cost might be part of what respondents have in mind, and that issue has been raised in the past with the CAHPS developers. Nonetheless, this question has been retained and widely reported for many years. As the report acknowledges, this is information that is "highly valued by consumers." Many want an overall measure. Also, it is worth noting that cost is likely a larger consideration in other measures we are recommending like the low back pain measure .

Measures like overall rating of care don't give enough of the picture—ignoring customer service, claims handling, and possible hassles, unresponsiveness, or unfairness that many consumers worry they might experience in a plan.

We have always encouraged the CAHPS team to try to include a measure that looks at plan quality overall other than cost, but a measure that begins with "apart from the cost, how would you rate…" has never been put in place. And the global plan rating has been used for years.

PQA

Woody Eisenberg

PQA agrees with the MAP's recommendation to include NQF measure #0541 Proportion of Days Covered (PDC), rates by therapeutic class. Chronic conditions account for the great majority of the health burden to patients and costs to our health care system, and for most of these conditions, medications are a first line of therapy. Poor adherence to medications is a widely recognized factor in failure of therapy, contributes substantially to increased costs. Yet, there are very few QRS measures related to medication use, and specifically for adherence to medications treating chronic conditions.

Additionally, this PQA- and NQF-endorsed adherence measure #0541 is currently implemented in federal, state and private sector programs. This harmonization across various programs is another stated goal for the QRS program that is currently being developed.

The PDC adherence measure has been thoroughly tested, has been in use in the marketplace for several years, and is based on readily available automated data sources. These include pharmacy claims data, pharmacy dispensing data, prescription drug event (PDE) data, electronic prescribing data and the Long Term Care Minimum Data Set (MDS). Importantly, steady improvement in adherence has been demonstrated for several years using this measure in the CMS Star Ratings program.

We agree with the MAP's recommendation on inclusion of the NQF measure #0541 to address the widely recognized and important problem of poor adherence to medications essential in the management of chronic illnesses.

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