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.[2]

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.[3] 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-decision making.
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.

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[2] 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 www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf. Last accessed August 2011.

[3] http://www.healthcare.gov/law/resources/reports/nationalqualitystrategy032011.pdf

Coordination with Other Quality Efforts

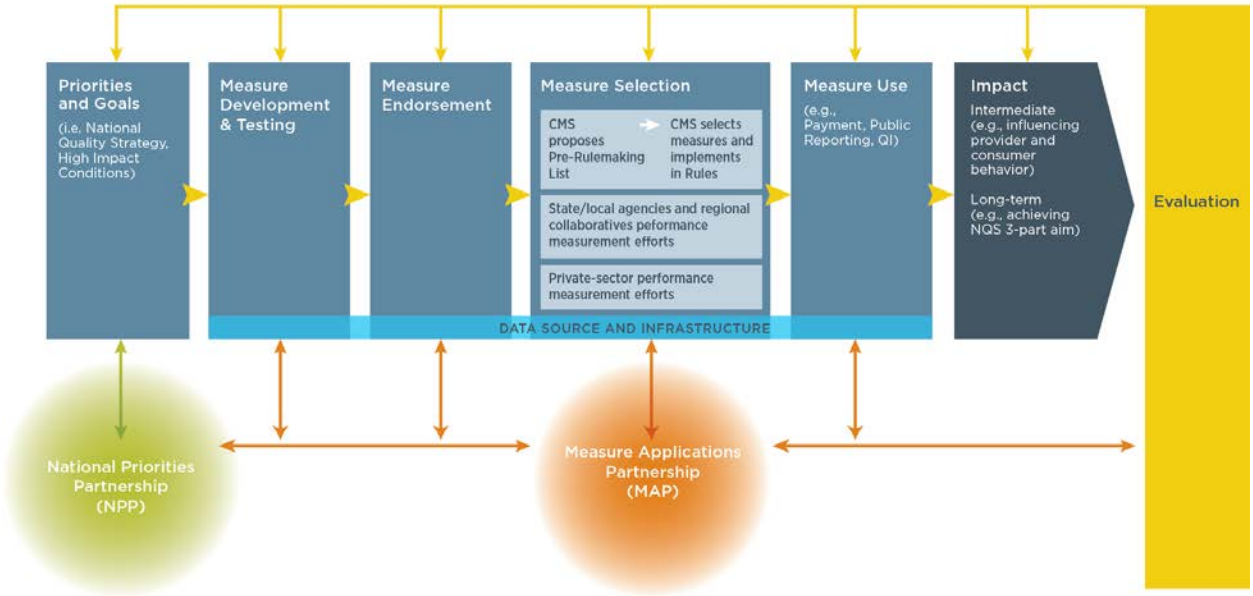
MAP activities are designed to coordinate with and reinforce other efforts for improving health outcomes and healthcare quality. Key strategies for reforming healthcare delivery and financing include publicly reporting performance results for transparency and healthcare decision-making, aligning payment 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 1) that includes:

- **Setting priorities and goals.** The National Priorities Partnership (NPP) is a multi-stakeholder group convened by NQF to provide input to HHS on the NQS, by identifying priorities, goals, and global measures of progress. The priorities and goals established serve as a guiding framework for the Quality Enterprise.
- **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.

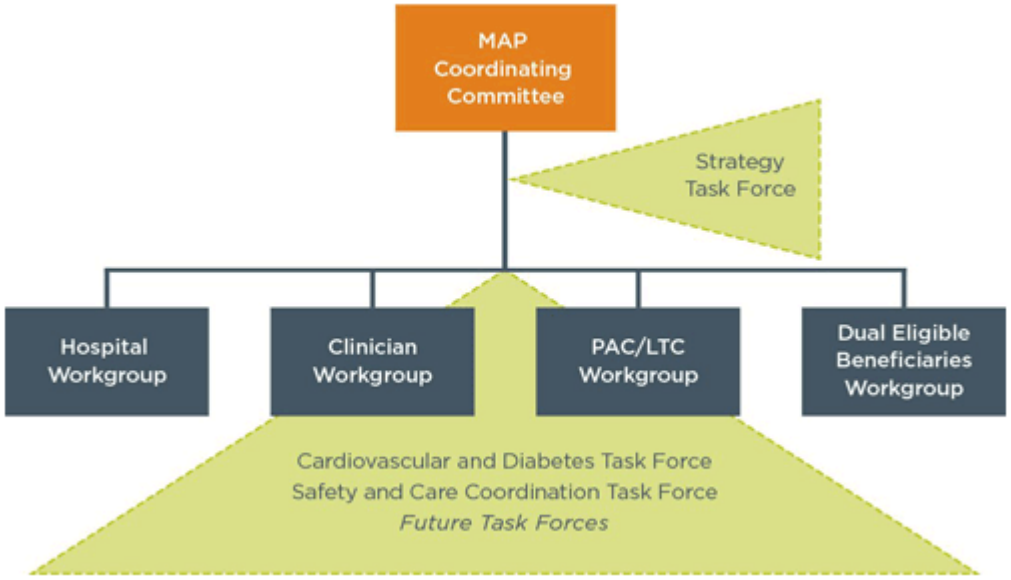
Figure 1. Functions of the Quality Enterprise.



Structure

MAP operates through a two-tiered structure (see Figure 2). 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.

Figure 2. MAP 2012 Structure



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 decision-making is based on a foundation of established guiding frameworks. The NQS is the primary basis for the overall MAP strategy. Additional frameworks include the high-impact conditions determined by the NQF-convened Measure Prioritization Advisory Committee, the NQF-endorsed® Patient-Focused Episodes of Care framework,[4] the HHS Partnership for Patients safety initiative,[5] the

[4] NQF, Measurement Framework: Evaluating Efficiency Across Patient Patient-Focused Episodes of Care. Washington DC: NQF; 2010. Available at www.qualityforum.org/Publications/2010/01/Measurement_Framework__Evaluating_Efficiency_Across_Patient-Focused_Episodes_of_Care.aspx. Last accessed March 2012.

[5] 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 March 2012.

HHS Prevention and Health Promotion Strategy,[6] the HHS Disparities Strategy,[7] and the HHS Multiple Chronic Conditions framework.[8]

Additionally, the MAP Coordinating Committee has developed Measure Selection Criteria to help guide MAP decision-making. The MAP Measure Selection Criteria are intended to build on, not duplicate, the NQF endorsement criteria. The Measure Selection Criteria characterize the fitness of a measure set for use in a specific program by, among other things, how the measure set addresses the NQS's priority areas and the high-impact conditions, and by whether the measure set advances the purpose of the specific program without creating undesirable consequences.

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 2012 Pre-Rulemaking Report submitted to HHS February 1, 2012 and 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 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 October 15, 2013

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[6] 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 March 2012.
[7] HHS,. National Partnership for Action to End Health Disparities, Washington, DC: HHS; 2011. Available at http://minorityhealth.hhs.gov/npa/. Last accessed March 2012.
[8] HHS, HHS Initiative on Multiple Chronic Conditions, Washington, DC: HHS: 2011. Available at www.hhs.gov/ash/initiatives/mcc/. Last accessed March 2012.

- Provided a measurement strategy and best available measures for evaluating the quality of care provided to Medicare/Medicaid **Dual Eligible Beneficiaries**.
    - 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
- 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

Introduction

The Measure Applications Partnership (MAP) is a public-private partnership convened by the National Quality Forum (NQF) for the purpose of providing input to the Department of Health and Human Services (HHS) on the selection of performance measures for use in federal public reporting, performance-based payment programs, and other purposes (see MAP Background) MAP's careful balance of interests is designed to provide HHS and the field with thoughtful and varied input from stakeholders who are invested in the use of measures. MAP also assesses and promotes alignment of measurement across federal programs and between public- and private-sector initiatives to streamline the costs of measurement and focus improvement efforts.

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

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

Under statute, HHS is required to publish annually a list of measures under consideration for future federal rulemaking and to consider MAP's recommendations about the measures during the rulemaking process. Now in its third year, this annual pre-rulemaking process affords MAP the opportunity to review the measures under consideration for federal rulemaking and provide upstream input to HHS in a global and strategic manner.

During its review of the measures under consideration, MAP built on its previous pre-rulemaking decisions and looked to the coordination strategies and families of measures it has created to prioritize the most significant measures and prominent gaps. In addition, the MAP Measure Selection Criteria enabled MAP to offer specific and actionable pre-rulemaking input that continues to emphasize alignment across programs and the need to fill high-priority gaps in measurement. This 2014 MAP Pre-Rulemaking Report provides recommendations on 234 unique measures under consideration by HHS for 20 clinician, hospital, and post-acute care/long-term care performance measurement programs.

MAP Strategic Plan

In recognition of the complexity and importance of MAP's role, MAP completed a strategic planning process in 2012 and produced the MAP Strategic Plan: 2012-2015. The plan offers objectives and actionable steps to make MAP's work more useful to a variety of public- and private-sector stakeholders, representative of a true partnership in pursuit of national improvement priorities.

To meet its stated objectives, MAP identified strategies and tactics designed to ensure that the goals are addressed with increasing sophistication as MAP evolves. The table below lists MAP's tactics to achieve its goals and objectives, accomplishments in 2013, and the contribution of these efforts to enhancing the current pre-rulemaking cycle.

Table 1. MAP Strategic Plan Tactics, Accomplishments, and Contribution to Pre-Rulemaking

MAP Strategic Plan Tactic	Accomplishments in 2013	Contribution to 2014 Pre-Rulemaking Activities
Approach to Stakeholder Engagement – MAP articulated the need to collaborate across multiple stakeholder perspectives to support informed decision-making and to determine whether MAP recommendations are meeting stakeholder needs.	Improved stakeholder balance on MAP Coordinating Committee and workgroups. • 106 nominations submitted for MAP membership, in 2014 (versus 55 in 2012), leading to a broader spectrum of participants and increased consumer and purchaser representation. • New stakeholders added to MAP include: supplier/industry organizations; subject matter experts in palliative care, surgical care, care coordination, Medicaid accountable care organizations, and emergency medicine. Increase in the number of organizations providing public comments on MAP Pre-Rulemaking Report: • 93 organizational comments on 2013 Pre-Rulemaking Report (versus 48 organizational comments on 2012 Pre-Rulemaking Report).	NQF began offering an early public comment period on HHS' list of measures under consideration for 2014 rulemaking. MAP received 145 comments from 43 organizations. The early public comments were used to inform MAP's review of the measures under consideration.

MAP Strategic Plan Tactic	Accomplishments in 2013	Contribution to 2014 Pre-Rulemaking Activities
Identifying Families of Measures and Core Measure Sets – MAP has identified families of measures to promote measure alignment and create core measure sets to encourage the best use of available measures in specific public- and private-sector programs.	To date, MAP has developed seven sets of measures that function as families of measures. They cover the topics of cancer care, cardiovascular disease, care coordination, diabetes, dual eligible beneficiaries, hospice care, and patient safety. Consistent adoption of measures from the families of measures for federal and provide sector programs will increase alignment across measurement initiatives.	Families of measures served as an initial starting place for MAP's evaluation of program measure sets, identifying the best available measures that should be added to a program measure set or measures that should replace previously finalized measures in a program measure set.
Addressing Measure Gaps – To ensure that resources are focused on filling the highest priority gaps and to synchronize public- and private-sector gap-filling efforts, MAP identifies and prioritizes gaps along the measure life cycle.	MAP generated a comprehensive list of previously identified measure gaps compiled from all prior MAP reports to help focus pre-rulemaking discussions. When constructing each family of measures, MAP identified measure gaps for the high-leverage improvement opportunities that lack adequate performance measures. Additionally, MAP invited measure developers to meetings to discuss barriers related to measure gaps and potential solutions.	When reviewing program measure sets, MAP re-evaluated the previously identified gaps, noting where gaps persist and giving a sense of priorities. MAP identified numerous measures to fill gaps during the current pre-rulemaking cycle, and made recommendations to HHS regarding selection of those measures.
Defining Measure Implementation Phasing Strategies – MAP uses measure implementation phasing strategies to delineate how program measure sets should transition over time from current sets to ideal sets.	For MAP's 2013 Pre-Rulemaking Report, MAP provided rationale for each decision, indicating implementation-phasing recommendations when appropriate.	For the 2014 pre-rulemaking deliberations, MAP developed more granular rationale for each decision, designed to make MAP's recommendations clearer and more actionable by HHS as the agency implements changes to program measure sets over time.
Analytic Support for MAP Decision-Making –	NQF established an interdisciplinary team of staff to lead the data	MAP provided additional information—such as

MAP Strategic Plan Tactic	Accomplishments in 2013	Contribution to 2014 Pre-Rulemaking Activities
To provide thorough recommendations on the best performance measures for specific purposes, MAP's decision-making must be systematically informed by evidence, measurement data, and experience in the field.	management and analytic needs of MAP. NQF staff supporting MAP developed an internal MAP Analytics Plan identifying internal and external opportunities for collecting, analyzing, and summarizing measurement information relevant to MAP decision-making. NQF continued to develop an electronic infrastructure for storing and maintaining measurement information.	measure performance results, unintended consequences, impact, and implementation experience—when accessible to support MAP's pre-rulemaking review of measures.
Refining the MAP Measure Selection Criteria (MSC) – MAP envisioned that the MSC will evolve as MAP gains experience using the criteria. Over time, MAP will revisit the selection criteria to ensure that its goals and objectives are clearly articulated within the criteria.	MAP made careful enhancements to the MSC, including integrating the guiding principles developed by the Clinician and Hospital Workgroups. MAP used the MSC consistently to support decision-making, including development of families of measures.	MAP used the MSC to support decision-making about individual measures under consideration, what they would add to program measure sets, and their potential impact.
Evaluating MAP's Processes and Impact – MAP envisions periodic evaluations to gauge the effectiveness of MAP's processes and recommendations and determine whether MAP is meeting stakeholder needs.	NQF staff monitor uptake of MAP's recommendations by HHS as proposed and final rules are issued. MAP continues to observe a high level of concordance between MAP recommendations and measures finalized in federal rules.	NQF staff continued to refine short-term monitoring activities and conduct concordance analyses as federal rules are promulgated and measurement information becomes available. MAP continued to establish formal and informal feedback loops to support informed decision-making. For example, NQF offered a new, structured way for stakeholders to share

MAP Strategic Plan Tactic	Accomplishments in 2013	Contribution to 2014 Pre-Rulemaking Activities
		information on measure use and implementation experience by establishing a feedback form on NQF's online Quality Positioning System (QPS) and collaborating more closely with NQF member councils.

Approach to Pre-Rulemaking

MAP continued to enhance its pre-rulemaking process for the 2013-2014 pre-rulemaking cycle by utilizing the following stepwise approach.

Build on MAP's Prior Recommendations

MAP's prior strategic input and pre-rulemaking decisions provide important building blocks for MAP's ongoing deliberations. MAP's prior inputs and how they contributed to the pre-rulemaking process are described below (also see Table X).

Coordination Strategies elucidated opportunities for public and private stakeholders to accelerate improvement and alignment of measurement initiatives. Each coordination strategy addresses available measures, gaps, and measurement issues; data sources and health information technology implications; alignment opportunities across settings and across public- and private-sector programs; special considerations for dual-eligible beneficiaries; and approaches for improving measure application. The recommendations provided setting-specific considerations that served as background information for MAP's pre-rulemaking deliberations.

2012 and 2013 Pre-Rulemaking Reports provided program-specific input that included recommendations about measures previously finalized for various programs and about measures on the list of measures under consideration for future implementation by HHS. Previous measure-specific recommendations were incorporated into the measure-by-measure deliberations.

Families of Measures facilitate coordination of measurement efforts. Families of Measures are composed 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 (i.e., safety, care coordination), vulnerable populations (i.e., dual eligible beneficiaries, hospice) and high-impact conditions (i.e., cardiovascular, diabetes, cancer).

Table 1 below illustrates how MAP's prior work served as an input to MAP's pre-rulemaking deliberations.

Table 1. Using MAP's Prior Work in Pre-Rulemaking

MAP's Prior Efforts	Pre-Rulemaking Use
Coordination Strategies (i.e., Safety, Clinician, PAC-LTC, Dual Eligible Beneficiaries cross-cutting input)	• Provided topic and setting-specific considerations that served as background information for MAP's pre-rulemaking deliberations. • Key recommendations from each coordination strategy were compiled in background materials.
Families of Measures **NQS priorities (safety, care coordination)** **Vulnerable populations (dual eligible beneficiaries, hospice)** **High-impact conditions (cardiovascular, diabetes, cancer)**	• Represented a starting place for identifying the highest-leverage opportunities for addressing performance gaps within a particular content area. • Served as a basis for determining alignment between public and private sectors.
Decisions from 2012 and 2013 Pre-Rulemaking Reports	• Provided historical context and represented a starting place for pre-rulemaking discussions. • Prior MAP decisions were noted with the individual measure information in background materials.
Gaps identified across all MAP efforts	• Provided historical context of MAP measure gap identification. • Served as a foundation for measure gap prioritization. • A list of MAP's previously identified gaps was compiled and included in background materials.

Using MAP Measure Selection Criteria and Additional Information to Evaluate Program Measure Sets

The MAP Measure Selection Criteria (MSC) are intended to facilitate structured discussion and decision-making processes. MAP made enhancements to the MSC in 2013 for the 2013-2014 pre-rulemaking cycle. Key changes and highlights included: adding a preamble to emphasize that the criteria are meant as guidance rather than rules; balancing the need for strong measure standards with the priority of filling important measure gaps and promoting alignment within and across program measure sets; integrating content from the guiding principles previously developed by the Clinician and Hospital Workgroups; and taking a more inclusive approach to person- and family-centered care and services. Table 2 below identifies inputs available to MAP to evaluate program measure sets against the MSC.

Table 2. Evaluating Program Measure Sets Against the MAP Measure Selection Criteria

Measure Selection Criterion	Information Available and Evaluation
1. NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective	NQF endorsement status was noted for each measure, along with links to additional measure details via NQF's Quality Positioning System (QPS).
2. Program measure set adequately addresses each of the National Quality Strategy's three aims	Provided for each individual measure. MAP discussion determined adequacy of each program

Measure Selection Criterion	Information Available and Evaluation
	measure set in addressing each of the National Quality Strategy (NQS) aims and corresponding priorities.
3. Program measure set is responsive to specific program goals and requirements	For each program, a program information sheet was provided covering: • Statutory requirements • Program goals provided by CMS • Additional information provided in federal rules • MAP's prior key recommendations regarding the program For individual measures, the following information was also provided: • MAP decision history (e.g., supported/not supported, included in a family of measures) • Measure use in private sector initiatives (where available) • Measure use in public programs (where available) • Measure performance (where available)
4. Program measure set includes an appropriate mix of measure types	Measure type provided for each individual measure. MAP discussion determined whether the mix of measure types is appropriate for each program.
5. Program measure set enables measurement of person- and family-centered care and services	MAP discussion informed whether the program measure set addresses access, choice, self-determination, and community integration.
6. Program measure set includes considerations for healthcare disparities and cultural competency	Provided for each individual measure, based on NQF's Disparities Consensus Development Project. MAP discussion determined the adequacy of each program in promoting equitable access and treatment by considering healthcare disparities.
7. Program measure set promotes parsimony and alignment	Parsimony reflects the quantity, as well as the adequacy, of the measure set for each program. Alignment is evaluated through consideration of available information, such as where measures under consideration are used or being considered for other federal and private programs.

Evaluate Currently Finalized Program Measure Sets Using MAP Measure Selection Criteria

MAP used the MSC to evaluate each finalized program measure set (see Appendix X). During the past two years of providing pre-rulemaking input, HHS has asked MAP to review a large number of measures under consideration, under challenging time constraints, for various performance measurement programs. During this pre-rulemaking cycle, MAP reviewed currently finalized measure sets before reviewing measures under consideration to make the winter pre-rulemaking meetings more efficient. Information relevant to assessing the adequacy of the finalized program measure sets was provided to

MAP members. This assessment led to the identification of measure gaps, potential measures for inclusion, potential measures for removal, and other issues regarding program structure.

In reviewing currently finalized program measure sets, MAP provided rationales for one of the following recommendations for each finalized measure:

- **Retain** indicates measures that should remain in the program measure set.
- **Remove** indicates measures that should be removed from a program measure set, according to a justifiable timeline.

Evaluating Measures Under Consideration

The evaluation of each finalized program measure set served as a starting point for reviewing the measures under consideration. Next, MAP determined whether the measures under consideration enhanced the program measure sets. For each measure under consideration, MAP indicated a decision and rationale as well as noted any additional comments or considerations. Table 3 below lists MAP's decision categories and potential rationales.

Table 3. MAP Decision Categories and Rationale Examples

MAP Decision Category	Decision Description	Rationale (Examples)
Support	Indicates measures under consideration that should be added to the program measure set during the current rulemaking cycle	• NQF-endorsed measure • Addresses National Quality Strategy aim or priority not adequately addressed in program measure set • Addresses program goals/requirements • Addresses a measure type not adequately represented in the program measure set • Promotes person- and family-centered care • Provides considerations for healthcare disparities and cultural competency • Promotes parsimony • Promotes alignment across programs, settings, and/or public and private sector efforts • Addresses a high-leverage opportunity for improving care for dual eligible beneficiaries • Included in a MAP family of measures
Do Not Support	Indicates measures, measure concepts, or measure ideas that	• Measure does not adequately address any current needs of the

MAP Decision Category	Decision Description	Rationale (Examples)
	that are not recommended for inclusion in the program measure set	program • A finalized measure addresses a similar topic and better addresses the needs of the program • A 'Supported' measure under consideration addresses a similar topic and better addresses the needs of the program • NQF endorsement removed (the measure no longer meets the NQF endorsement criteria) • NQF endorsement retired (the measure is no longer maintained by the steward) • NQF endorsement placed in reserve status (performance on this measure is topped out) • Measure previously submitted for endorsement and was not endorsed
Conditionally Support	Indicates measures, measure concepts, or measure ideas that should be phased into program measure sets over time, subject to contingent factor(s)	• Not ready for implementation; measure concept is promising but requires modification or further development • Not ready for implementation; should be submitted for and receive NQF endorsement • Not ready for implementation; data sources do not align with program's data sources • Not ready for implementation; further experience or testing needed before being used in the program

To support MAP's pre-rulemaking review of measures, NQF staff identified information for each measure under consideration. The information noted in Table 2 assisted MAP in determining whether the measures under consideration would enhance the finalized program measure sets. Additionally, MAP utilized other information about measures—such as performance results, unintended consequences, impact, and implementation experiences—that NQF staff included in pre-rulemaking measure tables.

To assist MAP's systematic review of the measures under consideration, NQF staff prepared discussion guides for each meeting. The discussion guides facilitated MAP's response to the following questions regarding measures under consideration:

- Is there sufficient information to make a decision?
- Does the measure contribute to the program set (e.g., addresses a gap, advances programmatic goals)?
- Is the measure ready for implementation in a program (e.g., tested for that setting, data sources align with the program's structure)?

The discussion guides allowed MAP to revisit the previously finalized measures and determine whether any measures should be removed from programs. Additionally, the discussion guides provided context for how measures under consideration may enhance program measure sets.

Identifying High-Prioirty Measure Gaps

After reviewing the measures under consideration and making recommendations about which new measures to include in programs, MAP reassessed the program measure sets for remaining high-priority gaps. In addition, MAP highlighted barriers to gap-filling and suggested potential solutions to those barriers.

Physician Quality Reporting System (PQRS)

Program Type:

Pay for Reporting

Incentive Structure:

In 2012-2014, eligible professionals can receive an incentive payment equal to a percentage (2% in 2010, gradually decreasing to 0.5% in 2014) of the eligible professional's estimated total allowed charges for covered Medicare Part B services under the Medicare Physician Fee Schedule.[1] Beginning in 2015, eligible professionals and group practices that do not satisfactorily report data on quality measures will receive a reduction (1.5% in 2015, and 2% in subsequent years) in payment.[2,3]

Care Settings Included:

Multiple. Eligible professionals include:

- Physicians—medicine, osteopathy, podiatric med, optometry, oral surgery, dental med, chiropractic
- Practitioners—physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, clinical social worker, clinical psychologist, registered dietician, nutrition professional, audiologists
- Therapists—physical therapist, occupational therapist, qualified speech-language therapist[4]

Statutory Mandate:

The 2006 Tax Relief and Healthcare Act (TRHCA) required the establishment of a physician quality reporting system. The PQRS was initially implemented in 2007 and was extended as a result of the Medicare, Medicaid, and SCHIP Extension Act of 2008 (MMSEA), the Medicare Improvements for Patients and Providers Act of 2009 (MIPPA), and the Affordable Care Act.[5]

Statutory Requirements for Measures:

The number and type of measures required vary by reporting option (e.g. individual reporting, group web reporting option, EHR reporting).

Program Measure Set Evaluation Using MAP Measure Selection Criteria:

MAP Measure Selection Criteria	Evaluation
1. NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective	Only half of the finalized measures are NQF-endorsed.
2. Program measure set adequately addresses each of the National Quality Strategy's (NQS) three aims	Each of the NQS aims are addressed.
3. Program measure set is responsive to specific program goals and requirements	The measure set includes measures that are applicable to and appropriately tested for the program's intended care setting, level of analysis, and population.
4. Program measure set includes an appropriate mix of measure types	The measure set is comprised of mostly process measures and few outcome measures. Additionally, there is an underrepresentation of patient experience

	and a general lack of cost measures.
5. Program measure set enables measurement of person- and family-centered care and services	The measure set crosses the episode of care as the set includes primary prevention measures, evaluation and initial management, and follow-up care.
6. Program measure set includes considerations for healthcare disparities and cultural competency	A small number of measures are disparities sensitive.
7. Program measure set promotes parsimony and alignment	The measure set address nearly all of the MAP Measure Selection Criteria; however, any subset of measures a clinician chooses to report may not address the criteria. Additionally, very few measures are used in private sector programs.

[1] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/AnalysisAndPayment.html
[2] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Payment-Adjustment-Information.html
[3] CY 2013 PFS final rule. The Office of the Federal Register. http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1
[4] CMS.gov. Downloads Eligible professionals 03-08-2011. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html
[5] CY 2013 PFS final rule. The Office of the Federal Register. http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1

CMS Medicare and Medicaid EHR Incentive Program for Eligible Professionals

Program Type:

Incentive program.

Incentive Structure:

Eligible professionals who demonstrate meaningful use of certified EHR technology, which includes reporting clinical quality measures, can receive incentive payments. The incentives vary by program.[1]

- Medicare. Up to $44,000 over 5 continuous years. The program started in 2011 and will continue through 2014. The last year to begin participation is 2014. Penalties will take effect in 2015 and in each subsequent year for providers who are eligible but do not participate. The penalty is a payment adjustment to Medicare reimbursements that start at 1% per year, up to a maximum 5% annual adjustment.
- Medicaid. Up to $63,750 over 6 years. The program started in 2011 and will continue through 2021. The last year to begin participation is 2016. Payment adjustments do not apply to Medicaid.[2]

Care Settings Included:

Multiple. Under the Medicare EHR incentive program eligible professionals include doctors of medicine, osteopathy, dental surgery, dental medicine, podiatry, and optometry as well as chiropractors. Under the Medicaid EHR incentive program eligible professionals include doctors of medicine and osteopathy, nurse practitioners, certified nurse-midwives, dentists, and physicians assistances furnishing services in a federally qualified health center or rural health clinic.[3]

Statutory Mandate:

The program was created under the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act (ARRA) of 2009.

Statutory Requirements for Measures:

Measures are of processes and experience and outcomes of patient care that relate to one or more quality aims for health care such as effective, safe, efficient, patient-centered, equitable and timely care. Measures must be reported for all patients, not just Medicare and Medicaid beneficiaries.[4] Preference should be given to quality measures endorsed by NQF. [5]

Anticipated Future Rules:

It is anticipated that the Meaningful use Stage 3 proposed rule will be published in early 2014.

Additional Program Considerations:

The goal of the Medicare and Medicaid Electronic Health Record (EHR) Incentive program is to provide measures for eligible professionals under three main components of Meaningful Use:

- The use of a certified EHR in a meaningful manner, such as e-prescribing;
- The use of certified EHR technology for electronic exchange of health information to improve quality of healthcare; and
- The use of certified EHR technology to submit clinical quality and other measures.

For Stage 1:[6]

- Eligible professionals must report on six total clinical quality measures: three required core measures (substituting alternate core measures where necessary) and three additional measures (selected from a set of 38 clinical quality measures).

For Stage 2 (2014 and beyond):[7]

- Eligible Professionals must report on 9 total clinical quality measures that cover 3 of the National Quality Strategy Domains (selected from a set of 64 clinical quality measures).

Program Measure Set Evaluation Using MAP Measure Selection Criteria:

MAP Measure Selection Criteria	Evaluation
1. NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective	Three-quarters of finalized measures are NQF endorsed
2. Program measure set adequately addresses each of the National Quality Strategy's (NQS) three aims	The measure set addresses each of the NQS aims.
3. Program measure set is responsive to specific program goals and requirements	The measure set includes measures that are applicable to and appropriately tested for the program's intended care setting, level of analysis, and population.
4. Program measure set includes an appropriate mix of measure types	Over two-thirds of measures are process measures; outcome measures are included but the set does not include cost or experience measures.
5. Program measure set enables measurement of person- and family-centered care and services	The measure set crosses the episode of care as the set includes primary prevention measures, evaluation and initial management, and follow-up care. Additionally, five measures are patient reported outcome measures
6. Program measure set includes considerations for healthcare disparities and cultural competency	A small number(8) of measures are disparities sensitive
7. Program measure set promotes parsimony and alignment	The measure set addresses many of the MAP Measure Selection Criteria with 76 measures; however, the measure set could be enhanced with a few additional outcomes and cost measures.

[1] http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Basics.html
[2] http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Getting_Started.html
[3] http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/
[4] http://www.gpo.gov/fdsys/pkg/FR-2010-07-28/html/2010-17207.htm
[5] http://www.gpo.gov/fdsys/pkg/FR-2010-07-28/pdf/2010-17207.pdf
[6] http://www.gpo.gov/fdsys/pkg/FR-2010-07-28/html/2010-17207.htm
[7] http://www.gpo.gov/fdsys/pkg/FR-2012-09-04/pdf/2012-21050.pdf

Physician Compare

Program Type:

Public Reporting[1]

Incentive Structure:

None

Care Settings Included:

Multiple. Eligible professionals include:[2]

- Physicians—medicine, osteopathy, podiatric medicine, optometry, oral surgery, dental medicine, chiropractic
- Practitioners—physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, clinical social worker, clinical psychologist, registered dietician, nutrition professional, audiologists
- Therapists—physical therapist, occupational therapist, qualified speech-language therapist

Statutory Mandate:

Section 10331 of the Patient Protection and Affordable Care Act of 2010. The website was launched on December 30, 2010. Performance information will be reported on the website in 2013 or early 2014.

Statutory Requirements for Measures:

Data reported under the existing Physician Quality Reporting System will be used as an initial step for making physician measure performance information public on Physician Compare. The following types of measures are required to be included for public reporting on Physician Compare:[3]

- Patient health outcomes and functional status of patients
- Continuity and coordination of care and care transitions, including episodes of care and risk-adjusted resource use
- Efficiency
- Patient experience and patient, caregiver, and family engagement
- Safety, effectiveness, and timeliness of care

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[1] CMS. Physician Quality Reporting System (PQRS*)*. Baltimore, MD: CMS;2012. Available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/physician-compare-initiative/index.html. Accessed January 2013.
[2] CMS. Physician Quality Reporting System: Measures Codes. Baltimore, MD: CMS;2013. Available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html. Accessed January 2013.
[3] PFS Final Rule 2013.

Value-Based Payment Modifier/Physician Feedback Program

Program Type:

Pay for Performance

Incentive Structure:

Physician Feedback Program

CMS is statutorily required to provide confidential feedback reports to physicians that measure the quality and resources involved in furnishing care to Medicare Fee-for-Service (FFS) beneficiaries. Physician feedback reports also serve currently as the preview vehicle to inform physicians of the types of measures and methodologies that will comprise the value modifier. Starting in the fall of 2013, all groups of physicians with 25 or more eligible professionals will begin receiving Physician Feedback reports.[1]

Value-Based Payment Modifier

The VBPM begins in 2015 for groups of 100 or more eligible professionals and will expand to groups of 10 or more eligible professionals in 2016. VBPM will be applicable to all physicians and groups of physicians on or after January 1, 2017. The VBPM payment adjustment varies over time and must be implemented in a budget neutral manner. Payment adjustment amount is built on satisfactory reporting through PQRS.[2]

In 2015 and 2016, the VBPM will not be applied to groups of physicians that are participating in the Medicare Shared Savings Program, testing of the Pioneer ACO model, or the Comprehensive Primary Care Initiative.[3] Additionally, future rulemaking cycles will determine a VBPM for individuals, smaller groups, and hospital-based physicians.[4]

Care Settings Included:

Multiple. Eligible professionals include:

- Physicians—medicine, osteopathy, podiatric med, optometry, oral surgery, dental med, chiropractic
- Practitioners—physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, clinical social worker, clinical psychologist, registered dietician, nutrition professional, audiologists
- Therapists—physical therapist, occupational therapist, qualified speech-language therapist[5]

Statutory Mandate:

Section 1848(p) of the Social Security Act (the Act) as established by Section 3003 and 3007 of the Affordable Care Act of 2010 (ACA). [6]

Statutory Requirements for Measures:

The program must include a composite of appropriate quality measures and a composite of appropriate cost measures.[7] The Secretary is also required to use NQF-endorsed measures, whenever possible. Final rule indicated, for 2013 and beyond, the use of all measures included in the PQRS.

MAP Pre-Rulemaking 2013 Input:

- Although the recent Physician Fee Schedule final rule signaled CMS' intent to include all measures used in PQRS for VBPM, the Clinician Workgroup recommended a more targeted approach for measures to be used in this program.
- Measures should ideally drive toward value by linking the outcomes most important to patients with measures of cost of care and resource use.
- MAP supported the direction of eight episode grouper-based resource use measures under consideration and two per-capita cost resource use measures currently finalized for use in the VBPM and recommended that these measures be submitted for NQF endorsement and be linked with clinical outcome measures before being used in the VBPM. Those resource use measures are:
    - Episode Grouper: Acute Myocardial Infarction (AMI)
    - Episode Grouper: Pneumonia
    - Episode Grouper: Coronary Artery Bypass Graft (CABG)
    - Episode Grouper: Percutaneous Coronary Intervention (PCI)
    - Episode Grouper: Coronary Artery Disease
    - Episode Grouper: Congestive Heart Failure
    - Episode Grouper: Chronic Obstructive Pulmonary disease (COPD)
    - Episode Grouper: Asthma
- MAP supported the CG-CAHPS patient experience survey for VBPM, noting that the lack of infrastructure in clinician practices may be a barrier to broad application of CG-CAHPS and suggested exploring alternative methods for supporting implementation.

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[1] Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, DME Face-to-Face Encounters, Elimination of the Requirement for Termination of Non-Random Prepayment Complex Medical Review and Other Revisions to Part B for CY 2013 (Final Rule). *Fed Registr* (2012) 77 ;68892-69373. Available at https://www.federalregister.gov/articles/2012/11/16/2012-26900/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-dme-face-to-face. Accessed January 2013.

[2] Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, DME Face-to-Face Encounters, Elimination of the Requirement for Termination of Non-Random Prepayment Complex Medical Review and Other Revisions to Part B for CY 2013 (Final Rule). *Fed Registr* (2012) 77 ;68892-69373. Available at https://www.federalregister.gov/articles/2012/11/16/2012-26900/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-dme-face-to-face. Accessed January 2013.

[3] Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, DME Face-to-Face Encounters, Elimination of the Requirement for Termination of Non-Random Prepayment Complex Medical Review and Other Revisions to Part B for CY 2013 (Final Rule). *Fed Registr* (2012) 77 ;68892-69373. Available at https://www.federalregister.gov/articles/2012/11/16/2012-26900/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-dme-face-to-face. Accessed January 2013.

[4] Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, DME Face-to-Face Encounters, Elimination of the Requirement for Termination of Non-Random Prepayment Complex Medical Review and Other Revisions to Part B for CY 2013 (Final Rule). *Fed Registr* (2012) 77 ;68892-69373. Available at https://www.federalregister.gov/articles/2012/11/16/2012-26900/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-dme-face-to-face. Accessed January 2013.

[5] CMS.gov. Downloads Eligible professionals 03-08-2011. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html

[6] Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, DME Face-to-Face Encounters, Elimination of the Requirement for Termination of Non-Random Prepayment Complex Medical Review and Other Revisions to Part B for CY 2013 (Final Rule). *Fed Registr* (2012) 77 ;68892-69373. Available at https://www.federalregister.gov/articles/2012/11/16/2012-26900/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-dme-face-to-face. Accessed January 2013.

[7] Medicare Program; Payment Policies under the Physician Fee Schedule, Five-Year Review of Work Related Value Units, Clinical Laboratory Fee Schedule: Signature on Requisition, and other Revisions to Part B for CY 2011., *Fed Registr, (*2011) 76 (228): 73026-

73474. Available at https://www.federalregister.gov/articles/2011/11/28/2011-28597/medicare-program-payment-policies-under-the-physician-fee-schedule-five-year-review-of-work-relative. Accessed January 2013.

NATIONAL QUALITY FORUM

Medicare Shared Savings Program

Program Type:

Pay for Reporting and Pay for Performance.[1]

Incentive Structure:

Option for one-sided risk model (sharing of savings only for the first two years, and sharing of savings and losses in the third year) and a two-sided risk model (sharing of savings and losses for all three years).[2]

Care Settings Included:

Providers, hospitals, and suppliers of services

Statutory Mandate:

Sec. 3022 of the Affordable Care Act (ACA) requires the Centers for Medicare & Medicaid Services (CMS) to establish a Medicare Shared Savings Program (MSSP) that promotes accountability for a patient population, coordinates items and services under Medicare Parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery.[3]

Statutory Requirements for Measures:

Appropriate measures of clinical processes and outcomes; patient, and, wherever practicable, caregiver experience of care; and utilization (such as rates of hospital admission for ambulatory sensitive conditions).[4]

MAP 2013 Pre-Rulemaking Program-Specific Input:

- MAP considered the MSSP measure set to be a comprehensive set because it addresses patient experience, other cross-cutting measurement priorities, high-impact conditions, and key quality outcomes.
- MAP noted that the measure set has a heavy emphasis on ambulatory care and could be enhanced with additional acute and post-acute care measures, and measures more relevant to patients with complex medical needs.
- MAP would prefer to move to outcome measures (e.g., clinical depression improvement, rather than only screening) where available, or process measures proximal to outcomes.
- MAP also recommends that adding measures of patient identification of a usual source of care and health information exchange to understand access to care and coordination of services across the system.
- MAP recommends that the MSSP measure set and the Medicare Advantage 5-Star Quality Rating System measure set should be aligned.
- MAP recommends alignment of MSSP and Meaningful Use measures, because integrated systems are increasingly adopting health information technology (HIT) and should have aligned incentives across programs.

Program Measure Set Evaluation Using MAP Measure Selection Criteria:

MAP Measure Selection Criteria	Evaluation
1. NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective	Most (30) of the finalized measures are NQF endorsed.
2. Program measure set adequately addresses each of the National Quality Strategy's (NQS) three aims	The measures address each aim except affordable care.
3. Program measure set is responsive to specific program goals and requirements	The measure set includes measures that are applicable to and appropriately tested for the program's intended care setting, level of analysis, and population.
4. Program measure set includes an appropriate mix of measure types	The measure set is comprised of process, outcome, and patient experience measures, but lacks cost measures.
5. Program measure set enables measurement of person- and family-centered care and services	The measure set crosses the episode of care as the set includes primary prevention measures, evaluation and initial management, and follow-up care. Additionally, two measures are patient-reported outcome measures (PRO).
6. Program measure set includes considerations for healthcare disparities and cultural competency	A small number of measures are disparities sensitive.
7. Program measure set promotes parsimony and alignment	The measure set addresses many of the MAP Measure Selection Criteria with 33 measures; however, the measure set could be enhanced with additional measures of cost, functional status, and patient-reported outcomes. Additionally, over half of the measures are used in private programs; most of the measures are used in other Federal programs.

[1] http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO-Guide-Quality-Performance-2012.PDF
[2] http://www.healthcare.gov/news/factsheets/2011/03/accountablecare03312011a.html
[3] http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf
[4] http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf

Ambulatory Surgical Centers Quality Reporting Program

Program Type:

Pay for Reporting – Information is reported to the Centers for Medicare & Medicaid Services (CMS).[1]

Incentive Structure:

Beginning CY 2014, ambulatory surgical centers (ACSs) that treat Medicare beneficiaries and fail to report data will receive a 2.0 percent reduction in their annual market basket payment update (the measure of change in costs of goods and services used to treat Medicare patients).[2] Data collection for the ASC Quality Reporting Program began in 2012; most measures collected are to be used for payment determination beginning in 2014.

Care Settings Included:

The program includes ASCs operating exclusively to provide surgical services to patients not requiring hospitalization. The expected duration of services would not be expected to exceed 24 hours following admission to the ASC facility.[3]

Statutory Mandate:

CMS is authorized, but not required, to implement a reduction in annual payment updates for facilities failing to report on quality measures under the Medicare Improvements and Extension Act of the Tax Relief and Health Care Act (MIEA-TRHCA) of 2006.

Statutory Requirements for Measures:

The ASC Quality Reporting Program may include the same or similar measures reported in the Hospital Outpatient Quality Reporting (OQR) or Inpatient Quality Reporting (IQR) Programs.

The program measure set should include structure, process, outcome, patients' perspectives on care, efficiency, and costs of care measures. To the extent feasible, outcome and patient experience measures should be risk-adjusted. The Secretary of HHS may:

- Add measures reflecting consensus among the affected parties, and to the extent feasible, include measures set forth by one or more national consensus building entities.
- Replace any measures in appropriate cases (e.g., where all facilities are effectively in compliance or measures do not represent best practice).

In order to reduce the burden of measurement for smaller ASCs, CMS finalized only claims-based measures for the first year of the program and only structural measures for the second year of the program.

MAP 2013 Pre-Rulemaking Input on ASCQR:

- MAP considered five measures under consideration and supported 2 for the ASCQR program during the 2012/2013 pre-rulemaking cycle.
- MAP supported HHS' efforts to move toward greater alignment across the ASCQR program and OQR program.
- MAP supports the inclusion of ambulatory surgical centers (ASC) within a broader system-wide approach to measuring performance and improving care; however, measures should be tested, endorsed, and implemented for the intended level of analysis.
- MAP found the ASCQR program measure set to be inadequate. MAP encourages swift progress in developing, testing, and endorsing applicable measures to address the quality of care for additional procedures commonly performed in ASCs.
- Priority measure gap areas for the ASCQR program include follow-up after procedures, complications, cost, patient and family engagement, an ASC-specific CAHPS module, and patient-reported outcome measures.

Program Measure Set Evaluation Using MAP Measure Selection Criteria:

MAP Measure Selection Criteria	Evaluation
1. NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective	The majority of measures in the set are NQF-endorsed (10 of 12 total).
2. Program measure set adequately addresses each of the National Quality Strategy's (NQS) three aims	The measure set addresses the NQS aim of better care, specifically the priorities of effective clinical care and patient safety. It does not address priorities of patient and family engagement, communication and care coordination, healthy living, or affordability.
3. Program measure set is responsive to specific program goals and requirements	The measure set includes measures that are applicable to and appropriately tested for the program's intended care setting, level of analysis, and population. The set includes measures for public reporting that are meaningful to consumers and purchasers.
4. Program measure set includes an appropriate mix of measure types	The measure set contains structure, process, and outcome measures.
5. Program measure set enables measurement of person- and family-centered care and services	The measure set does not address patient, family, or caregiver experience; shared decision-making; or the assessment of a person's care and services across providers, settings, and time. The measure set does address transfers and admissions to a hospital after treatment in an ASC; these relate to problems with care transitions.
6. Program measure set includes considerations for healthcare disparities and	None of the measures are sensitive to known disparities in healthcare.

	cultural competency	
7.	**Program measure set promotes parsimony and alignment**	Most of the finalized measures are being used only in the ASCQR program and do not align with other Federal programs. Five measures in the set are included in a MAP family of measures.

[1]https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772497737

[2] http://www.gpo.gov/fdsys/pkg/FR-2011-11-30/pdf/2011-28612.pdf

[3] http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/ASCs.html#

Hospital-Acquired Condition Payment Reduction Program

Program Type:

Pay for Performance – Information will be reported on the Hospital Compare website beginning FY 2015.[1]

Incentive Structure:

Hospitals with rates of hospital acquired conditions (HACs)in the top quartile compared to the national average will have their Medicare payments reduced by 1 percent for all DRGs.[2] Prior to FY 2015 and in each subsequent fiscal year, hospitals will receive confidential reports from HHS on their HAC rates to give them the opportunity to review and submit corrections before the information is made public.

The HAC Reduction program consists of two domains of measures. Domain 1 includes Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicator (PSI) measures. Domain 2 includes measures developed by the Centers for Disease Control and Prevention's (CDC) National Health Safety Network (NHSN). Hospitals will be given a score for each measure within the two domains. A domain score will also be calculated—with Domain 1 weighted at 35 percent and Domain 2 weighted at 65 percent—to determine a total score for each hospital in the program. Risk factors such as patients' age, gender, and comorbidities will be considered in the calculation of the measure rates.

Care Settings Included:

Hospitals paid under the Inpatient Prospective Payment System (IPPS). This includes more than three-quarters of all hospitals.[3]

Statutory Mandate:

Section 3008 of the Affordable Care Act requires HHS to establish a program for IPPS hospitals to improve patient safety by imposing financial penalties on hospitals that perform poorly with regard to hospital-acquired conditions.

Statutory Requirements for Measures:

The conditions addressed by this program are the same as those for the policy that mandates no additional payment for treatment of HACs (HAC Payment Provision Program).[4] It can also include any other conditions acquired during a hospital stay that the Secretary deems appropriate. The conditions currently included are:

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Stage III and IV Pressure Ulcers
- Falls and Trauma
    - Fractures
    - Dislocations

    - Intracranial Injuries
    - Crushing Injuries
    - Burn
    - Other Injuries
- Manifestations of Poor Glycemic Control
    - Diabetic Ketoacidosis
    - Nonketotic Hyperosmolar Coma
    - Hypoglycemic Coma
    - Secondary Diabetes with Ketoacidosis
- Catheter-Associated Urinary Tract Infection (UTI)
- Vascular Catheter-Associated Infection
- Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG):
- Surgical Site Infection Following Bariatric Surgery for Obesity
    - Laparoscopic Gastric Bypass
    - Gastroenterostomy
    - Laparoscopic Gastric Restrictive Surgery
- Surgical Site Infection Following Certain Orthopedic Procedures:
    - Spine
    - Neck
    - Shoulder
    - Elbow
- Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)
- Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures:
    - Total Knee Replacement
    - Hip Replacement
- Iatrogenic Pneumothorax with Venous Catheterization

MAP 2013 Pre-Rulemaking Input on the HAC Payment Reduction Program:

- MAP recognized the fine balance between using high-impact measures in multiple programs to sharpen providers' focus on priority improvement areas and the need to avoid unintended consequences of compounding incentives.
- When discussing the possible inclusion of composite measures in the program, MAP cautioned that composites require careful testing and weighting of all individual components to ensure a scientifically rigorous measure. Public commenters reinforced these concerns about composite measures. MAP concluded that if composites were included within this program, then individual measures that are part of a given composite should not be separately included in the program.
- MAP named several measure gaps for this program, including adverse drug events (e.g., wrong dose, wrong patient, drug-drug interactions, drug-allergy interactions), ventilator-associated events (VAEs), sepsis, and an obstetric complications composite measure.

Program Measure Set Evaluation Using MAP Measure Selection Criteria:

MAP Measure Selection Criteria	Evaluation
1. NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective	All of the finalized measures are NQF-endorsed (6 of 6 total).
2. Program measure set adequately addresses each of the National Quality Strategy's (NQS) three aims	The measure set addresses the NQS aim of better care, specifically the priority of patient safety. It does not address the other five NQS priorities.
3. Program measure set is responsive to specific program goals and requirements	Measures in the program are appropriate, but the program does not yet address all conditions named in the HAC Payment Provision Program.
4. Program measure set includes an appropriate mix of measure types	The measure set is composed of outcome and composite measures.
5. Program measure set enables measurement of person- and family-centered care and services	The measure set does not include measures that support shared decision making, patient preferences, and the family/caregiver's role in achieving patient safety.
6. Program measure set includes considerations for healthcare disparities and cultural competency	None of measures are sensitive to known disparities in healthcare.
7. Program measure set promotes parsimony and alignment	The measure set is parsimonious with the inclusion of six measures. All of the measures in the program are in other Federal programs and 5 out of 6 are also used in one or more private sector programs.

[1] http://www.gpo.gov/fdsys/pkg/FR-2011-05-06/pdf/2011-10568.pdf
[2] http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/html/PLAW-111publ148.htm
[3] http://www.aha.org/advocacy-issues/medicare/ipps/index.shtml
[4] http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions.html

Hospital Readmission Reduction Program

Program Type:

Pay for Performance – Hospitals' readmissions information, including their risk-adjusted readmission rates, will be made available on the Hospital Compare website.

Incentive Structure:

CMS has defined a "readmission" as an admission to an acute care hospital within thirty days of a discharge from the same or another acute care hospital. CMS will calculate an excess readmission ratio for each of the applicable conditions selected for the program. These ratios will be measured by the hospital's readmission performance in the previous three years as compared to the national average and adjusted for factors that CMS deems clinically relevant, including patient demographic characteristics, comorbidities, and patient frailty. These ratios will be re-calculated each year using the most recent three years of discharge data and no less than 25 cases. DRG payment rates will be reduced based on a hospital's ratio of actual to expected admissions. In FY 2013, the maximum payment reduction is 1 percent, 2 percent in FY 2014, and capped at 3 percent for FY 2015 and beyond.

Care Settings Included:

Hospitals paid under the Inpatient Prospective Payment System (IPPS). This includes more than three-quarters of all hospitals.[1]

Statutory Mandate:

The Hospital Readmission Reduction Program (HRRP) was mandated by section 3025 of the Affordable Care Act.

Statutory Requirements for Measures:

The Affordable Care Act requires that each condition selected by the Secretary of HHS for the Hospital Readmission Reduction Program have measures of readmissions that have been NQF-endorsed and that the endorsed measures have exclusions for readmissions unrelated to the prior discharge.[2] Measures should address conditions and procedures for which readmissions are high volume or high expenditure.[3]

The ACA required the program to begin with the use of the use of the NQF-endorsed readmission measures for acute myocardial infarction (heart attack) (#0505), heart failure (#0330), and pneumonia (#0506). Beginning in FY 2015, the Secretary of HHS can expand the program to include other applicable conditions.[4]

MAP 2013 Pre-Rulemaking Input on HRRP:

- MAP supported the updated versions of acute myocardial infarction (#0505), heart failure (#0330), and pneumonia (#0506). The updated versions include new methodology excluding planned readmissions.

- MAP supported two measures under consideration addressing high-volume elective hip and knee surgeries and supported the direction of a chronic obstructive pulmonary disease (COPD) readmission measure.
- MAP encouraged the development of additional condition-specific readmission measures to address high-impact conditions, such as diabetes and cancer, behavioral health conditions, and conditions particularly relevant to the adult commercially insured population (individuals aged 18-64).
- MAP members noted the need to exclude unrelated readmissions, beyond planned readmissions, such as readmissions related to traumatic injury or burn.
- MAP recognized that readmissions are multi-factorial and are often related to broader issues, such as access to care, socioeconomic status, presence of community supports, and other psychosocial factors. Concurrent implementation of measures to monitor patient experience and post-discharge follow-up are important, and risk-stratification methodologies related to race, gender, and socioeconomic status may be needed.
- MAP considered the balance between all-cause, all-condition measures and condition-specific measures of readmissions. MAP recognized that condition-specific measures highlight opportunities to improve workflow and processes specific to a particular condition, while all-condition measures uncover system-wide issues.

Program Measure Set Evaluation Using MAP Measure Selection Criteria:

MAP Measure Selection Criteria	Evaluation
1. NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective	All 5 of the measures in the program set are NQF-endorsed.
2. Program measure set adequately addresses each of the National Quality Strategy's (NQS) three aims	The measure set addresses the NQS aim of better care, specifically the priorities of prevention and treatment of leading causes of mortality, patient safety, and effective communication and care coordination. It does not address the priorities of patient and family engagement, healthy living, or affordability.
3. Program measure set is responsive to specific program goals and requirements	The set addresses conditions and procedures for which readmissions are high volume or high expenditure. The measures in the set are NQF-endorsed and the endorsed measures have exclusions for readmissions unrelated to the prior discharge.
4. Program measure set includes an appropriate mix of measure types	The program set includes outcomes measures.
5. Program measure set enables measurement of person- and family-centered care and services	While the set does not enable measurement across a full episode of care, readmissions relate to the transition from one setting to the next.
6. Program measure set includes considerations for healthcare	The measures in the program set are not sensitive to healthcare disparities.

	disparities and cultural competency	
7.	**Program measure set promotes parsimony and alignment**	The measure set includes 5 measures. All measures in the set are also included in the IQR set. In addition, four measures are being used in private programs.

[1] http://www.aha.org/advocacy-issues/medicare/ipps/index.shtml
[2] http://www.gpo.gov/fdsys/pkg/FR-2011-05-05/pdf/2011-9644.pdf
[3] https://www.federalregister.gov/articles/2012/08/31/2012-19079/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the
[4] http://www.gpo.gov/fdsys/pkg/FR-2011-08-18/pdf/2011-19719.pdf

Inpatient Psychiatric Facilities Quality Reporting Program

Program Type:

Pay for Reporting – Information will be reported on the Hospital Compare website.[1]

Incentive Structure:

Non-participating inpatient psychiatric hospitals or psychiatric units will receive a reduction of 2.0 percent of their annual market basket update (the measure of change in costs of goods and services used by hospitals in treating Medicare patients) to the Prospective Payment System (PPS).[2]

Care Settings Included:

Inpatient Psychiatric Facilities (IPFs) required to report in the program include inpatient psychiatric hospitals or psychiatric units paid under the IPF PPS. The IPF Quality Reporting Program applies to freestanding psychiatric hospitals, government-operated psychiatric hospitals, and distinct psychiatric units of acute care hospitals and critical access hospitals. The IPF Quality Reporting Program does not apply to children's hospitals, which are paid under a different system.

Statutory Mandate:

Section 1886(s)(4) of the Social Security Act as amended by sections 3401(f) and 10322(a) of the Affordable Care Act (ACA) and requires CMS to establish quality measures for the IPF Quality Reporting Program.

Statutory Requirements for Measures:

The program measure set should include structure, process, outcome, patients' perspectives on care, efficiency, and costs of care measures. The Secretary of HHS may:

- Add measures reflecting consensus among the affected parties, and to the extent feasible, include measures set forth by one or more national consensus building entities.
- Replace any measures in appropriate cases (e.g., where all facilities are effectively in compliance or measures do not represent best practice).

MAP 2013 Pre-Rulemaking Input on IPFQR:

- MAP reviewed five measures under consideration and supported two measures for inclusion during the 2012/2013 pre-rulemaking activities.
- MAP encouraged alignment, as appropriate, of measures for this psychiatric care-specific program with IQR measures to ensure that the quality of care for other medical conditions remains high for patients treated in these facilities and units. Further, MAP supported the extension of psychiatric care quality measurement to outpatient settings, particularly EDs, and inpatient hospitals without psychiatric units.

- Efforts by hospitals to improve person-centered psychiatric care, such as assessing patient and family/caregiver experience and engagement and establishing relationships with community resources, are priority measure gap areas. Additional measure gaps in the IPFQR program include behavioral health assessments and care in the ED, readmissions, identification and management of general medical conditions, partial hospitalization or day programs, and a psychiatric care module for CAHPS.

Program Measure Set Evaluation Using MAP Measure Selection Criteria:

MAP Measure Selection Criteria	Evaluation
1. NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective	The majority of the finalized measures are NQF-endorsed (7 out of 8 total).
2. Program measure set adequately addresses each of the National Quality Strategy's (NQS) three aims	The measure set addresses the NQS aims of better care and healthy people/communities, specifically the priorities of effective prevention and treatment, patient safety, communication and care coordination, and healthy living. It does not address the priorites of patient/family enagement or affordability.
3. Program measure set is responsive to specific program goals and requirments	The measure set includes measures that are applicable to and appropriately tested for the program's intended care setting, level of analysis, and population. The set includes measures for public reporting that are meaningful to consumers and purchasers.
4. Program measure set includes an appropriate mix of measure types	The measure set includes only process measures.
5. Program measure set enables measurement of person- and family-centered care and services	The measure set addresses follow-up care and transition planning. The measure set does not address patient/family/caregiver experience or measures that support shared decision making and patient preferences.
6. Program measure set includes considerations for healthcare disparities and cutltural competency	None of the measures are sensitive to known disparities in healthcare.
7. Program measure set promotes parsimony and alignment	The set includes eight measures, one of which is being used in additional Federal and private sector programs. Five measures in the set are included in a MAP family of measures.

[1] http://www.gpo.gov/fdsys/pkg/FR-2011-05-06/pdf/2011-10568.pdf
[2] http://www.cms.gov/Medicare/medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html

Hospital Inpatient Quality Reporting Program

Program Type:

Pay for Reporting – Information is reported on the Hospital Compare website.[1]

Incentive Structure:

Hospitals receive a reduction of 2.0 percentage points of their annual market basket payment update (the change in costs of goods and services used by hospitals in treating Medicare patients) for non-participation.[2]

Care Settings Included:

Hospitals paid under the Inpatient Prospective Payment System (IPPS). This includes more than three-quarters of all hospitals.[3]

Statutory Mandate:

The Hospital Inpatient Quality Reporting Program (IQR) was originally mandated by Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 and subsequently updated in the Deficit Reduction Act of 2005.

Statutory Requirements for Measures:

The program was required to begin with the baseline set of performance measures set forth in a November 2005 report by the Institute of Medicine under section 238(b) of the MMA.

According to statute, the program measure set should include process, structure, outcome, patients' perspectives on care, efficiency, and costs of care measures. Measures should align with the National Quality Strategy[4] and promote the health and well-being of Medicare beneficiaries.[5,6]Measures should align with the Meaningful Use program when possible.[7,8]

The Secretary of HHS may:

- Add measures reflecting consensus among the affected parties, and to the extent feasible, include measures set forth by one or more national consensus building entities.
- Replace any measures in appropriate cases (e.g., where all hospitals are effectively in compliance or measures do not represent best practice).

MAP 2013 Pre-Rulemaking Input on the IQR Program:

- NQF-endorsed measures are preferred over measures that are not endorsed or endorsed in reserve status. Similarly, measures that are not NQF-endorsed, are topped out, or no longer represent the standard of care should be removed or suspended from IQR reporting.
- Measures selected should be meaningful to consumers, purchasers, and providers and address the NQS aims and priorities, as well as high-impact conditions. The program measure set should be parsimonious, balancing conciseness and comprehensiveness.
- MAP supported including updated methodologies for the readmissions measures in IQR to better exclude planned readmissions.

- MAP supported updated Centers for Disease Control and Prevention (CDC)–National Healthcare Safety Network (NHSN) measures under consideration with additional risk adjustment for volume of exposure within a facility, contingent on NQF endorsement of the new methodology.
- MAP highlighted priority gaps in the IQR program measure set. To expand the populations covered by the IQR program, MAP called for additional pediatric and maternal/child health measures to be included in this set. MAP also suggested including cancer and behavioral health measures from the PPS-Exempt Cancer Hospital Quality Reporting Program (PCHQR) and the Inpatient Psychiatric Facility Quality Reporting Program (IPFQR) in the IQR program to better align measurement for these populations. MAP stressed the need for additional safety measures, especially in the areas of medication reconciliation and culture of patient safety.

Program Measure Set Evaluation Using MAP Measure Selection Criteria

MAP Measure Selection Criteria	Evaluation
1. NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective	The majority of measures in the set are NQF-endorsed (53 of 66 total). Three measures in the set are in reserve status, indicating that performance is topped-out, and six measures in the set have had endorsement removed.
2. Program measure set adequately addresses each of the National Quality Strategy's (NQS) three aims	The measure set addresses each NQS aim, specifically the priorities of prevention and treatment of leading causes of mortality, patient safety, affordable care, effective communication and care coordination, and healthy living.
3. Program measure set is responsive to specific program goals and requirements	The measure set addresses all statutory requirements. The measure set includes measures that are applicable to and appropriately tested for the program's intended care setting, level of analysis, and population. The set includes measures for public reporting that are meaningful to consumers and purchasers.
4. Program measure set includes an appropriate mix of measure types	The measure set contains structure, process, outcome, efficiency, and patient engagement/experience measures.
5. Program measure set enables measurement of person- and family-centered care and services	The measure set addresses patient/family/caregiver experience and transition planning. The measure set does not address follow-up care or measures that support shared decision making and patient preferences.
6. Program measure set includes considerations for healthcare disparities and cultural competency	Four measures are sensitive to known disparities in healthcare.
7. Program measure set promotes parsimony and alignment	66 measures have been finalized for the program. Measures in the program align with Value-Based Purchasing, Meaningful Use, Hospital Readmissions Reduction Program, HAC Reduction Program, and the PPS-Exempt Cancer Hospital Quality Reporting Program.

[1] http://www.gpo.gov/fdsys/pkg/FR-2011-05-06/pdf/2011-10568.pdf
[2] https://www.cms.gov/HospitalQualityInits/08_HospitalRHQDAPU.asp
[3] http://www.aha.org/advocacy-issues/medicare/ipps/index.shtml
[4] https://www.federalregister.gov/articles/2012/08/31/2012-19079/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the#h-345
[5] Institute of Medicine, "Performance Measurement: Accelerating Improvement," December 1, 2005, available at: http://www.iom.edu/CMS/3809/19805/31310.aspx.
[6] http://www.gpo.gov/fdsys/pkg/PLAW-108publ173/html/PLAW-108publ173.htm
[7] https://www.federalregister.gov/articles/2010/08/16/2010-19092/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the#h-181
[8] http://www.gpo.gov/fdsys/pkg/FR-2012-09-04/pdf/2012-21050.pdf

NATIONAL QUALITY FORUM

Medicare Shared Savings Program

Program Type:

Pay for Reporting and Pay for Performance.[1]

Incentive Structure:

Option for one-sided risk model (sharing of savings only for the first two years, and sharing of savings and losses in the third year) and a two-sided risk model (sharing of savings and losses for all three years).[2]

Care Settings Included:

Providers, hospitals, and suppliers of services

Statutory Mandate:

Sec. 3022 of the Affordable Care Act (ACA) requires the Centers for Medicare & Medicaid Services (CMS) to establish a Medicare Shared Savings Program (MSSP) that promotes accountability for a patient population, coordinates items and services under Medicare Parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery.[3]

Statutory Requirements for Measures:

Appropriate measures of clinical processes and outcomes; patient, and, wherever practicable, caregiver experience of care; and utilization (such as rates of hospital admission for ambulatory sensitive conditions).[4]

MAP 2013 Pre-Rulemaking Program-Specific Input:

- MAP considered the MSSP measure set to be a comprehensive set because it addresses patient experience, other cross-cutting measurement priorities, high-impact conditions, and key quality outcomes.
- MAP noted that the measure set has a heavy emphasis on ambulatory care and could be enhanced with additional acute and post-acute care measures, and measures more relevant to patients with complex medical needs.
- MAP would prefer to move to outcome measures (e.g., clinical depression improvement, rather than only screening) where available, or process measures proximal to outcomes.
- MAP also recommends that adding measures of patient identification of a usual source of care and health information exchange to understand access to care and coordination of services across the system.
- MAP recommends that the MSSP measure set and the Medicare Advantage 5-Star Quality Rating System measure set should be aligned.
- MAP recommends alignment of MSSP and Meaningful Use measures, because integrated systems are increasingly adopting health information technology (HIT) and should have aligned incentives across programs.

Program Measure Set Evaluation Using MAP Measure Selection Criteria:

MAP Measure Selection Criteria	Evaluation
1. NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective	Most (30) of the finalized measures are NQF endorsed.
2. Program measure set adequately addresses each of the National Quality Strategy's (NQS) three aims	The measures address each aim except affordable care.
3. Program measure set is responsive to specific program goals and requirements	The measure set includes measures that are applicable to and appropriately tested for the program's intended care setting, level of analysis, and population.
4. Program measure set includes an appropriate mix of measure types	The measure set is comprised of process, outcome, and patient experience measures, but lacks cost measures.
5. Program measure set enables measurement of person- and family-centered care and services	The measure set crosses the episode of care as the set includes primary prevention measures, evaluation and initial management, and follow-up care. Additionally, two measures are patient-reported outcome measures (PRO).
6. Program measure set includes considerations for healthcare disparities and cultural competency	A small number of measures are disparities sensitive.
7. Program measure set promotes parsimony and alignment	The measure set addresses many of the MAP Measure Selection Criteria with 33 measures; however, the measure set could be enhanced with additional measures of cost, functional status, and patient-reported outcomes. Additionally, over half of the measures are used in private programs; most of the measures are used in other Federal programs.

[1] http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO-Guide-Quality-Performance-2012.PDF
[2] http://www.healthcare.gov/news/factsheets/2011/03/accountablecare03312011a.html
[3] http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf
[4] http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf

Medicare and Medicaid EHR Incentive Program for Hospitals and Critical Access Hospitals (CAHs)

Program Type:

Pay for Reporting – Information not publicly reported at this time.

Incentive Structure:

The Medicare and Medicaid EHR Incentive Programs provide incentive payments to eligible professionals, eligible hospitals, and critical access hospitals (CAHs) as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology. For the Medicare Incentive program (hospitals), incentive payments began in 2011 and are comprised of an Initial Amount, Medicare Share, and Transition Factor.[1] The CAH EHR Incentive payment is based on a formula for Allowable Costs and the Medicare Share.[2] The Medicaid Incentive program includes an Overall EHR Amount and Medicaid Share.[3] Medicare payment penalties will take effect in 2015 for providers who are eligible but do not participate. Payment penalties do not apply to Medicaid.[4]

Care Settings Included:

Hospitals paid under the Inpatient Prospective Payment System (IPPS), Medicare Advantage, and critical access hospitals.[5]

Statutory Mandate:

The program was created under the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act (ARRA) of 2009.

Statutory Requirements for Measures:

The program should include measures of processes, experience, and/or outcomes of patient care as well as observations or treatment that relate to one or more quality aims for health care, such as effective, safe, efficient, patient-centered, equitable and timely care. Measures must be reported for all patients, not just Medicare and Medicaid beneficiaries.[6] Preference should be given to quality measures endorsed by NQF.[7] For Stage 1, eligible facilities must report on all 15 total clinical quality measures.[8] For Stage 2 (2014 and beyond) eligible facilities must report on 16 clinical quality measures that cover 3 of the National Quality Strategy domains. Measures are selected from a set of 29 clinical quality measures that includes the 15 measures from Stage 1.[9]

MAP 2013 Pre-Rulemaking Input on Meaningful Use (from Hospital Perspective):

- Measures should represent the future of measurement (facilitating information exchange between institutions and longitudinal tracking of care, such as delta measures that monitor incremental changes in a patient's condition over time).
- Measure set should align with other hospital performance measurement programs.
- MAP noted that the Hospital Meaningful Use program is quite complex; hospitals have had difficulty understanding and implementing the program requirements.

Program Measure Set Evaluation Using MAP Measure Selection Criteria

MAP Measure Selection Criteria	Evaluation
1. NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective	The majority of measures (24 out of 29 total) in this program are NQF-endorsed.
2. Program measure set adequately addresses each of the National Quality Strategy's (NQS) three aims	The measure set addresses each NQS aim, specifically the priorities of prevention and treatment of leading causes of mortality, patient safety, affordable care, effective communication and care coordination, and healthy living. The set does not address the priority of patient and family engagement.
3. Program measure set is responsive to specific program goals and requirements	The measure set addresses all statutory requirements. The measure set includes measures that are applicable to and appropriately tested for the program's intended care setting, level of analysis, and population. The set includes measures for public reporting that are meaningful to consumers and purchasers.
4. Program measure set includes an appropriate mix of measure types	The measure set includes process and outcome measures. There are no structural, cost, or patient experience measures in this set.
5. Program measure set enables measurement of person- and family-centered care and services	The measure set does not include follow-up care, transition planning, or measures that support shared decision making and patient preferences.
6. Program measure set includes considerations for healthcare disparities and cultural competency	None of the measures are sensitive to known disparities in healthcare.
7. Program measure set promotes parsimony and alignment	29 measures have been finalized for the program. Most of the finalized measures are being used in one or more additional federal programs and/or private sector programs; six measures are included in a MAP family of measures

[1] http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/EHR_TipSheet_Medicare_Hosp.pdf
[2] http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/CAH-Payment-Tip-Sheet.pdf

[3] http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicaid_Hosp_Incentive_Payments_Tip_Sheets.pdf
[4] http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Getting_Started.html
[5] http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Eligible_Hospital_Information.html
[6] http://www.gpo.gov/fdsys/pkg/FR-2010-07-28/html/2010-17207.htm
[7] http://www.gpo.gov/fdsys/pkg/FR-2010-07-28/pdf/2010-17207.pdf
[8] http://www.gpo.gov/fdsys/pkg/FR-2010-07-28/html/2010-17207.htm
[9] http://www.gpo.gov/fdsys/pkg/FR-2012-09-04/pdf/2012-21050.pdf

Hospital Outpatient Quality Reporting

Program Type:

Pay for Reporting – Information is reported on the Hospital Compare website.[1]

Incentive Structure:

Non-participating hospitals will receive a 2.0 percent reduction in their annual market basket payment update (the measure of change in costs of goods and services used by hospitals in treating Medicare patients).[2] Hospitals providing outpatient services such as clinic visits, emergency department visits, or critical care services (including trauma team activation) that do not meet the minimum Outpatient Quality Reporting Program (OQR) requirements will not receive the Outpatient Prospective Payment System (OPPS) payment updates for the calendar year, which may result in a reduction in the OPPS payments.

Care Settings Included:

Hospitals providing outpatient services such as clinic visits, emergency department visits, and critical care services paid under the OPPS.

Statutory Mandate:

The OQR Program was first established in the Balanced Budget Act of 2007. The program was mandated by Congress to replace Title XVIII of the Social Security Act reasonable cost-based payment methodology with a prospective payment system (PPS). The Balanced Budget Act of 2007 established PPS for outpatient services rendered on or after August 2010.[3] The Affordable Care Act of 2010 established the role of the OQR Program as a pay for reporting program for hospitals.

Statutory Requirements for Measures:

The OQR program measure set should include structure, process, outcome, patients' perspectives on care, efficiency, and costs of care measures. The Secretary of HHS may:

- Add measures reflecting consensus among the affected parties, and to the extent feasible, include measures set forth by one or more national consensus building entities.
- Replace any measures in appropriate cases (e.g., where all hospitals are effectively in compliance or measures do not represent best practice).

Future rulemaking will consider measures of clinical quality of care, care coordination, patient safety and experience, population health, and efficiency.[4]

MAP 2013 Pre-Rulemaking Input on OQR:

- MAP reviewed seven measures under consideration for OQR and supported four during MAP's 2012/2013 pre-rulemaking activities.
- MAP noted that measures for outpatient hospital programs should be aligned with ambulatory care measures in programs such as PQRS and Physician Compare.

- Specific gap areas for the OQR program measure set include measures of ED overcrowding, wait times, and disparities in care—specifically, disproportionate use of EDs by vulnerable populations. Other gaps include measures of cost, patient-reported outcomes, patient and family engagement, follow-up after procedures, fostering important ties to community resources to enhance care coordination efforts, and an outpatient CAHPS module.

Program Measure Set Evaluation Using MAP Measure Selection Criteria:

MAP Measure Selection Criteria	Evaluation
1. NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective	The majority (19 of 28 total) measures are NQF endorsed; seven with time-limited endorsement, indicating that additional testing on the measure is being performed.
2. Program measure set adequately addresses each of the National Quality Strategy's (NQS) three aims	The measure set addresses the NQS aims of better care and affordable care, specifically the priorities of prevention and treatment of leading causes of mortality, patient safety, effective communication and care coordination, and making care affordable.
3. Program measure set is responsive to specific program goals and requirements	The measure set includes measures that are applicable to and appropriately tested for the program's intended care setting, level of analysis, and population. The set includes measures for public reporting that are meaningful to consumers and purchasers.
4. Program measure set includes an appropriate mix of measure types	The measure set includes structure, process, outcome, and efficiency measures.
5. Program measure set enables measurement of person- and family-centered care and services	The measure set does not address patient, family, or caregiver experience; shared decision-making; or the assessment of a person's care and services across providers, settings, and time. The measure set does address transfers and admissions to a hospital after treatment that can be related to care transitions.
6. Program measure set includes considerations for healthcare disparities and cultural competency	One of the measures is sensitive to known disparities in healthcare.
7. Program measure set promotes parsimony and alignment	28 measures have been finalized for the program. Measures in the set are also included in the Physician Feedback, Physician Quality reporting System, and Meaningful Use programs. Six measures in the set are included in a MAP family of measures

[1] http://www.gpo.gov/fdsys/pkg/FR-2012-07-30/pdf/2012-16813.pdf

[2] https://www.cms.gov/HospitalQualityInits/08_HospitalRHQDAPU.asp
[3] http://healthreformgps.org/wp-content/uploads/opps-rule.pdf
[4] http://www.gpo.gov/fdsys/pkg/FR-2011-11-30/pdf/2011-28612.pdf

PPS-Exempt Cancer Hospital Quality Reporting Program

Program Type:

Required Public Reporting – Information will be reported on the CMS website.[1]

Incentive Structure:

The Prospective Payment System-Exempt Cancer Hospital (PCH) Quality Reporting Program does not currently include an incentive or a penalty for failing to report quality measures. CMS plans to address incentives for the PCH Quality Reporting Program in future rulemaking.[2]

Care Settings Included:

Hospitals that are exempt from the Prospective Payment System (PPS) because they primarily provide care for persons with cancer, as described in Section 1866(k)(1) of the Social Security Act.

Statutory Mandate:

Section 3005 of the Affordable Care Act (ACA) requires CMS to establish a quality reporting program for PCHs beginning in FY 2014.

Statutory Requirements for Measures:

The program measure set should include structure, process, outcome, patients' perspectives on care, efficiency, and costs of care measures. The measure set should also include measures that reflect the level of care and most important aspects of care furnished by PCHs, in addition to the gaps in the quality of cancer care. The Secretary of HHS may:

- Add measures reflecting consensus among the affected parties, and to the extent feasible, include measures set forth by one or more national consensus building entities.
- Replace any measures in appropriate cases (e.g., where all hospitals are effectively in compliance or measures do not represent best practice).

Future rulemaking will consider measures of clinical quality of care, care coordination, patient safety and experience, population health, and efficiency. PPS-exempt cancer hospitals will also be measured in the future on informed decision-making and quality improvement programs.[3]

MAP 2013 Pre-Rulemaking Input on PCHQR:

- MAP reviewed 19 measures under consideration and supported 17 for PCHQR during the 2012/2013 pre-rulemaking activities.
- MAP reinforced the need for alignment of measures for this cancer hospital-specific program with IQR and OQR measures where appropriate for the cancer population.
- While some of the measures under consideration for the PCHQR program may be considered "topped out" in other programs, MAP noted that potential performance variation or disparities in care quality within these specialized facilities are not known.

- Given the unique nature of cancer care and its overall effect on cancer patients and their families and caregivers, MAP placed a high priority on measures of patient and family/caregiver experience as well as other patient-reported outcome measures. Other measure gaps MAP identified for this program include measures of survival, patient-reported symptoms and clinical outcomes, palliative and hospice care, and psychosocial/supportive services for the patient and family or caregiver.

Program Measure Set Evaluation Using MAP Measure Selection Criteria:

MAP Measure Selection Criteria	Evaluation
1. NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective	All (18) finalized measures are NQF-endorsed.
2. Program measure set adequately addresses each of the National Quality Strategy's (NQS) three aims	The measure set addresses the NQS aims of better care and affordable care, specifically the priorities of effective prevention and treatment, communication and care coordination, safety, patient and family engagement, and making care affordable.
3. Program measure set is responsive to specific program goals and requirements	The measure set includes measures that are applicable to and appropriately tested for the program's intended care setting, level of analysis, and population. The set includes measures for public reporting that are meaningful to consumers and purchasers.
4. Program measure set includes an appropriate mix of measure types	The measure set includes process, outcome, and patient engagement/experience measures.
5. Program measure set enables measurement of person- and family-centered care and services	The measure set addresses patient/family/caregiver experience. The set does not address follow-up care, transition planning, or measures that support shared decision making and patient preferences.
6. Program measure set includes considerations for healthcare disparities and cultural competency	Two of the measures are sensitive to known disparities in healthcare.
7. Program measure set promotes parsimony and alignment	Most of the finalized measures are being used in one or more additional federal programs and/or private sector programs. 13 measures are included in a MAP family of measures.

[1] http://www.gpo.gov/fdsys/pkg/FR-2011-05-06/pdf/2011-10568.pdf
[2] https://www.cms.gov/HospitalQualityInits/08_HospitalRHQDAPU.asp
[3] http://www.gpo.gov/fdsys/pkg/FR-2012-08-31/pdf/2012-19079.pdf

NATIONAL QUALITY FORUM

Hospital Value-Based Purchasing Program

Program Type:

Pay for Performance – Payments are based on information publicly reported on the Hospital Compare website.[1]

Incentive Structure:

Starting on October 1, 2012, Medicare began basing a portion of hospital reimbursement on performance through the Hospital Value-Based Purchasing Program (VBP). Medicare began withholding 1 percent of its regular hospital reimbursements from all hospitals paid under its inpatient prospective payment system (IPPS) to fund a pool of VBP incentive payments. The amount withheld from reimbursements increases over time:

- FY 2014: 1.25%
- FY 2015: 1.5%
- FY 2016: 1.75%
- FY 2017 and future fiscal years: 2%

Hospitals are scored based on their performance on each measure within the program relative to other hospitals as well as on how their performance on each measure has improved over time. The higher of these scores on each measure is used in determining incentive payments.

Care Settings Included:

Hospitals paid under the IPPS. This includes more than three-quarters of all hospitals.[2]

Statutory Mandate:

Hospital VBP was mandated by section 3001 of the Patient Protection and Affordable Care Act.

Statutory Requirements for Measures:

Measures selected for the VBP program must be included in IQR and reported on the Hospital Compare website for at least 1 year prior to use in the VBP program.

The program was required to begin with a baseline set of performance measures for FY 2013 that included measures addressing acute myocardial infarction (heart attack or AMI), heart failure, pneumonia, surgeries as measured by the Surgical Care Improvement Project (SCIP), healthcare-associated infections as measured by the prevention metrics and targets established in the HHS Action Plan to Prevent Healthcare-Associated Infections (or any successor plan), and HCAHPS (a standardized survey instrument and data collection methodology for measuring patients' perspectives on hospital care). For FY 2014 or a subsequent fiscal year, the program set should include efficiency measures including measures of "Medicare Spending per Beneficiary."

The Secretary of HHS can replace any measures in appropriate cases (e.g., where all hospitals are effectively in compliance or measures do not represent best practice). Measures of readmissions are statutorily excluded from the Hospital VBP program.[3]

MAP 2013 Pre-Rulemaking Input on Hospital VBP:

- Measures within this program should emphasize areas of critical importance for high performance and quality improvement, and ideally, link clinical quality and cost measures to capture value. For the VBP program, NQF-endorsed measures are strongly preferred and the program measure set should be parsimonious to avoid diluting the payment incentives.
- MAP supported including outcome measures and process measures strongly tied to positive outcomes for the VBP program measure set. Measures under consideration for the VBP program and supported by MAP addressed safety, prevention, affordability, and care transitions.

- MAP strongly supported the direction of emergency department (ED) throughput measures, recognizing the significance of ED overcrowding and improving wait times, but noting validity concerns regarding the ED measures under consideration.
- MAP identified a number of gap areas that should be addressed within the VBP program measure set, including medication errors, mental and behavioral health, and patient and family engagement.

Program Measure Set Evaluation Using MAP Measure Selection Criteria

MAP Measure Selection Criteria	Evaluation
1. NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective	The majority of the finalized measures (20) are NQF-endorsed.
2. Program measure set adequately addresses each of the National Quality Strategy's (NQS) three aims	The measure set addresses each NQS aim, specifically the priorities of prevention and treatment of leading causes of mortality, patient safety, affordable care, and effective communication and care coordination. The set does not address the priority of healthy living.
3. Program measure set is responsive to specific program goals and requirements	The measure set addresses the statutory requirements set forth by the ACA. All measures in VBP are included in IQR.
4. Program measure set includes an appropriate mix of measure types	The measure set contains process, outcome, efficiency, and patient engagement/experience measures.
5. Program measure set enables measurement of person- and family-centered care and services	The measure set addresses patient/family/caregiver experience. The measure set does not include follow-up care, transition planning, or measures that support shared decision making and patient preferences.
6. Program measure set includes considerations for healthcare disparities and cultural competency	Three measures are sensitive to known healthcare disparities.
7. Program measure set promotes parsimony and alignment	All measures in VBP are included in the IQR program and therefore align across the two programs.

[1] http://www.gpo.gov/fdsys/pkg/FR-2011-05-06/pdf/2011-10568.pdf
[2] http://www.aha.org/advocacy-issues/medicare/ipps/index.shtml
[3] http://www.gpo.gov/fdsys/pkg/FR-2011-05-06/html/2011-10568.htm

End Stage Renal Disease Quality Reporting Program

Program Type:

Pay for Performance, Public Reporting

Incentive Structure:

Starting in 2012, payments to dialysis facilities are reduced if facilities do not meet or exceed the required total performance score, which is the sum of the scores for established individual measures during a defined performance period. Payment reductions will be on a sliding scale, which could amount to a maximum of two percent per year.[1] Performance is reported on the Dialysis Facility Compare website.

Care Settings Included:

Dialysis Providers/Facilities

Statutory Mandate:

The ESRD Quality Incentive Program (QIP), required by section 1881 (h) of the Social Security Act and added by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) section 153(c), was developed by CMS to be the first pay-for-performance (also known as "value-based purchasing") model quality incentive program.[2]

Statutory Requirements for Measures:

Measures of anemia management that reflect labeling approved by the Food and Drug Administration (FDA), dialysis adequacy, patient satisfaction, iron management, bone mineral metabolism, and vascular access. [3]

MAP 2013 Pre-Rulemaking Program-Specific Input:

- MAP supported the only measure under consideration that addresses a cross-cutting topic, NQF # 0258 CAHPS In-Center Hemodialysis Survey, in alignment with its previous recommendation that the measure set expand beyond dialysis procedures to include non-clinical aspects of care, such as care coordination.
- Recognizing that the program is statutorily required to include measures of dialysis adequacy, MAP supported 11 measures under consideration that are clinically focused.
- MAP supported the direction of an additional 9 clinically focused measures under consideration, because the measures would address statutory requirements but they are undergoing development and need to be brought forward for NQF endorsement.
- MAP did not support 1 measure under consideration because its NQF endorsement has been removed.

- MAP recommended exploring whether the clinically focused measures could be combined in a composite measure for assessing optimal dialysis care.
- The core measure concepts not addressed in this measure set include advance care planning, care coordination, medication reconciliation, functional status, patient engagement, pain, falls, and measures covering comorbid conditions such as depression.

Program Measure Set Evaluation Using MAP Measure Selection Criteria:

MAP Measure Selection Criteria	Evaluation
1. NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective	Seven out of fifteen measures in the program measure set are NQF-endorsed.
2. Program measure set adequately addresses each of the National Quality Strategy's (NQS) three aims	The measure set addresses the NQS aim of better care, specifically the priorities of effective clinical care and person and caregiver-centered experience and patient safety.
3. Program measure set is responsive to specific program goals and requirments	The measure set addresses the MAP PAC/LTC core measure concept of infection rates and experience of care. The set does not address cross-cutting concepts such as advance care planning, care coordination, and patient engagement.
4. Program measure set includes an appropriate mix of measure types	The measure set is comprised of outcome, intermediate outcome, process, and structure measures.
5. Program measure set enables measurement of person- and family-centered care and services	The measure set does not include follow-up care, transition planning, or measures that support shared decision making and patient preferences.
6. Program measure set includes considerations for healthcare disparities and cutltural competency	None of the measures is disparities-sensitive and addresses cultural competency.
7. Program measure set promotes parsimony and alignment	Two measures are used in private programs.

[1] Federal Register. Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Bad Debt Reductions for All Medicare Providers. https://www.federalregister.gov/articles/2012/07/11/2012-16566/medicare-program-end-stage-renal-disease-prospective-payment-system-quality-incentive-program-and

[2] Final rule ESRD PY 2012-2013-2014. The Office of the Federal Register. http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1

[3]Final rule ESRD PY 2012-2013-2014. The Office of the Federal Register. http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1

Home Health Quality Reporting Program

Program Type:

Pay for Reporting, Public Reporting

Incentive Structure:

Medicare-certified[1] home health agencies (HHAs) are required to collect and submit the Outcome Assessment Information Set (OASIS). The OASIS is a group of data elements that represent core items of a comprehensive assessment for an adult home care patient and form the basis for measuring patient outcomes for purposes of outcome-based quality improvement.[2] Home health agencies meet their quality data reporting requirements through the submission of OASIS assessments and Home Health CAHPS. HHAs that do not submit data will receive a 2 percentage point reduction in their annual HH market basket percentage increase.

Subsets of the quality measures generated from OASIS are reported on the Home Health Compare website, which provides information about the quality of care provided by HHAs throughout the country.[3] Currently, 23 of the 97 OASIS measures are finalized for public reporting on Home Health Compare.

Care Settings Included:

Medicare-certified home health agencies

Statutory Mandate:

Section 1895(b)(3)(B)(v)(I) of the Social Security Act, as amended by section 5201 of the Deficit Reduction Act, established the requirement that HHAs that do not report quality data would not receive the full market basket payment increase.

Statutory Requirements for Measures:

None.

MAP 2013 Pre-Rulemaking Program-Specific Input:

- MAP reviewed two measures under consideration for the Home Health Quality Reporting Program. MAP supported the direction of both because they address the PAC/LTC core concept of avoidable admissions. MAP recognized the importance of reducing rehospitalizations and ED visits but noted that these measures should replace or be harmonized with currently finalized measures addressing hospitalizations and ED visits in order to reduce redundancy in the set.
- MAP noted that the large measure set reflects the heterogeneity of home health population; however, the measure set could be more parsimonious.

Program Measure Set Evaluation Using MAP Measure Selection Criteria:

MAP Measure Selection Criteria	Evaluation
1. NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective	The majority of measures in the set are not NQF-endorsed.
2. Program measure set adequately addresses each of the National Quality Strategy's (NQS) three aims	The measure set addresses the NQS aim of better care and healthy people and communities. Specifically the priorities of community and population health, prevention and treatment of leading causes of mortality, patient safety, effective communication and care coordination, and patient and family engagement are addressed. The priority of making care affordable is not addressed.
3. Program measure set is responsive to specific program goals and requirments	The measure set addresses 10 core measure concepts.
4. Program measure set includes an appropriate mix of measure types	The set includes process, outcome, and patient experience of care measures. The set does not include structure or cost measures.
5. Program measure set enables measurement of person- and family-centered care and services	The measure set addresses follow-up care,transition planning, establishment of patient goals. The set does not include measures that support shared decision making and patient preferences.
6. Program measure set includes considerations for healthcare disparities and cutltural competency	Two of the measures are disparities sensitive.
7. Program measure set promotes parsimony and alignment	There are 84 measures finalized for HHQR. In the CY 2014 Home Health Rule CMS removed 17 process measures that were stratified by episode with the goal of simplifing the reporting process.

[1] "Medicare-certified" means the home health agency is approved by Medicare and meets certain Federal health and safety requirements.
[2] Centers for Medicare and Medicaid Services. Background. June 2011. Available at http://www.cms.gov/OASIS/02_Background.asp#TopOfPage. Last accessed October 2011.

[3] The Official U.S. Government Site for Medicare. Introduction. Available at http://www.medicare.gov/HomeHealthCompare/About/overview.aspx. Last accessed October 2011.

Hospice Quality Reporting Program

Program Type:

Pay for Reporting, Public Reporting

Incentive Structure:

Failure to submit required quality data, beginning in FY 2014 and for each year thereafter, shall result in a 2 percentage point reduction to the market basket percentage increase for that fiscal year.[1] The data must be made publicly available, with Hospice Programs having an opportunity to review the data prior to its release. No date has been specified to begin public reporting of hospice quality data. [2]

Care Settings Included:

Multiple; hospice care can be provided in inpatient and outpatient settings.

Statutory Mandate:

Section 3004 of the Affordable Care Act directs the Secretary to establish quality reporting requirements for Hospice Programs.[3]

Statutory Requirements for Measures:

None.

MAP 2013 Pre-Rulemaking Program-Specific Input:

- MAP reviewed two measures currently finalized for the program measure set and seven measures under consideration; they supported all of these measures since they were all included in the 2012 MAP Hospice and Palliative Care Coordination Strategy.
- MAP recommended that other measures in the MAP Hospice Family of Measures be added to the measure set; specifically, NQF #1647 Percentage of Hospice Patients with Documentation in the Clinical Record of a Discussion of Spiritual/Religious Concerns or Documentation That the Patient/Caregiver Did Not Want to Discuss.
- MAP noted that the measure set failed to address several core measure concepts, including pain, goal attainment, patient engagement, care coordination, and depression
- MAP also recommended that the measure set would be enhanced with measures that address the caregiver's role and timely referral to hospice.

Program Measure Set Evaluation Using MAP Measure Selection Criteria:

MAP Measure Selection Criteria	Evaluation
1. NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective	All of the measures are endorsed, with the exception of the Hospice Experience of Care Survey that CMS is building.
2. Program measure set adequately addresses each of the National Quality Strategy's (NQS) three aims	The measure set addresses the aim of better care, specifically the priorities of person- and family-centered care and effective communication and care coordination.
3. Program measure set is responsive to specific program goals and requirments	The measure set addresses person- centered care at end of life, but could be enhanced by measures addressing shared decision making, timely referral to hospice, the caregiver's role, and advance care planning.
4. Program measure set includes an appropriate mix of measure types	All of the measures in this set are process measures.
5. Program measure set enables measurement of person- and family-centered care and services	There are five palliative and pain screening/assessment measures. Three of the measures are patient reported outcome measures. The measure set could be enhanced by measures addressing the family and caregiver's role and shared decision making.
6. Program measure set includes considerations for healthcare disparities and cutltural competency	Four of the measures are disparities sensitive. None of the measures addresses cultural competency.
7. Program measure set promotes parsimony and alignment	Three measures are included in the Safety Family of Measures. None of the measures are used in other programs.

[1] Ibid

[2] CMS. Hospice Quality Reporting. http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/index.html
[3] Ibid

Inpatient Rehabilitation Facility Quality Reporting

Program Type:

Pay for Reporting, Public Reporting

Incentive Structure:

For fiscal year of 2014, and each year thereafter, Inpatient Rehabilitation Facility providers (IRFs) must submit data on quality measures to the Centers for Medicare & Medicaid Services (CMS) to receive annual payment updates. Failure to report quality data will result in a 2 percent reduction in the annual increase factor for discharges occurring during that fiscal year.[1] The data must be made publicly available, with IRF providers having an opportunity to review the data prior to its release. No date has been specified to begin public reporting of quality data.[2]

Care Settings Included:

Inpatient Rehabilitation Facilities

Statutory Mandate:

Section 3004(b) of the Affordable Care Act (ACA) directs the Secretary to establish quality reporting requirements for IRFs.

Statutory Requirements for Measures:

Measures should align with the National Quality Strategy (NQS), be relevant to the priorities of IRFs (such as patient safety, reducing adverse events, better coordination of care, and person- and family-centered care), and address the primary role of IRFs—rehabilitation needs of the individual, including improved functional status and achievement of successful return to the community post-discharge. [1]

MAP 2013 Pre-Rulemaking Program-Specific Input:

- MAP found the program measure set too limited and noted that it could be greatly enhanced by addressing the core measures concepts not addressed in the set—care coordination, functional status, and medication reconciliation—and the safety issues that have high incidence in IRFs, such as MRSA, falls, CAUTI, and *C. difficile*.
- MAP supported the direction of two measures that address CAUTI and *C. difficile*, in addition to supporting three immunization measures.

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[1] FY 2012 IRF PPS final rule The Office of the Federal Register. http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1.

- MAP supported the direction of three functional status outcome measures and one avoidable admissions measure, noting that the measures are important but still in development.
- MAP did not support one CLABSI measure, which has a low incidence in this setting.

Program Measure Set Evaluation Using MAP Measure Selection Criteria:

MAP Measure Selection Criteria	Evaluation
1. NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective	Four out of five measures in the program measure set are NQF-endorsed.
2. Program measure set adequately addresses each of the National Quality Strategy's (NQS) three aims	The measure set addresses the NQS aim of better care and the NQS priority of patient safety. The priorities of patient and family engagement, community and population health, and making care more affordable are not addressed.
3. Program measure set is responsive to specific program goals and requirments	The measure set addresses three MAP PAC/LTC core measure concepts — infection rates, pressure ulcers, and avoidable admissions. The set does not address other core measure concepts relevant to this setting.
4. Program measure set includes an appropriate mix of measure types	The measure set includes outcome and process measures. The set lacks structure and cost measures.
5. Program measure set enables measurement of person- and family-centered care and services	The measure set does not include follow-up care, transition planning, or measures that support shared decision making and patient preferences.
6. Program measure set includes considerations for healthcare disparities and cutltural competency	None of the measures is disparities-sensitive or addresses cultural competency.
7. Program measure set promotes parsimony and alignment	Four measures in the set are used in other federal programs. One measure is used in private programs. Two measures are in one or two MAP Families of measures.

[1] CMS.gov. http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/index.html

[2] CMS.gov. http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/index.html

Long-Term Care Hospital Quality Reporting

Program Type:

Pay for Reporting, Public Reporting

Incentive Structure:

For fiscal year 2014, and each year thereafter, Long-Term Care Hospital providers (LTCHs) must submit data on quality measures to the Centers for Medicare & Medicaid Services (CMS) to receive full annual payment updates; failure to report quality data will result in a 2 percent reduction in the annual payment update.[1] The data must be made publicly available, with LTCH providers having an opportunity to review the data prior to its release. No date has been specified to begin public reporting of quality data.[2]

Care Settings Included:

Long-Term Care Hospitals

Statutory Mandate:

Section 3004 of the Affordable Care Act directs the Secretary to establish quality reporting requirements for LTCHs.

Statutory Requirements for Measures:

Measures should align with the National Quality Strategy (NQS), promote enhanced quality with regard to the priorities most relevant to LTCHs (such as patient safety, better coordination of care, and person- and family-centered care), and address the primary role of LTCHs—furnishing extended medical care to individuals with clinically complex problems (e.g., multiple acute or chronic conditions needing hospital-level care for relatively extended periods of greater than 25 days).[3]

MAP 2013 Pre-Rulemaking Program-Specific Input:

- MAP noted that many measures under consideration would support alignment with other settings; however, measures should be tested in LTCHs to determine if they are feasible for implementation.

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[1] CMS.gov. LTCH Quality Reporting.http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html?redirect=/LTCH-Quality-Reporting/
[2] CMS.gov. LTCH Quality Reporting.http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html?redirect=/LTCH-Quality-Reporting/
[3] FY 2012 IPPS/LTCH PPS final rule. The Office of the Federal Register. http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1

- MAP supported the direction of one cost measure, noting that the measure under consideration would exclude LTCHs because the measure methodology excludes hospitals whose average inpatient length of stay exceeds 25 days. MAP recommends that additional measures be added to address cost. For example, assessing whether individuals are appropriately placed in LTCHs would help determine whether they could receive care in less costly settings.
- MAP did not support four measures under consideration that did not address PAC/LTC core concepts or had lost NQF endorsement.
- Measures should address the PAC/LTC core measures not currently addressed in the measure set including cognitive status assessment (e.g. dementia identification), advance care planning and treatment, and inappropriate medication use (e.g., use of antipsychotic medications).

Program Measure Set Evaluation Using MAP Measure Selection Criteria:

MAP Measure Selection Criteria	Evaluation
1. NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective	The majority of the finalized measures are NQF-endorsed.
2. Program measure set adequately addresses each of the National Quality Strategy's (NQS) three aims	The measure set addresses the NQS aim of better care, specifically the priorities of prevention and treatment of leading causes of mortality, patient safety, and communication and care coordination.
3. Program measure set is responsive to specific program goals and requirments	The measure set addresses the MAP PAC/LTC coe measure concepts of avoidable admissions, infection rates, falls, and pressure ulcers. The measure set lacks measures addressing person- and family-centered care.
4. Program measure set includes an appropriate mix of measure types	The measure set has two process and seven outcome measures. The set lacks structure and cost measures.
5. Program measure set enables measurement of person- and family-centered care and services	The measure set does not include follow-up care, transition planning, or measures that support shared decision making and patient preferences.
6. Program measure set includes considerations for healthcare disparities and cutltural	None of the measures are disparities

	competency	sensitive or addresses cultural competency.
7.	**Program measure set promotes parsimony and alignment**	Most of the finalized measures are being used in one or more additional federal programs and/or private sector programs; six of them are included in a MAP family of measures.

Nursing Home Quality Initiative and Nursing Home Compare

Program Type:

Pay for Reporting, Public Reporting

Incentive Structure:

Skilled nursing facilities (SNFs) and nursing facilities (NFs) are required to be in compliance with the requirements in 42 CFR Part 483, Subpart B, to receive payment under the Medicare or Medicaid programs. Part of this requirement includes completing the Minimum Data Set (MDS), a clinical assessment of all residents in Medicare- or Medicaid-certified nursing facilities. Quality measures are reported on the Nursing Home Compare website using a Five-Star Quality Rating System, which assigns each nursing home a rating of 1 to 5 stars, with 5 representing highest standard of quality, and 1 representing the lowest.[1]

Care Settings Included:

Medicare- or Medicaid-certified nursing facilities

Statutory Mandate:

The 1987 Omnibus Budget Reconciliation Act mandated the development of a nursing home resident assessment instrument.

Statutory Requirements for Measures:

OBRA mandated the inclusion of the domains of resident health and quality of life in the resident assessment instrument.

MAP 2013 Pre-Rulemaking Program-Specific Input:

- MAP supported the direction of 2 measures that address the PAC/LTC core concept of inappropriate medication use, noting that the measures should have as few exclusions as possible and monitoring should be incorporated into program implementation to detect unintended consequences. MAP noted the need for measures that address the overall improvement of dementia care and cautioned that focus on reducing inappropriate use of one class of medication may lead to inappropriate use of other medication classes.
- MAP also supported the direction of two measures addressing avoidable admissions, a core measure concept. MAP recognized the importance of measuring readmissions in the nursing home setting but would prefer fewer measures to address readmissions across settings.

Program Measure Set Evaluation Using MAP Measure Selection Criteria:

MAP Measure Selection Criteria	Evaluation
1. NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective	More than half of measures (16) in the set are NQF-endorsed.
2. Program measure set adequately addresses each of the National Quality Strategy's (NQS) three aims	The measure set addresses the NQS aim of better care. Specifically the priorities of community and population health, prevention and treatment of leading causes of mortality, patient safety, effective communication and care coordination are addressed. The priorities of patient and family engagement and making care affordable are not addressed.
3. Program measure set is responsive to specific program goals and requirements	The measure set addresses resident health and quality of life. Additionally, the measure set addresses several MAP PAC/LTC core measure concepts—falls, functional and cognitive status assessment, inappropriate medication use, infection rates, mental health, and pressure ulcers.
4. Program measure set includes an appropriate mix of measure types	The set includes process, outcome, and structure measures. The set does not include patient experience of care or cost measures.
5. Program measure set enables measurement of person- and family-centered care and services	The measure set does not include follow-up care, transition planning, or measures that support shared decision making and patient preferences.
6. Program measure set includes considerations for healthcare disparities and cultural competency	One measure in the set is disparities-sensitive.
7. Program measure set promotes parsimony and alignment	Two measures in the set are used in other federal programs. Additionally, all measures are collected through MDS, a required

	assessment for home health patients, which reduces reporting burden.

[1] Centers for Medicare and Medicaid Services. Five-Star Quality Rating System. Available at https://www.cms.gov/CertificationandComplianc/13_FSQRS.asp#TopOfPage. Last accessed October 2011.

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 decision-making, 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)

MAP Decision Categories

	MAP Decision (standardized options)	Decision Description	MAP Rationale (suggested options)	MAP Findings (open text)
Measures Under Consideration	Support	Indicates measures under consideration that should be added to the program measure set during the current rulemaking cycle.	• NQF-endorsed measure • Addresses National Quality Strategy aim or priority not adequately addressed in program measure set • Addresses program goals/requirements • Addresses a measure type not adequately represented in the program measure set • Promotes person- and family-centered care • Provides considerations for healthcare disparities and cultural competency • Promotes parsimony • Promotes alignment across programs, settings, and public and private sector efforts • Addresses a high-leverage opportunity for improving care for dual eligible beneficiaries • Included in a MAP family of measures	*MAP findings will highlight additional considerations raised by the group.*
	Do Not Support	Indicates measures that are not recommended for inclusion in the program measure set.	• Measure does not adequately address any current needs of the program • A finalized measure addresses a similar topic and better addresses the needs of the program • A 'Supported' measure under consideration addresses as similar topic and better addresses the needs of the program • NQF endorsement removed (the measure no longer meets the NQF endorsement criteria) • NQF endorsement retired (the measure is no longer maintained by the steward) • NQF endorsement placed in reserve status (performance on this measure is topped out) • Measure previously submitted for endorsement and was not endorsed	*MAP findings will highlight additional considerations raised by the group.*
	Conditionally Support	Indicates measures, measure concepts, or measure ideas that should be phased into program measure sets over time, subject to contingent factor(s).	• Not ready for implementation; measure concept is promising but requires modification or further development • Not ready for implementation; should be submitted for and receive NQF endorsement • Not ready for implementation; data sources do not align with program's data sources • Not ready for implementation; measure needs further experience or testing before being used in the program	*MAP findings will highlight the contingent factors that should be met before a measure is included in the program.* For example: • Guidance on modifications • Description of how the measure concept will add value when fully developed and NQF-endorsed

				• Additional programmatic considerations, such as needing at least 1 year of results before implementation in other programs
Finalized Measures	**Decision Category**	**Decision Description**	**Rationale Category**	**Rationale Description**
	Remove	Indicates measures that should be removed from a program measure set.	• NQF endorsement removed (the measure no longer meets the NQF endorsement criteria) • NQF endorsement retired (the measure is no longer maintained by the steward) • NQF endorsement placed in reserve status (performance on this measure is topped out) • A 'Supported' measure under consideration addresses a similar topic and better addresses the needs of the program and promotes alignment	*MAP findings will indicate the timing of removal.*

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)
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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 E. 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 Margaret Nora, MD, JD, MBA
National Committee for Quality Assurance	Peggy O'Kane, MHS
The Joint Commission	Mark Chassin, MD, FACP, MPP, MPH

BIOS OF THE MAP COORDINATING COMMITTEE

CO-CHAIRS (VOTING)

George J. Isham, MD, MS

George Isham, MD, MS is Senior Advisor to HealthPartners, responsible for working with the board of directors and the senior management team on health and quality of care improvement for patients, members and the community. Dr. Isham is also Senior Policy Fellow, HealthPartners Research Foundation and facilitates forward progress at the intersection of population health research and public policy. Dr. Isham is active nationally and currently co-chairs the National Quality Forum convened Measurement Application Partnership, chairs the National Committee for Quality Assurances' clinical program committee and a is member of NCQA's committee on performance measurement. Dr. Isham is chair of the Institute of Medicine's Roundtable on Health Literacy and has chaired three studies in addition to serving on a number of IOM studies related to health and quality of care. In 2003 Isham was appointed as a lifetime National Associate of the National Academies of Science in recognition of his contributions to the work of the Institute of Medicine. He is a former member of the Center for Disease Control and Prevention's Task Force on Community Preventive Services and the Agency for Health Care Quality's United States Preventive Services Task Force and currently serves on the advisory committee to the director of Centers for Disease Control and Prevention. His practice experience as a general internist was with the United States Navy, at the Freeport Clinic in Freeport, Illinois, and as a clinical assistant professor of medicine at the University of Wisconsin Hospitals and Clinics in Madison, Wisconsin.

Elizabeth A. McGlynn, PhD, MPP

Elizabeth A. McGlynn, PhD, is the Director of Kaiser Permanente's Center for Effectiveness and Safety Research (CESR). She is responsible for the strategic direction and scientific oversight of CESR, a virtual center designed to improve the health and well-being of Kaiser's 9 million members and the public by conducting comparative effectiveness and safety research and implementing findings in policy and practice. Dr. McGlynn is an internationally known expert on methods for evaluating the appropriateness, quality and efficiency of health care delivery. She has conducted research in the U.S. and in other countries. Dr. McGlynn has also led major initiatives to evaluate health reform options under consideration at the federal and state levels. Dr. McGlynn is a member of the Institute of Medicine. She serves as the Secretary and Treasurer of the American Board of Internal Medicine Foundation Board of Trustees. She is on the Board of AcademyHealth and the Institute of Medicine Board of Health Care Services. She chairs the Scientific Advisory Group for the Institute for Healthcare Improvement. She co-chairs the Coordinating Committee for the National Quality Forum's Measures Application Partnership. She serves on the editorial boards for Health Services Research and The Milbank Quarterly and is a regular reviewer for many leading journals. Dr. McGlynn received her B.A. in international political economy from The Colorado College, her MPP from the University of Michigan's Gerald R. Ford School of Public Policy, and her Ph.D. in public policy analysis from the Pardee RAND Graduate School.

ORGANIZATIONAL MEMBERS (VOTING)

AARP

Joyce Dubow, MUP

Ms. Dubow, who had been at AARP for 22 years, is a Principal for health policy and strategy in AARP's Office of the Executive vice-president for Policy and Strategy. She has responsibility for a portfolio related to AARP's health care reform initiatives with a special focus on health care quality, HIT, and consumer decision making, as well as private health plans in the Medicare program. Her multi-faceted professional career in health care spans diverse experiences in health plan leadership, government service, public policy, and consumer advocacy. Dubow serves on several external multi-stakeholder groups that focus on improving the quality and delivery of health care services. She is a member of the board of the National Quality Forum (NQF) and was recently co-chair of the NQF Patient-reported Outcomes Expert Panel. She is a member of: the Coordinating Committee of the Measure Application Partnership; the National Committee for Quality Assurance's Committee on Physician Programs and its Measurement Panel on Geriatrics; and the National Advisory Committee for Aligning Forces for Quality of the Robert Woods Johnson Foundation. Previously, Ms. Dubow was the executive vice-president of the Georgetown University Community Health Plan, a university-sponsored prepaid group practice plan. She was also the Director of Policy and Legislation in the federal Office of Health Maintenance Organizations. Ms. Dubow holds a B.A. in Political Science from the University of Michigan and a Masters in Urban Planning from Hunter College of the University of the City of New York.

ACADEMY OF MANAGED CARE PHARMACY

Marissa Schlaifer, RPh, MS

Marissa Schlaifer joined CVS Caremark as Head of Policy in April 2013. Based out of the CVS Caremark Washington, D.C., office, Marissa leads the team responsible for creating policy positions that help shape the laws and regulations impacting CVS Caremark business, and she also serves as a key contact with federal agencies. Marissa brings deep experience with policy analysis and issue advocacy, having spent ten years as Director of Pharmacy and Regulatory Affairs at the Academy of Managed Care Pharmacy (AMCP). Marissa was involved in providing input to the Centers for Medicare & Medicaid Services (CMS) on the development and implementation of the Medicare prescription drug benefit and aspects of the Affordable Care Act. In addition, she served on various Part D Medication Measures technical expert panels (TEPs), providing input on the development of quality measures, served on the Department of Defense Uniform Formulary Beneficiary Advisory Panel, and represents AMCP in many capacities within the Pharmacy Quality Alliance (PQA), formerly as a staff member and currently as a member. Marissa currently serves on the National Quality Forum Measure Application Partnership (MAP) representing the Academy of Managed Care Pharmacy. Marissa brings experience in both the managed care pharmacy and community pharmacy segments of the profession as well as leadership experience in several pharmacy organizations. Prior to joining AMCP, Marissa was Healthy Outcomes Director at H-E-B Grocery Company, where she was responsible for disease management and health improvement programs, immunization programs and new business opportunities. Previously, Marissa worked for PacifiCare of Texas and Prescription Solutions as a clinical pharmacist, and for Eckerd Drug Company as pharmacy manager and a regional manager for managed care sales. She received her B.S. in Pharmacy and M.S. in Pharmacy Administration from The University of Texas at Austin College of Pharmacy. Marissa has been active in leadership positions within AMCP, the American Pharmacists Association and the Texas Pharmacy Association.

ADVAMED

Steven Brotman, MD, JD

Steven J. Brotman, MD, JD is Senior Vice President, Payment and Policy, for the Advanced Medical Technology Association (AdvaMed). Dr. Brotman leads AdvaMed's health care quality initiatives, working closely with member companies on key policy issues. Dr. Brotman is a Board Certified Pathologist. Dr. Brotman received his M.D. from The Mount Sinai School of Medicine in New York City, where he also completed a residency in Pathology, after performing an internship in General Surgery. He had additional clinical and research fellowship training at the Johns Hopkins Hospital in the field of immuno-pathology, with in-depth training in immuno-dermatology and hematopathology. Additionally, Dr. Brotman earned a J.D. from the University Of Maryland School of Law and was a Federal Judicial Intern working under the Honorable Paul Grimm at the United States Federal Court in Baltimore, MD. Subsequently, he joined Morgan, Lewis, and Bockius, L.L.P. in Washington, D.C. as an associate in the FDA Regulatory/Healthcare group, where he worked with various domestic and international companies on pharmaceutical/device lifecycle, regulatory and healthcare issues. He most recently was a Senior Regulatory and Research Attorney at Wyeth Pharmaceuticals (now Pfizer) specializing in complex safety, drug development, clinical trial and compliance issues. Dr. Brotman has authored several peer-reviewed scientific publications and made numerous presentations to the scientific, pharmaceutical and legal communities. He is on the editorial board of Maryland Medicine, the Maryland Medical Society Journal and developed and taught the Seminar Series on Scientific Evidence at the University Of Maryland School of Law.

AFL-CIO

Gerry Shea

(Pending)

AMERICA'S HEALTH INSURANCE PLANS

Aparna Higgins, MA

Ms. Higgins is Senior Vice President, Private Market Innovations at America's Health Insurance Plans (AHIP), where she is focused on a number of key initiatives including performance measurement, innovative payment models and delivery system reform. She led AHIP Foundation's efforts to pilot-test a data aggregation methodology, a component of the High-Value Health Care project funded by the Robert Wood Johnson Foundation, for individual physician performance measurement across regions and health plans. She is a healthcare economist with expertise and experience in study design and economic modeling and has directed a number of research and analytic projects employing multi-disciplinary teams. She serves on a number of expert panels on performance measurement. Prior to AHIP, she was at Booz Allen Hamilton where she led a team of health services researchers focused on studies related to electronic health record (EHR) adoption, quality measurement, and value-based purchasing. She was the principal investigator for two research studies on physician adoption of EHRs and evaluation design of the business case for Health Information Technology (HIT) in Long-Term Care for the Department of Health and Human Services (HHS) Assistant Secretary for Planning and Evaluation (ASPE). She played a key leadership role in assisting the Centers for Medicare and Medicaid Services (CMS) with the design of a Medicare Hospital Value-based purchasing (VBP) program and was closely involved in developing the hospital VBP report to Congress.

AMERICAN COLLEGE OF PHYSICIANS

David W. Baker, MD, MPH, FACP

David W. Baker, MD, MPH is Michael A. Gertz Professor in Medicine and Chief of the Division of General Internal Medicine, Northwestern University. He received his MD from the UCLA School of Medicine and his MPH from the UCLA School of Public Health. He completed his research training in the UCLA Robert Wood Johnson Clinical Scholars' Program. His research has focused on access to health care, racial and ethnic disparities in care, health communication, and quality of care for chronic diseases. He has led studies examining many aspects of quality, including whether hospital mortality "report cards" lead to changes in market share for hospitals and improvements in outcomes, the effect of disease management programs for patients with heart failure, and an evaluation of the Institute for Healthcare Improvement's Improving Chronic Illness Care Collaborative. His current work is examining quality measurement and quality improvement using electronic health record systems. Dr. Baker has served in many national roles as well. He served as the Associate Project Director for the AHCPR-funded Heart Failure guideline and was lead author for a series of manuscripts in JAMA on quality of care for patients with heart failure. He has served as an advisor to both the Ohio and the Georgia Peer Review Organizations' heart failure quality improvement projects, and he was part of the American Heart Association's first working group for measuring quality of care and outcomes for cardiovascular disease. He served on the American College of Cardiology/American Heart Association Heart Failure Practice Guideline committee and the American Board of Internal Medicine's Committee for their new Heart Failure Practice Improvement Module. He has served as a member of the Health Information Technology Expert Panel's (HITEP) Quality Data Set subcommittee. He currently serves on the Physicians' Consortium for Performance Improvement (PCPI) Measure Implementation and Evaluation subcommittee and the American College of Physicians' Performance Measure Advisory Committee.

AMERICAN COLLEGE OF SURGEONS

Frank G. Opelka, MD, FACS

Frank G. Opelka, MD, FACS is the Vice Chancellor for Clinical Affairs and Professor of Surgery at Louisiana State University Health Sciences Center in New Orleans. In LSU, he actively teaches in the 4 health sciences schools developing programs for innovation and delivery system redesign. He also works at the LSU seven hospital system to support efforts for the development of a safety net ACO to address various challenges such as the dual eligible. He also represents the American College of Surgeons, Washington DC Office in the Division of Health Policy and Advocacy. Dr. Opelka founded and serves as the chair of the Surgical Quality Alliance, with over 20 surgical organizations sitting in the alliance. He serves as one of the original members of the National Priorities Partnership in the National Quality Forum, a member of the NQF's Consensus Standards Advisory Committee, and has served as a chair of an NQF steering committee. Dr. Opelka continues to serve on the Quality Alliance Steering Committee, the AQA, and the AMA's Physician Consortium for Performance Improvement. He has served on several advisory committees to several health plans, including United Health Group, Blue Cross Blue Shield of America, and Humana. Dr. Opelka has developed and assisted the American Board of Medical Specialties in their clinical registry efforts for the Maintenance of Certification Part IV. Prior to serving in the quality arena, Dr. Opelka worked closely with CMS in the Ambulatory APG relative values, AMA's Relative Value Updates Committee, Practice Expense Committee, and an advisory to the CPT Editorial Committee. Dr. Opelka served 12 years on active duty in the US Army where he did his residency in General Surgery at the Walter Reed Army Medical Center and Eisenhower Army Medical Center. His colorectal surgery fellowship was at the Ochsner Clinic New Orleans where he served for 12 years as faculty and attending

surgeon. His career then included time at the Beth Israel Deaconess Medical Center in Boston before returning to New Orleans just in time for Hurricane Katrina. Dr. Opelka is a board certified colon and rectal surgery. He is a fellow of the American College of Surgeons and the American Society of Colon and Rectal Surgeons.

AMERICAN HOSPITAL ASSOCIATION

Rhonda Anderson, RN, DNSc, FAAN

Rhonda Anderson, RN, DNSC, FAAN, is Chief Executive Officer of Cardon Children's Medical Center in Mesa, Arizona. She is a Fellow in the American Academy of Nursing and the American College of Healthcare Executives. She also serves on the Institute for Interactive Patient Care (GetWell Network) National Advisory Board, National Guideline Clearinghouse and National Quality Measures Clearinghouse Expert Panel, American Hospital Association Board of Trustees, American Hospital Association Health Research and Educational Trust Board, and a member of the National Association of Children's Hospitals and Related Institutions Quality Council. Rhonda received the Distinguished Achievement Award from Arizona State University College of Nursing and was a selected participant in The First International Institute: Executive Nurse Leadership in the United Kingdom and the United States-Florence Nightingale Trust in London, England. She attended the Wharton School of Business as a selected participant in The Johnson & Johnson Fellowship Program. In November 2005, Rhonda was awarded the Nursing Legends Nurse of the Year Award by the March of Dimes. Rhonda was awarded the American Organization of Nurse Executive's Lifetime Achievement Award in April of 2006, NurseWeek's Lifetime Achievement Award in September of 2006, and is a Phoenix Business Journal 2011 Women in Business Honoree.

AMERICAN MEDICAL ASSOCIATION

Carl A. Sirio, MD

Carl A. Sirio, MD, a board certified internist and critical care physician, was elected to the American Medical Association (AMA) Board of Trustees (BOT) in June 2010. Prior to his election, Dr. Sirio served in the AMA House of Delegates as a delegate from Pennsylvania. Dr. Sirio has a long history of service to the profession. He served eight years on the AMA Council on Medical Education, including serving as chair. He helped establish and chaired the AMA Initiative to Transform Medical Education since inception. In addition, he also represented the AMA to the Liaison Committee on Medical Education where he was in part responsible for the new standards related to building greater diversity in medicine and to understanding the impact the learning environment has on students as they prepare for careers as physicians. Prior to this he served on the Internal Medicine Residency Review Committee, responsible for policy and accreditation of all graduate medical education programs in internal medicine. Dr. Sirio has broad interests that include the organization and delivery of health care services, medical education, patient safety, quality of care, patient risk assessment, evaluation of clinical performance, process improvement, and health care management and financing. Capitalizing on these interests he serves on the Executive Committee of the Physician Consortium for Performance Improvement, helping to drive the development of evidenced based measures for use by doctors in their efforts to improve care. Dr. Sirio is a co-founder of the Pittsburgh Regional Healthcare Initiative (PRHI), a nationally recognized multi-stakeholder collaborative designed to improve care over a large geographic area. With PRHI he facilitated the work of 40 competing institutions in an effort to improve care for all patients by reducing infections and improving medication safety. He was the recipient of several large grants from the Agency for Healthcare Research and Quality, equaling more than $6.5 million in total, for work designed to foster meaningful improvement in the care of patients. In addition, he has worked with the National

Quality Forum, the National Institute of Medicine, The Joint Commission (TJC), and the U.S. Pharmacopoeia, among others, in his efforts related to patient care quality and safety. He currently serves TJC as a Commissioner. After spending 17 years at the University of Pittsburgh School Medicine where he was a professor, Dr. Sirio moved to the Pittsburgh campus of the Drexel University School Medicine. Dr. Sirio joined the University of Toledo in 2012 as the Vice President for Medical Affairs, Associate Dean for Clinical Affairs, and Chief Medical Information Officer. Completing his undergraduate and medical school training at Columbia University and Rutgers Medical School (now Robert Wood Johnson School of Medicine), Dr. Sirio received post graduate medical training at the Milton S. Hershey Medical Center Pennsylvania State University, the National Institutes of Health and George Washington University. Dr. Sirio is married to Mary Beth Sirio, RN, MBA, and has four children—Alex, Nicholas, James and Alessandra ranging in age from 3 to 21 years.

AMERICAN MEDICAL GROUP ASSOCIATION

Sam Lin, MD, PhD, MBA

Samuel Lin received his MD and PhD from the Oregon Health Sciences University and is a member of the Alpha Omega Alpha Medical Honor Society. His other degrees include a BS (Seattle Pacific University), MS (Oregon State), MPA (Troy State University) and MBA (Johns Hopkins University). He began his professional career as a US Public Health Service (PHS) Commissioned Officer in the US Department of Health and Human Services (DHHS) and received exceptional capability promotions to the ranks of Captain and to Rear Admiral. From his first assignment as a General Medical Officer and Clinical Director in the US Indian Health Service (IHS), he next headed the IHS Physician Branch. Later, he headed the Office for Europe, DHHS Office of International Health and served as the US Executive Secretary for Joint US Health Commissions with the former USSR, Poland and former Yugoslavia. He was appointed DHHS Deputy Assistant Secretary for Health from 1981 to 1992. During this time, he also served as Acting Director of the National Center for Health Services Research (now Agency for Healthcare Research and Quality), as Acting Director of the Office of Minority Health and as Chair of the Special Committee to Investigate the FDA's Center for Veterinary Medicine. He also served on various policy committees of DHHS UnderSecretaries and FDA Commissioners and as an ex-officio member of a number of NIH Advisory Councils. From 1992 until 1994, he served as Acting DHHS Deputy Assistant Secretary for Minority Health and then as Senior Advisor to the DHHS Deputy Assistant Secretary for International Health focusing on Asian-Pacific Rim and US-Mexico Border health issues. While in Federal service, he co-founded several organizations (the Asian Pacific Islanders American Health Forum, the Association of Asian Pacific Community Health Organizations and the Asian Pacific Nurses Association). He has served, or currently serves, on Boards of VetsFirst, United Spinal Association, Daiichi Sankyo, Inc., Military Officers Association of America, National Capital Area Epilepsy Foundation, China Foundation, Inc., Hepatitis Foundation International, Rock-Asia Capital Group, Ltd., Omega Systems Group, Inc., National Military Family Association, as Commissioner and Vice Chair of the Maryland Health Services Cost Review Commission and as Commissioner and Chair of the Maryland Community Health Resources Commission. He serves as the American Medical Group Association's Alternate Delegate to the American Medical Association (AMA). He has been recognized with the Veterans of Foreign Wars' Commander-in-Chief Gold Medal of Merit, institution of the US Public Health Service Samuel Lin Award, Seattle Pacific University's 2008 Alumnus of Year, AMA Foundation's 2008 Excellence in Medicine Leadership Award, Oregon Health & Sciences University 2009 Alumni Award for Medical Leadership. After leaving Federal service, he joined the then-Upjohn Company as Executive Director for Federal Medical Affairs. He established new business relationships and marketing opportunities in diverse arenas including the healthcare of military beneficiaries. He subsequently established The Lin Group, LLC

and then Humetrics, Inc., a service disabled, veteran owned small business, and serves as a proprietary consultant or project director for domestic and global healthcare ventures in areas such as health care management and administration, biomedical research and development, biomedical technology and transfer, pharmaceutical and device approvals, health information technology, health management and administration, health facility financing and construction, health systems-medical home and accountable care organizations, alternative and complementary medicine and applied technologies in counter-bioterrorism and homeland security.

AMERICAN NURSES ASSOCIATION

Marla J. Weston, PhD, RN

Marla J. Weston, PhD, RN, a nurse leader with nearly 30 years of diverse management experience in health care operations, is the chief executive officer (CEO) of the American Nurses Association (ANA), and the American Nurses Foundation (ANF). Dr. Weston currently is involved in multiple performance measurement and public reporting initiatives. She is ANA's representative to the National Priorities Partnership, Hospital Quality Alliance, and Nursing Alliance for Quality Care. Prior to assuming the leadership post at ANA, Dr. Weston developed and managed U.S. Department of Veterans Affairs initiatives to improve the quality of health care for veterans in all Veterans Healthcare Administration facilities nationwide, with a focus on improving the VA nursing workforce. She implemented strategies to improve the work environment, created policies and programs to attract and retain a highly qualified nursing workforce, and promoted nursing as a career choice. Dr. Weston served for four years as the Arizona Nurses Association's executive director, where she led efforts to advocate for nurses on the state and national level and promoted the Magnet Recognition concept, an indication of excellent quality of nursing in hospitals. As a principal in her own consulting firm, Dr. Weston has advised hospitals and educational institutions on quality improvements, as well as resource management, recruitment and retention, and regulatory compliance. Earlier in her career, Dr. Weston worked in a variety of hospital nursing roles for 18 years, including direct patient care in intensive care and medical-surgical units, nurse educator, clinical nurse specialist, director of patient care support and nurse executive. As a hospital administrator, Dr. Weston oversaw structural changes in services that resulted in improved patient satisfaction scores and quality measures. Dr. Weston graduated from Indiana University of Pennsylvania with a bachelor's of science degree in nursing. She graduated from Arizona State University, with a master's of science degree in nursing. She earned her doctoral degree at the University of Arizona. Her dissertation topic, "Antecedents to control over nursing practice," addressed ways to increase the decision-making role of the hospital nurse – in short, nurse influence and power.

CATALYST FOR PAYMENT REFORM

Suzanne F. Delbanco, PhD

Suzanne F. Delbanco is the executive director of Catalyst for Payment Reform (www.catalyzepaymentreform.org). Catalyst for Payment Reform (CPR) is an independent, non-profit corporation working on behalf of large employers and public health care purchasers to catalyze improvements in how we pay for health services and to promote higher-value care in the U.S. In addition to her duties at CPR, Suzanne serves on the board of the Health Care Incentives Improvement Institute, the Anvita Health Advisory Council and participates in the Healthcare Executives Leadership Network. Prior to CPR, Suzanne was President, Health Care Division at Arrowsight, Inc., a company using video to help hospitals measure the performance of health care workers and provide them with feedback while they are working to improve adherence to safety and quality protocols. From 2000-2007, Suzanne was the founding CEO of The Leapfrog Group. The Leapfrog Group uses the collective leverage

of its large corporate and public members to initiate breakthrough improvements in the safety, quality, and affordability of health care for Americans. Before joining Leapfrog, Suzanne was a senior manager at the Pacific Business Group on Health where she worked on the Quality Team. Prior to PBGH, Suzanne worked on reproductive health policy and the changing healthcare marketplace initiative at the Henry J. Kaiser Family Foundation. Suzanne holds a Ph.D. in Public Policy from the Goldman School of Public Policy and a M.P.H. from the School of Public Health at the University of California, Berkeley.

CONSUMERS UNION

Lisa McGiffert

Lisa McGiffert, directs Consumers Union's Safe Patient Project. Consumers Union is the advocacy arm of *Consumer Reports*. The campaign works on state and national levels to make information available to consumers about medical harm, focusing on healthcare-acquired infections, medical errors, physician safety and medical device safety. Beginning in 2003, the campaign initiated state laws to publish hospital infection rates and raise public awareness about the problem; today more than half of the states and Medicare require such reporting. The campaign's collaboration with individuals who have personal experiences with medical harm has developed into a national consumer network to make health care safer. McGiffert routinely lends the consumer voice on these issues at conferences, with the media and when serving on national and state-based patient safety advisory committees. From 1991-2003, McGiffert directed CU advocacy efforts on the full array of health issues in Texas. Prior to joining CU, Lisa was a policy analyst for the Texas Senate Committee on Health and Human Services where, for seven years, she was actively involved in the development and implementation of state policies. She has also worked as a juvenile probation/parole officer. McGiffert has a BA in psychology from Midwestern State University, Texas.

FEDERATION OF AMERICAN HOSPITALS

Charles N. Kahn III

Charles N. ("Chip") Kahn III is President and CEO of the Federation of American Hospitals (FAH), the national advocacy organization for investor-owned hospitals and health systems. Before coming to the FAH, he was President of the former Health Insurance Association of America and a professional staff person on Capitol Hill specializing in health policy issues. Mr. Kahn holds a Masters of Public Health (M.P.H.) degree from Tulane University School of Public Health and Tropical Medicine, which in 2001 bestowed upon him its prestigious "Champion of Public Health" award. He received a Bachelor of Arts degree from The Johns Hopkins University.

LEADINGAGE (FORMERLY AAHSA)

Cheryl Phillips, MD, AGSF

Cheryl Phillips, MD is Senior VP of Advocacy at LeadingAge (formerly the American Association of Homes and Services for the Aging). Prior to joining LeadingAge, she was Chief Medical Officer of On Lok Lifeways, the parent to the PACE (Program of All-inclusive Care for the Elderly) model that serves nursing home eligible seniors in the greater San Francisco bay area. Dr. Phillips is the past president of the American Geriatrics Society, the national organization for geriatric health care professionals, and the past president of the American Medical Directors Association, an organization for physicians in long-term care. Dr. Phillips has served on multiple national boards and advisory groups for chronic care including the CMS Technical Expert Panel on Quality Indicators in Long-Term Care, the NCQA Geriatric Measurement Advisory Panel, and the CMS Technical Advisory Panel for Independence at Home Demonstration. She has twice provided testimony to the U.S. Senate Special Committee on Aging. In

2005, she was appointed by Governor Schwarzenegger as a governor's delegate to the White House Conference on Aging, and is a Governor's appointee to the California Commission on Aging and the California Olmstead Committee. In 2002, she served as one of 30 fellows for the Primary Health Care Policy Fellowship under Secretary Tommy Thompson, Department of Health and Human Services. Dr. Phillips completed her family practice residency and geriatric fellowship at the University of California, Davis.

MAINE HEALTH MANAGEMENT COALITION

Elizabeth Mitchell

Elizabeth Mitchell serves as President & CEO of the Network for Regional Healthcare Improvement, a national network of multistakeholder Regional Health Improvement Collaboratives with over 30 members across the US. Prior to this, Elizabeth was the CEO of the Maine Health Management Coalition, an employer-led, multi-stakeholder coalition working to improve the value of healthcare services. Elizabeth also served as the CEO of the Maine Health Management Coalition Foundation leading its performance measurement and public reporting program and engaging the public in the use of cost and quality information. While at the Coalition, she led many multistakeholder payment reform and healthcare system redesign efforts, established the MHMC Data and Analytics program with a multipayer claims database and was the nation's 4th designee in CMS' Qualified Entity Certification Program. Elizabeth was integral to the development of Maine's successful State Innovation Model grant in which MHMC was named as the State's 'Implementation Partner'. Elizabeth serves on the Board of the National Quality Forum and on the Coordinating Committee of NQF's Measure Application Partnership. She served for several years on the Board of the National Business Coalition on Health and Chair of its Government Affairs Committee and as Vice-Chair and Chair of the Board of the Network for Regional Healthcare Improvement. Elizabeth is past-chair of Maine's Chartered Value Exchange, a convener of Maine's Aligning Forces for Quality Alliance, and served on the Advisory Council of the Maine Quality Forum. Prior to being appointed CEO of the Maine Health Management Coalition, Elizabeth worked for MaineHealth, Maine's largest integrated health system where she worked with employers and led several transparency and quality improvement efforts. She served two terms representing Portland in the Maine State Legislature, and chaired the Health and Human Services Committee. Elizabeth has held posts at the National Academy for State Health Policy, and London's Nuffield Trust. Elizabeth was selected for an Atlantic Fellowship in Public Policy by the Commonwealth Fund and the British Council. While in the UK, she completed the International Health Leadership Program at Cambridge University's Judge School of Management, while pursuing graduate studies at the London School of Economics. Elizabeth lives in Portland, Maine with her husband and four children.

NATIONAL ALLIANCE FOR CAREGIVING

Gail Hunt

Gail Hunt is President and CEO of the National Alliance for Caregiving, a non-profit coalition dedicated to conducting research and developing national programs for family caregivers and the professionals who serve them. Prior to heading NAC, Ms. Hunt was President of her own aging services consulting firm for 14 years. She conducted corporate eldercare research for the National Institute on Aging and the Social Security Administration, developed training for caregivers with the American Occupational Therapy Association, and designed a corporate eldercare program for EAPs with the Employee Assistance Professional Association. Prior to having her own firm, she was Senior Manager in charge of human services for the Washington, DC, office of KPMG Peat Marwick. She was appointed by the White House to serve on the Policy Committee for the 2005 White House Conference on Aging. Ms. Hunt was on the

Advisory Panel on Medicare Education, is chair of the National Center on Senior Transportation, is a Commissioner of the Center for Aging Service Technology, and is Secretary of the Long-Term Quality Alliance. Additionally, Ms. Hunt is on the Governing Board of the Patient-Centered Outcomes Research Institute (PCORI).

NATIONAL ASSOCIATION OF MEDICAID DIRECTORS

Foster Gesten, MD, FACP

Foster Gesten is the Medical Director for the Office of Quality & Patient Safety in the New York State Department of Health. Dr. Gesten provides clinical direction and leadership for a team of professionals engaged in quality oversight, performance measurement and clinical improvement within health plans and public insurance programs in New York. Major initiatives include the development of statewide public reporting systems for commercial, Medicaid, and Child Health managed care programs on quality, access, and satisfaction, medical home demonstrations, provider based quality measurement and improvement, and patient safety. His interests include population health, health service research, and quality improvement projects directed at prevention services and chronic care. Dr. Gesten is a member of the Committee on Performance Measurement (CPM) at the National Committee for Quality Assurance (NCQA), and a member of the Measure Application Partnership Coordinating Committee of the National Quality Forum (NQF). Dr. Gesten was trained in general internal medicine at Brown University.

NATIONAL BUSINESS GROUP ON HEALTH

Shari Davidson

Shari Davidson is vice president of the National Business Group on Health. The Business Group is a non-profit organization devoted exclusively to representing large employers' perspectives on national health policy issues and providing practical solutions to its members' most important health care problems. She is responsible for the Institute on Health Care Costs and Solutions (including the National Committee on Evidence-Based Benefit Design, the National Leadership Committee on Consumerism and Engagement, the Payment and Delivery Reform: Employer and Health Plans Committee and the National Committee on Pharmacy Benefits and Personalized Medicine) and the annual Business Health Agenda conference. Previously Davidson was vice president of benefits at Visant Corporation (Visant). At Visant, she was responsible for the design, finance, communication and administration of health, welfare and wellness programs, retirement plans, Human Resources Information Systems and payroll. Visant was named a Best Employer for Healthy Lifestyles® seven years in a row and had medical trend well below the national average. Prior to joining Visant, Davidson worked for a large printing company, Quebecor World, for eight years in a similar capacity and spent eight years as a benefits consultant with Hewitt and William M. Mercer. Before joining the staff, Davidson was an active member of the Business Group for 12 years, including being a founding member and co-chair of the Institute on Health Care Costs and Solutions, a founding member of the Institute on the Costs and Health Effects of Obesity, now the Institute on Innovation in Workforce Well-being, and a participant on the National Committee on Evidence-Based Benefit Design and the Public Policy Advisory Group. She served on the Client Advisory Boards for Anthem BlueCross BlueShield (as chair of the Clinical Strategy and Measurement Initiative Group), CVS Caremark, Castlight and Truven and on the Special Expertise Panel for Total Rewards/Compensation and Benefits for the Society for Human Resource Management (SHRM). Davidson received her B.S. in human development and family studies from Cornell University. She earned her certified employee benefit specialist (CEBS) designation from the Wharton School at the University of Pennsylvania.

NATIONAL PARTNERSHIP FOR WOMEN AND FAMILIES

Alison Shippy

Alison Shippy currently works for the National Partnership for Women and Families and serves as Associate Director with the Consumer-Purchaser Alliance – a collaboration of leading consumer, employer and labor groups working together to promote the use of performance measurement in health care to inform consumer choice, value-based purchasing, and payment. Earlier in her career, Alison worked in clinical research and hospital quality/patient safety for Memorial Sloan-Kettering Cancer Center in New York City and most recently worked for the American Academy of Dermatology on issues of performance measurement, patient safety, and value. Alison holds an MPH in health policy and management from Columbia University.

PACIFIC BUSINESS GROUP ON HEALTH

William E. Kramer, MBA

Bill Kramer is Executive Director of National Policy for the Pacific Business Group on Health. In this role he leads the organization's policy work at the federal and state level helping to ensure health care reform is implemented in ways that improve health care quality and reduce costs. Kramer also serves as Project Director for the Consumer-Purchaser Disclosure Project, a collaborative led by PBGH and the National Partnership for Women & Families to bring purchasers and consumers together to improve the quality and affordability of health care. Bill has a long and distinguished career in health care. Most recently, he led his own consulting practice where he was actively involved in health reform in Oregon. There he provided policy analysis and guidance to the Oregon Business Council and strategic and technical assistance to the state government. At the national level, Kramer worked with a group of organizations, including the Small Business Majority, on the design and implementation of health insurance exchanges. Prior to developing his consulting practice, Bill was a senior executive with Kaiser Permanente for over 20 years--most recently as Chief Financial Officer for Kaiser Permanente's Northwest Region. Bill also served as general manager for Kaiser Permanente's operations in Connecticut; earlier in his career, he managed marketing, human resources, and medical economics functions. Prior to his career at Kaiser, he was Chief of Budget and Program Analysis Services for the Washington State Department of Social and Health Services. Bill has an MBA from Stanford Graduate School of Business and a BA from Harvard.

PHARMACEUTICAL RESEARCH AND MANUFACTURERS OF AMERICA (PHRMA)

Christopher M. Dezii, RN, MBA,CPHQ

Christopher Dezii is Director, Healthcare Quality and Performance Measures in the US Health Services Group at the Bristol-Myers Squibb Company with a primary function of advancing Healthcare Quality for all. A contributing member of Quality focused organizations such as the NQF, IOM, CMS and PCORI while achieving Certified Professional in Healthcare Quality (CPHQ) status. Over the last 18 years in industry, Demonstrated competencies in Health Economics, Disease Management, Outcomes Research, and Phase IV Retrospective Clinical Research with over 55 publications in various journals spanning Oncology, HIV, Diabetes, and Cardiovascular Disease . I've earned my degree in Nursing maintaining professional licensure, a Bachelors degree (Magna cum laude) in Business Administration and MBA in Strategic Management (Summa cum laude).

INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)

CHILD HEALTH

Richard C. Antonelli, MD, MS

Rich is the Medical Director of Integrated Care and of Physician Relations and Outreach for Boston Children's Hospital. He is on the faculty of Harvard Medical School in the Department of Pediatrics. Between 1987 and 2005, he was in full time, community-based general pediatrics, founding Nashaway Pediatrics in Sterling, MA. Since 1987, his clinical work has focused on providing comprehensive, family-centered care for all children, youth, and young adults, but especially for those with special health care needs. He is a member of the Project Advisory Committee of the National Center for Medical Home Implementation at the American Academy of Pediatrics. He has published data about the outcome efficacy and cost of care coordination services for children and youth with special health care needs and their families in primary care settings. Rich has also published work defining mechanisms for integration and coordination of care across systems including the development of strategies and interventions to improve collaborative efforts between families, primary care providers, and subspecialists. He has served on the Steering Committee for Care Coordination at the National Quality Forum and as an advisor to the Patient-Centered Medical Home measurement tool work group at the National Committee for Quality Assurance (NCQA). In conjunction with researchers and policy representatives from internal medicine and family medicine, he represented the Academic Pediatrics Association in the national initiative *Establishing a Policy Relevant Research Agenda for the Patient-Centered Medical Home: A Multi-Disciplinary Approach.* He co-authored *Making Care Coordination a Critical Component of the Pediatric Health System: A Multidisciplinary Framework*, supported by The Commonwealth Fund. He has been appointed to the Measure Applications Partnership at the National Quality Forum since its inception. He has provided consultation on care coordination and integration methodologies and measures to multiple states, to US federal agencies, and to some international stakeholders. He is currently funded by the Lucile Packard Foundation for Children's Health to develop a family-reported measure of care integration. Since care coordination is so central to the effective transformation of the American health care system, Antonelli's work has been used for both adult and pediatric health care delivery systems. He has general pediatrics clinical responsibilities in the Primary Care Clinic setting at Boston Children's Hospital where he teaches residents, students, and fellows. He still is the primary care provider for several patients who have been with him since he first completed his residency!

POPULATION HEALTH

Bobbie Berkowitz, PhD, RN, CNAA, FAAN

Bobbie Berkowitz is currently the Dean and Mary O'Neil Mundinger Professor of Nursing at Columbia University School of Nursing and Senior Vice President of the Columbia University Medical Center. She was previously the Alumni Endowed Professor of Nursing and Chair of the Department of Psychosocial and Community Health at the University Of Washington School Of Nursing and Adjunct Professor in the School of Public Health and Community Medicine. In addition, she served as a Consulting Professor with Duke University and the University of California at Davis. Dr. Berkowitz directed the NIH/NINR funded Center for the Advancement of Health Disparities Research and the National Program Office for the RWJF funded Turning Point Initiative. She joined the faculty at the University of Washington after having served as Deputy Secretary for the Washington State Department of Health and Chief of Nursing Services for the Seattle-King County Department of Public Health. Dr. Berkowitz has been a member of

the Washington State Board of Health, the Washington Health Care Commission, the board of the American Academy of Nursing, and chaired the Board of Trustees of Group Health Cooperative. She serves on a number of editorial boards, including the *Journal of Public Health Management and Practice, Policy, Politics, and Nursing Practice*, and as Associate Editor of *Nursing Outlook*. Dr. Berkowitz is an elected Fellow in the American Academy of Nursing and elected member of the Institute of Medicine. She holds a Ph.D. in Nursing Science from Case Western Reserve University and Master of Nursing and Bachelor of Science in Nursing from the University of Washington. Her areas of expertise and research include public health systems and health equity.

DISPARITIES

Marshall Chin, MD, MPH, FACP

Marshall H. Chin, MD, MPH, FACP, Richard Parrillo Family Professor of Healthcare Ethics in the Department of Medicine at the University of Chicago, is a general internist with extensive experience improving the care of vulnerable patients with chronic disease. Dr. Chin is Director of the RWJF Finding Answers: Disparities Research for Change National Program Office. He was a member of the IOM Committee on Future Directions for the National Healthcare Quality and Disparities Reports. He is a member of the NQF Healthcare Disparities and Cultural Competency Consensus Standards Steering Committee and served on the NQF MAP Clinician Workgroup 2011-2012.

RURAL HEALTH

Ira Moscovice, PhD

Dr. Moscovice is the Mayo Professor and Head of the Division of Health Policy and Management at the University of Minnesota School of Public Health. He is director of the University of Minnesota Rural Health Research Center funded by the Federal Office of Rural Health Policy (ORHP). He has written extensively on issues related to rural health care and use of health services research to improve health policy decision making in state government. Dr. Moscovice is one of the leading rural health services researchers in the nation and was the first recipient of the National Rural Health Association's Distinguished Researcher Award in 1992. In 2002, he received a Robert Wood Johnson Foundation Investigator Award in Health Policy Research and in 2004 he served as a member of the Future of Rural Health Care Panel of the Institute of Medicine, National Academies. Dr. Moscovice has served as the principal investigator for numerous rural health studies funded by, among others, ORHP, the Centers for Medicare and Medicaid Studies, AHRQ, the Robert Wood Johnson Foundation, and the U.S. Department of Veterans Affairs. His current research interests include the quality of rural health care, the evaluation of alternative rural health care delivery systems, hospice and end-of-life care for rural Medicare beneficiaries, technology diffusion in rural areas, and the implementation and the assessment of rural health networks.

MENTAL HEALTH

Harold A. Pincus, MD

Harold Alan Pincus, MD is Professor and Vice Chair of the Department of Psychiatry at Columbia University's College of Physicians and Surgeons, Director of Quality and Outcomes Research at New York Presbyterian Hospital and Co-Director of Columbia's Irving Institute for Clinical and Translational Research. Dr. Pincus also serves as a Senior Scientist at the RAND Corporation. Previously he was Director of the RAND-University of Pittsburgh Health Institute and Executive Vice Chairman of the Department of Psychiatry at the University of Pittsburgh. He is the National Director of the Health and Aging Policy Fellows Program (funded by Atlantic Philanthropies), and directed the Robert Wood

Johnson Foundation's National Program on Depression in Primary Care and the John A. Hartford Foundation's national program on Building Interdisciplinary Geriatric Research Centers. Dr. Pincus was also the Deputy Medical Director of the American Psychiatric Association and the founding director of APA's Office of Research and Special Assistant to the Director of the NIMH and also served on White House and Congressional staffs. Dr. Pincus was Vice Chair of the Task Force on Diagnostic and Statistical Manual, Fourth Edition (DSM IV) and has been appointed to the editorial boards of ten major scientific journals. He has edited or co-authored 23 books and over 300 scientific publications on health services research, science policy, research career development and the diagnosis and treatment of mental disorders. Among other projects, he is currently leading the national evaluation of mental health services for veterans and the redesign of primary care/ behavioral health relationships in New Orleans. He has also been a consultant to federal agencies and private organizations, including the U.S. Secret Service, Institute of Medicine, John T. and Catherine D. MacArthur Foundation and served on multiple national and international committees. He is a member of the Scientific Council of the National Alliance for the Mentally Ill and chairs the NIH/NCRR Evaluation Key Function Committee for Clinical and Translational Science Awards and the WHO/ICD 11 Technical Advisory Group on Quality and Patient Safety. For over 22 years he worked one night a week treating the severely mentally ill at a community clinic.

POST-ACUTE CARE/ HOME HEALTH/ HOSPICE

Carol Raphael, MPA

Carol Raphael served as the President and Chief Executive Officer of the Visiting Nurse Service of New York (VNSNY), the largest nonprofit home health care organization in the United States from 1989 to 2011. Ms. Raphael expanded the organization's services and launched innovative models of care for complex populations with chronic illness. Prior to joining VNSNY, Ms. Raphael held executive positions at Mt. Sinai Medical Center and in New York City government. Currently, Ms. Raphael is a Visiting Fellow at Harvard University. She chairs the New York eHealth Collaborative, a public-private partnership working to advance the adoption of health information technology. She is the Chair of the Long-Term Quality Alliance, Chair of the National Quality Forum MAP Workgroup on Post Acute and Long Term Care, a strategic adviser to NCQA and was a member of New York State Governor Cuomo's Medicaid Redesign Team. Ms. Raphael is a nationally recognized expert on health care policy and in particular, high-risk, complex populations with chronic illnesses and long term services and supports. She served on numerous commissions including the Medicare Payment Advisory Commission, the New York State Hospital Review and Planning Council and several Institute of Medicine committees. She has served on a number of boards including the Lifetime Blue Cross/Blue Shield Board and the American Foundation for the Blind. She is currently Vice-Chair of the AARP Board and serves on the boards of the Primary Care Development Corporation, Pace University, the Medicare Rights Center and the New York City Citizens Budget Commission. She is a member of several advisory boards including the Harvard School of Public Health's Health Policy Management Executive Council, the New York City Health and Mental Hygiene Advisory Council, The New York City Age-Friendly Commission and the New York University School of Nursing Advisory Board. She co-edited the book *Home Based Care for a New Century.* She was a Visiting Fellow at the Kings Fund in the United Kingdom, and was listed in *Crain's New York Business 50 Most Powerful Women in New York City.*

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ)

Nancy J. Wilson, MD, MPH

Nancy J. Wilson, MD, MPH is Senior Advisor to the Director of the Agency for Healthcare Research and Quality and leads the Agency's work to develop and implement a national strategy for quality improvement that improves the healthcare delivery system, patient health outcomes, and population health. She also supports the newly established federal-wide Working Group to address healthcare quality. She provides strategic leadership and technical assistance on improvement implementation and data sharing among state Medicaid Medical Directors and is currently working with CMS to identify a core set of quality measures for Medicaid eligible adults. Dr. Wilson has a bachelor's degree in nursing from the University of Pittsburgh, a medical degree from Johns Hopkins, and a master's degree in public health/health care management from the Harvard School of Public Health where she completed a health services research fellowship.

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)

Gail Janes, PhD, MS

Gail Janes is a Sr. Health Scientist in health policy, with the Office of Prevention Through Healthcare (OPTH) in the Centers for Disease Control and Prevention (CDC), in Atlanta, GA. Her area of concentration is health data policy, and evidence based processes, as they relate to public health practice and policy. Since joining CDC in 1992, she has held various positions including Senior Scientist with the CDC Guide to Community Preventive Services, and Lead Scientist for Guideline Development with the Division of HIV Prevention, where she developed a protocol for applying evidence-based methodologies to the development of programmatic guidelines. She has recently worked closely with the Center for Medicare and Medicaid Services, on the application of value-based purchasing and public reporting to efforts to reduce hospital-associated infections, using CDC's National Healthcare Safety Network. She has also worked on comparative effectiveness methodologies with AHRQ's Center for Outcome Effectiveness, and served as a CDC liaison to the U.S. Preventive Services Task Force. Dr. Janes received her undergraduate degree from the University of Maryland and her doctoral degree in cell biology from Georgetown University. She also received a MS in biostatistics from the University of Illinois. Prior to joining CDC, she served as Senior Statistician with the Department of Veterans Affairs Multicenter Clinical Trial Program, and as Head of the Rotterdam Regional Cancer Registry, in the Netherlands.

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

Patrick Conway, MD, MSc

Patrick Conway, MD, MSc, is Chief Medical Officer for the Centers for Medicare & Medicaid Services (CMS) and Director of the Office of Clinical Standards and Quality. This office is responsible for all quality measures for CMS, quality improvement programs in all 50 states, clinical standards, and all coverage decisions for treatments and services for CMS. The office budget exceeds $1.3 billion. Previously, he was Director of Hospital Medicine and an Associate Professor at Cincinnati Children's Hospital. He was also AVP Outcomes Performance, responsible for leading measurement, including the electronic health record measures, and facilitating improvement of health outcomes across the $1.5 billion health care system, including all Divisions and Institutes. Previously, he was Chief Medical Officer at the Department of Health and Human Services (HHS) in the Office of the Assistant Secretary for Planning and Evaluation.

In 2007-08, he was a White House Fellow assigned to the Office of Secretary in HHS and the Director of the Agency for Healthcare Research and Quality. As Chief Medical Officer, he had a portfolio of work focused primarily on quality measurement and links to payment, health information technology, and policy, research, and evaluation across the entire Department. He also served as Executive Director of the Federal Coordinating Council on Comparative Effectiveness Research coordinating the investment of the $1.1 billion for CER in the Recovery Act. He was a Robert Wood Johnson Clinical Scholar and completed a Master's of Science focused on health services research and clinical epidemiology at the University of Pennsylvania and Children's Hospital of Philadelphia. Previously, he was a management consultant at McKinsey & Company, serving senior management of mainly health care clients on strategy projects. He has published articles in journals such as JAMA, New England Journal of Medicine, Health Affairs, and Pediatrics and given national presentations on topics including health care policy, quality of care, comparative effectiveness, hospitalist systems, and nurse staffing. He is a practicing pediatric hospitalist, completed pediatrics residency at Harvard Medical School's Children's Hospital Boston, and graduated with High Honors from Baylor College of Medicine. He is married with two children.

HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)

John E. Snyder, MD, MS, MPH (FACP)

After earning B.S. and M.S. degrees in Biology from the University of Massachusetts at Boston, Dr. Snyder received his M.D. degree from the University of Massachusetts Medical School. He completed his residency training at the Brown University Residency Program in Internal Medicine and then also served as Chief Medical Resident at Brown. He is board certified in Internal Medicine and a Fellow of the American College of Physicians (FACP). Dr. Snyder previously served as an Assistant Professor of Medicine at John Hopkins School of Medicine and was the Assistant Program Director of the Osler Internal Medical Residency Program at Johns Hopkins Hospital. After joining the medical school faculty at UNC Chapel Hill in 2005, based at the South East AHEC in Wilmington, he later became the SEAHEC residency Program Director in Internal Medicine and the Vice Chair of Medicine at New Hanover Regional Medical Center. He earned his MPH degree from UNC Chapel Hill in 2011. Dr. Snyder's research and writing interests center around issues related to health care access, medical ethics, and cultural competency. In addition to authoring numerous journal articles, he recently was the primary author on two books: Evidence-Based Medical Ethics and Breaking Down Barriers to Care. He currently (as of 2011) serves as a Medical Officer in the U.S. Health Resources and Services Administration (HRSA), a branch of the U.S. Department of Health and Human Services. His work at HRSA mainly centers around initiatives through the Affordable Care Act (commonly, the "health care reform" act) that seek to meet the health care needs of underserved populations in the U.S. This effort includes endeavors to build and strengthen the country's primary care work force and reduce the cost and improve the efficiency of health care delivery.

OFFICE OF PERSONNEL MANAGEMENT/FEHBP (OPM)

Edward Lennard, PharmD, MBA

(Pending)

OFFICE OF THE NATIONAL COORDINATOR FOR HIT (ONC)

Kevin Larsen, MD, FACP

Kevin Larsen, MD is Medical Director of Meaningful Use at the Office of the National Coordinator for Health IT. In that role he is responsible for coordinating the clinical quality measures for Meaningful Use

Certification and overseas the development of the Population Health Tool http://projectpophealth.org. Prior to working for the federal government he was Chief Medical Informatics Officer and Associate Medical Director at Hennepin County Medical Center in Minneapolis, Minnesota. He is also an Associate Professor of Medicine at the University of Minnesota. Dr. Larsen graduated from the University of Minnesota Medical School and was a resident and chief medical resident at Hennepin County Medical Center. He is a general internist and teacher in the medical school and residency programs. His research includes health care financing for people living in poverty, computer systems to support clinical decision making, and health literacy. In Minneapolis he was also the Medical Director for the Center for Urban Health, a hospital, community collaboration to eliminate health disparities. He served on a number of state and national committees in informatics, data standards and health IT.

ACCREDITATION/CERTIFICATION LIAISONS (NON-VOTING)

AMERICAN BOARD OF MEDICAL SPECIALTIES

Lois Margaret Nora, MD, JD, MBA

Dr. Lois Margaret Nora is President and Chief Executive Officer of the American Board of Medical Specialties (ABMS). Prior to ABMS, Dr. Nora served as Interim President and Dean of The Commonwealth Medical College (TCMC) in Scranton, Pennsylvania, one of the nation's newest medical schools. Under Dr. Nora's leadership, TCMC achieved major milestones en route to fulfilling its promise to improve health care in northeastern Pennsylvania through innovative, community-focused, patient-centered, evidence-based medical education. From 2002-2010, Dr. Nora served as President and Dean of Medicine at Northeast Ohio Medical University (then NEOUCOM). During Dr. Nora's tenure, institutional accomplishments included the founding of a College of Pharmacy and College of Graduate Studies; a founding partnership in the Austen BioInnovation Institute in Akron; and selection as one of Ohio's best workplaces, among others. Previously, Dr. Nora served as Associate Dean of Academic Affairs and Administration and Professor of Neurology at the University of Kentucky College of Medicine, and Assistant Dean and Assistant Professor of Neurology at Rush Medical College in Chicago. Dr. Nora's scholarly work focuses on issues in medical education, particularly the student environment, and issues at the intersection of law and medicine. Her honors include the American Medical Women's Association President's Recognition Award, the AAMC Group on Educational Affairs Merrel Flair Award in Medical Education, The Phillips Medal of Public Service from the Ohio University College of Osteopathic Medicine, and the 2010 Northeast Ohio Medical University College of Pharmacy Dean's Leadership Award, among others. Dr. Nora received her medical degree from Rush Medical College, a law degree and certificate in clinical medical ethics from the University of Chicago and a Master of Business Administration degree from the University of Kentucky Gatton College of Business and Economics. She is Board Certified and participating in Maintenance of Certification in neurology by the American Board of Psychiatry and Neurology.

NATIONAL COMMITTEE FOR QUALITY ASSURANCE

Margaret E. O'Kane, MHS

Since 1990, Margaret E. O'Kane has served as President of the National Committee for Quality Assurance (NCQA), an independent, non-profit organization whose mission is to improve the quality of health care everywhere. Under her leadership, NCQA has developed broad support among the consumer, employer and health plan communities. About three-quarters of the nation's largest employers evaluate plans that serve their employees using Healthcare Effectiveness Data and Information Set (HEDIS®) data. In recent years, NCQA has received awards from the National Coalition for Cancer Survivorship, the American Diabetes Association and the American Pharmacists' Association. In addition to her leadership of NCQA, Ms. O'Kane plays a key role in many efforts to improve health care quality. Recently, she was awarded the 2009 Picker Institute Individual Award for Excellence in the Advancement of Patient-Centered Care for her leadership of NCQA and lifetime achievement in improving patient-centered health care. In 1999, Ms. O'Kane was elected as a member of the Institute of Medicine. She also serves as co-chair of the National Priorities Partnership, a broad-based group of high-impact stakeholder organizations, working together to bring transformative improvement to our health care system. Ms. O'Kane began her career in health care as a respiratory therapist and went on to earn a master's degree in health administration and planning from the Johns Hopkins University.

THE JOINT COMMISSION

Mark R. Chassin, MD, FACP, MPP, MPH

Mark R. Chassin, MD, FACP, MPP, MPH, is president of The Joint Commission. In this role, he oversees the activities of the nation's predominant standards-setting and accrediting body in health care. Joint Commission accreditation and certification is recognized worldwide as a symbol of quality that reflects an organization's commitment to quality improvement and to meeting state-of-the-art performance standards. Dr. Chassin is also president of the Joint Commission Center for Transforming Healthcare. Established in 2009 under Dr. Chassin's leadership, the Center works with the nation's leading hospitals and health systems to address health care's most critical safety and quality problems such as health care-associated infection (HAI), hand-off communications, wrong site surgery, surgical site infections, and preventing avoidable heart failure hospitalizations. The Center is developing solutions through the application of the same Robust Process Improvement™ (RPI) methods and tools that other industries rely on to improve quality, safety and efficiency. In keeping with its objective to transform health care into a high reliability industry, The Joint Commission will share these proven effective solutions with the more than 19,000 health care organizations and programs it accredits and certifies. Previously, Dr. Chassin was the Edmond A. Guggenheim Professor of Health Policy and founding Chairman of the Department of Health Policy at the Mount Sinai School of Medicine, New York, and Executive Vice President for Excellence in Patient Care at The Mount Sinai Medical Center. Before coming to Mount Sinai, Dr. Chassin served as Commissioner of the New York State Department of Health. He is a board-certified internist and practiced emergency medicine for 12 years. His background also includes service in the federal government and many years of health services and health policy research. While at Mount Sinai Medical Center, Dr. Chassin built a nationally recognized quality improvement program. The focus of the program was on achieving substantial gains in all aspects of quality of care, encompassing safety, clinical outcomes, the experiences of patients and families, and the working environment of caregivers. This initiative was a combined effort of The Mount Sinai Hospital and The Mount Sinai School of Medicine and aimed to create models of world-class excellence that produce major, measurable, and sustainable improvements in all of these vital dimensions of patient care. Dr. Chassin's research during his 12 years at Mount Sinai focused on developing health care quality measures; using those measures in quality improvement; understanding the relationship of quality measurement and improvement to health policy. In addition, he used his experience in quality measurement and improvement to design and deploy a number of effective community-based intervention trials that reduced racial and ethnic disparities in health and health care. Dr. Chassin has been recognized for his contributions to the fields of quality measurement and improvement with several honors. He is a member of the Institute of Medicine of the National Academy of Sciences and was selected in the first group of honorees as a lifetime member of the National Associates of the National Academies, a new program which recognizes career contributions. In addition, Dr. Chassin was a member of the IOM committee that authored "To Err is Human" and "Crossing the Quality Chasm." He is a recipient of the Founders' Award of the American College of Medical Quality and the Ellwood Individual Award of the Foundation for Accountability. Dr. Chassin received his undergraduate and medical degrees from Harvard University and a master's degree in public policy from the Kennedy School of Government at Harvard. He also holds a master's degree in public health from the University of California at Los Angeles.

NATIONAL QUALITY FORUM STAFF

DISCERN HEALTH CONSULTING

Thomas B. Valuck, MD, JD, MHSA

Thomas B. Valuck, MD, JD, is a Partner with Discern Health Consulting. He previously served four years as Senior Vice President, Strategic Partnerships, at the National Quality Forum (NQF) where he oversaw NQF-convened partnerships—the Measure Applications Partnership (MAP) and the National Priorities Partnership (NPP)—as well as NQF's engagement with states and regional community alliances. These NQF initiatives aim to improve health and healthcare through use of performance information for public reporting, payment incentives, accreditation and certification, and systems improvement. Dr. Valuck currently continues to work with the MAP project as a consultant. Dr. Valuck comes to NQF from the Centers for Medicare & Medicaid Services (CMS), where he advised senior agency and Department of Health and Human Services leadership regarding Medicare payment and quality of care, particularly value-based purchasing. While at CMS, Dr. Valuck was recognized for his leadership in advancing Medicare's pay-for-performance initiatives, receiving both the 2009 Administrator's Citation and the 2007 Administrator's Achievement Awards. Before joining CMS, Dr. Valuck was the vice president of medical affairs at the University of Kansas Medical Center, where he managed quality improvement, utilization review, risk management, and physician relations. Before that he served on the Senate Health, Education, Labor, and Pensions Committee as a Robert Wood Johnson Health Policy Fellow; the White House Council of Economic Advisers, where he researched and analyzed public and private healthcare financing issues; and at the law firm of Latham & Watkins as an associate, where he practiced regulatory health law. Dr. Valuck has degrees in biological science and medicine from the University of Missouri-Kansas City, a master's degree in health services administration from the University of Kansas, and a law degree from the Georgetown University Law School.

Allison Ludwig, RN, MPH, MHA

Allison Ludwig is a Senior Project Manager, Strategic Partnerships, at the National Quality Forum. Ms. Ludwig staffs the NQF-convened Measures Application Partnership (MAP), leading an expert group of stakeholders on the over-arching Coordinating Committee, in addition to supporting efforts for quality measurement for Medicaid eligible beneficiaries, and the health work force. Prior to joining NQF, Ms. Ludwig spent two years as an Administrative Fellow at the University of Pittsburgh Medical Center (UPMC) where she worked in various capacities, primarily working to support quality initiatives and further build quality infrastructure at the UPMC Cancer Centers. Before joining UPMC, Ms. Ludwig began her career as a surgical oncology staff nurse at the University of Minnesota Medical Center - Fairview in Minneapolis, MN. Ms. Ludwig received her Bachelor of Science in Nursing from the University of Wisconsin, a Master of Public Health - Health Policy and Master of Health Administration from the University of Iowa.

Amaru J. Sanchez, MPH

Amaru J. Sanchez, MPH, is a Project Analyst at the National Quality Forum (NQF), a private, nonprofit membership organization created to develop and implement a national strategy for healthcare quality measurement and reporting. Mr. Sanchez is currently supporting the work of the NQF Measure Applications Partnership, established to provide multi-stakeholder input to the Department of Health and Human Services on the selection of performance measures for public reporting and payment reform programs. Prior to joining NQF, Mr. Sanchez served as a Health Policy Research Analyst for the bicameral Public Health Committee at the Massachusetts Legislature. At the legislature, Mr. Sanchez influenced

the passage of several novel public health and healthcare related laws as well as drafted legislative proposals relative to medical debt, chronic disease management, health disparities and health care transparency. Mr. Sanchez is a graduate of the Boston University School of Public Health (MPH, Social Behavioral Sciences/Health Policy and Management) and the University of Florida (BS, Integrative Biology). Mr. Sanchez is currently pursuing a Juris Doctor (JD) at The Catholic University of America, Columbus School of Law.