NATIONAL QUALITY FORUM

Agenda

Measure Applications Partnership Coordinating Committee Meeting January 7-8, 2014

NQF Conference Center at 1030 15th Street NW, 9th Floor, Washington, DC 20005

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Meeting Objectives:

- Review progress on measure alignment and measure gaps.
- Finalize recommendations to HHS on measures for use in federal programs for the clinician, hospital, and post-acute care/long-term care settings.
- Finalize plan for MAP off-cycle measure review.
- Finalize recommendation to HHS on the structure and measures for the Health Insurance Marketplaces Quality Rating System.
- Provide early input on the MAP Affordability, Person- and Family-Centered Care, and Population Health Families of Measures.
- Provide input on determining potential measure impact and improving MAP's processes.

Day 1: January 7, 2014

8:30 am **Breakfast**

8:45 am **Welcome, Review Meeting Objectives, and Pre-Rulemaking Approach**
George Isham, MAP Coordinating Committee Co-Chair
Christine Cassel, President and CEO, NQF
Allison Ludwig, Senior Project Manager, NQF

9:15 am **MAP Pre-Rulemaking Strategic Issues**
Allen Leavens, Senior Director, NQF
- Measure Alignment
- Measure Gaps
- Measure Selection Criteria and Decision Categories

10:15 am **MAP Pre-Rulemaking: Finalize Pre-Rulemaking Recommendations for Clinician Programs, including the Medicare Shared Savings Program**
Mark McClellan, MAP Clinician Workgroup Chair

11:45 am **Opportunity for Public Comment**

12:00 pm **Cross-Program Input from Dual Eligible Beneficiaries Workgroup**
Alice Lind, MAP Dual Eligible Beneficiaries Workgroup Chair

12:30 pm **Lunch**

1:00 pm **MAP Pre-Rulemaking: Finalize Pre-Rulemaking Recommendations for Hospital Programs**
Frank Opelka, MAP Hospital Workgroup Chair

3:30 pm **Opportunity for Public Comment and Break**

3:45 pm **MAP Pre-Rulemaking: Finalize Pre-Rulemaking Recommendations for PAC/LTC Programs**
Carol Raphael, MAP PAC/LTC Workgroup Chair

4:45 pm **Opportunity for Public Comment**

5:00 pm **Adjourn for the Day**

Day 2: January 8, 2014

8:30 am	**Breakfast**
9:00 am	**Follow-up on MAP Off-Cycle Measure Review Process** *George Isham*
9:45 am	**Finalize Input on the Health Insurance Marketplaces Quality Rating System** *Elizabeth Mitchell, MAP Health Insurance Exchange Quality Rating System Task Force Chair*
11:45 pm	**Opportunity for Public Comment**
12:00 pm	**Lunch**
12:30 pm	**MAP Families of Measures: Affordability Definitions** *Mark McClellan, MAP Affordability Task Force Chair*
1:30 pm	**MAP Families of Measures: Preview of Person- and Family-Centered Care and Population Health Families of Measures** *Rhonda Anderson, MAP Person and Family Centered Care Task Force Chair* *Bobbie Berkowitz, MAP Population Health Task Force Chair*
2:30 pm	**Round-Robin Discussion: Determining Potential Measure Impact, and Improving MAP's Processes** *George Isham*
4:00 pm	**Opportunity for Public Comment**
4:45 pm	**Adjourn**

Hospital Performance Measurement Programs

MAP reviewed measures in currently finalized program measure sets and measures under consideration for nine hospital programs that have varying purposes and constructions. This section covers the key issues and reviews MAP's recommendations for each hospital program.

Key Issues

During its pre-rulemaking review of hospital programs, MAP discussed a number of challenging issues. In particular, MAP considered the balance between rapid implementation of measures that address outcomes critical to patients and concerns about measures' reliability, validity, feasibility, and potential unintended consequences. The importance of this balance was particularly evident in MAP's decisions regarding stroke outcome measures, healthcare-acquired condition measures, and implementation of the all-cause readmission measure in a payment program.

Stroke Outcome Measures

In reviewing measures for currently finalized program measure sets, MAP made recommendations on the retention of the stroke readmission and mortality measures in the Inpatient Quality Reporting (IQR) program. In addition, MAP made recommendations on the use of the stroke readmission measure within the Hospital Readmissions Reduction Program (HRRP).

MAP Prior Actions and HHS Responses on Stroke Outcome Measures

During the Hospital Workgroup's October web meeting to review the finalized IQR measure set, the group began to discuss two measures related to stroke outcomes for possible removal: 1) Stroke: 30-day all-cause risk-standardized mortality measure, and 2) Hospital 30-day all-cause risk-standardized readmission rate following an acute ischemic stroke hospitalization. MAP did not support these measures in its 2013 pre-rulemaking recommendations because they are not NQF-endorsed, but identified stroke mortality and readmissions to be measure gaps in the IQR program. These measures were not endorsed in part because of concerns that an indicator of stroke severity, particularly the NIH Stroke Scale, was not included in the risk adjustment model. CMS subsequently finalized the measures for use in the IQR program, citing the importance of the topics and a lack of other feasible or practical measures.

Stroke is a high-impact condition, and stroke outcomes are of particular interest to consumers and purchasers. However, providers have expressed concerns about the scientific acceptability of these particular measures. One of the primary concerns raised by providers is that some facilities, such as those with specialized stroke centers, see more severe patients and use of these measures may unfairly penalize facilities that have higher-acuity patients. Moreover, publicly reporting inaccurate data about performance could have the unintended consequence of misdirecting patients.

CMS believes that the measures are sound, and they have reiterated their commitment to improving them. CMS has noted that the measures are currently designed to account for severity, and it is not feasible to incorporate the NIH Stroke Scale into the risk adjustment model. CMS has also suggested that implementation of ICD-10 will allow for more granular coding for stroke location, a factor closely tied to severity and outcomes. Further, CMS and ONC are working to develop an eMeasure that could be included in Meaningful Use Stage 3 and includes a marker of severity collected as part of certification. Finally, CMS has commissioned a study from Yale to explore whether stoke centers are unfairly penalized by the use of these measures. Preliminary results show that distribution of performance is

similar between stroke centers and other types of facilities, with high volume driving outlier results at both ends of the curve.

MAP 2014 Pre-Rulemaking Input on Stroke Outcome Measures

The Hospital Workgroup continued discussion of the stroke measures during its pre-rulemaking meeting and ultimately agreed on retaining the stroke readmission measure in the IQR program. Some workgroup members raised issues about the Yale study results, questioning whether the results reflect inadequate clinical guidelines for treating stroke, the definition of a stroke center, risk adjustment of the measures, or some combination of factors. Other workgroup members argued that consumers need data on stroke outcomes to see possible variation among hospitals. The workgroup did not support the readmission measure for the HRRP program, noting the need for more experience with the measure before it is incorporated into a payment program. The Hospital Workgroup was unable to reach a decision on the retention of the stroke mortality measure in IQR, so the issue will be presented to the Coordinating Committee for resolution as part of its role in providing final input to HHS.

Hospital-Acquired Condition Measures

In its 2012 Pre-Rulemaking Report, MAP recommended removing several hospital-acquired condition (HAC) rates from the IQR program that populates Hospital Compare and replacing them with NQF-endorsed measures. Subsequently, HHS removed the rates from the program. To date, not all conditions previously covered by an HAC rate have been replaced with an endorsed measure, leading to an absence of publicly-reported information on some HACs. In its 2014 pre-rulemaking activities, MAP sought measures under consideration and other endorsed measures to fill current gaps in HACs on Hospital Compare.

Background on Hospital-Acquired Condition Measures

Each HAC rate was a calculation of how often a particular preventable event occurred at a given hospital. The rates were calculated for fee-for-service Medicare beneficiaries who were discharged from a hospital paid through the Inpatient Prospective Payment System (IPPS). The rate for each HAC measure was calculated by dividing the number of each HAC that occurred by the number of eligible Medicare discharges and multiplying the resulting figure by 1,000. The HAC rates were not risk-adjusted to account for differences in hospital patients' characteristics. In addition, no tests of statistical significance or comparisons to national benchmarks were performed on the data.

MAP Prior Actions and HHS Responses on Hospital-Acquired Condition Measures

In its 2012 Pre-Rulemaking Report, MAP recommended removing all eight HAC rates from the IQR program and replacing them with NQF-endorsed measures. In making this recommendation, MAP also noted concerns about the reliability of using secondary diagnosis codes from administrative claims to report HAC-related complications. Subsequently, HHS removed these measures from the program, citing MAP's recommendation and a desire to reduce redundancy between the IQR and HAC Reduction programs.

In addition to the patient safety measures in IQR, the recently launched HAC Reduction Program also includes a variety of safety measures. CMS recently confirmed that the agency plans to report the safety measures from the HAC Reduction Program on Hospital Compare; specifically, the PSI-90 composite and the eight individual rates within the composite.

MAP 2014 Pre-Rulemaking Input on Hospital-Acquired Conditions

Without the original HAC rates in IQR, Hospital Compare will lack data on some safety issues. Specifically, there were once rates for four safety issues that are not currently addressed by measures finalized for IQR or the HAC Reduction Program. Upon reviewing the measure sets for IQR and the HAC Reduction Program, MAP determined that measure gaps existed for air embolism, blood incompatibility, foreign body left during procedure, and manifestations of poor glycemic control. During the current pre-rulemaking cycle, MAP supported two endorsed measures and conditionally supported two non-endorsed measures across the programs to fill these gaps, including NQF #0349 PSI 16 Transfusion Reaction, NQF #0363 PSI 5 Foreign Body Left During Procedure, Adverse Drug Events – Hyperglycemia, and Adverse Drug Events – Hypoglycemia. As no measures were available to address air embolism, this condition was called out as a gap area.

All-Cause Hospital Readmissions Measure

MAP was asked to provide input on the potential implementation of NQF #1789 Hospital-Wide All-Cause Unplanned Readmission Measure in the Hospital Readmissions Reduction Program (HRRP), a pay for performance program.

Background on the All-Cause Readmissions Measure

NQF #1789 Hospital-Wide All-Cause Unplanned Readmission Measure (HWR) estimates the hospital-level, risk-standardized rate of unplanned, all-cause readmissions for any eligible condition within 30 days of discharge for patients ages 18 and older. The measure generates a single summary readmission rate that is risk-adjusted through hierarchical logistic regression. The measure was tested in Medicare fee-for-service and commercial populations that included five clinical cohorts: medicine, surgery/gynecology, cardiorespiratory, cardiovascular, and neurology.

During the NQF endorsement process for the All-Cause Readmission Measure, concerns were raised about the need to risk adjust for socioeconomic status and about the usability of the measure. The NQF Board of Directors asked MAP to consider the complex issue of admission/readmission measure use as part of a broader Care Coordination Family of Measures applicable to all types of providers and to outline principles and issues for implementing admission/readmission measures.

MAP Prior Actions and HHS Responses on Readmission Measures

During MAP's work to identify a Care Coordination Family of Measures, MAP developed a Guidance Document for the Selection of Avoidable Admission and Readmission Measures to establish important implementation principles. The principles state:

- Readmission measures should be part of a suite of measures to promote a system of patient-centered care coordination.
- All-cause and condition-specific measures of avoidable admissions and readmissions are both important.
- Monitoring by program implementers is necessary to understand and mitigate potential unintended consequences of measurement.
- Risk adjustment is necessary for fair comparisons of readmission rates.
- Readmission measures should exclude planned readmissions.

During its 2012 and 2013 pre-rulemaking work, MAP supported the implementation of NQF #1789 in IQR, noting that consumers and purchasers need all-cause readmission information. However, some MAP members raised concerns about potential unintended consequences and the need for appropriate risk adjustment and exclusions. CMS subsequently finalized NQF #1789 for the IQR program.

MAP 2014 Pre-Rulemaking Input on the All-Cause Readmission Measure

During its review of the All-Cause Readmission Measure for HRRP, the Hospital Workgroup was unable to reach consensus. Workgroup members reiterated the importance of all-cause readmission data and the need to improve readmissions across all diagnoses, not just the conditions currently addressed in the HRRP measure set. Workgroup members recognized the important role readmission measures have played in driving recent gains in quality improvement and that patients, purchasers, and payers need readmission information to support their decision-making.

Workgroup members also noted that this measure has only recently been implemented in the IQR program and more experience with its use may be needed before the measure is implemented in HRRP. Workgroup members raised concerns about the need to fully understand the implications of implementing this measure in a pay-for-performance program, especially potential effects on rural and safety net providers. Workgroup members reiterated that issues of socioeconomic status and disparities in care should not be conflated and that all patients deserve high-quality care. Workgroup members noted that implementing MedPAC's recommendation to compare hospitals to like peer groups for purposes of HRRP incentives could help to minimize these issues.

The Hospital Workgroup also raised concerns about all-cause and condition-specific readmission measures leading to "double jeopardy" when used together within the same program and across programs. Workgroup members suggested that CMS consider programmatic approaches to alleviate this concern, such as creating domains within the program for all-cause and condition-specific measures. Statute may prevent the removal of some condition-specific measures.

The MAP Dual Eligible Beneficiaries Workgroup provided guidance that all-cause readmissions are a crucial issue for vulnerable populations and NQF #1789 is included in the Dual Eligible Beneficiaries Family of Measures. Participants noted that measurement of outcomes is always related to socioeconomic circumstances but that alone is not a reason to avoid measurement. The Dual Eligible Beneficiaries Workgroup also strongly supported MedPAC's recommendation to compare safety net hospitals to their peers as these facilities disproportionately care for economically disadvantaged populations and the group would not want to further disadvantage under-resourced hospitals because of case mix.

The MAP Coordinating Committee will review this measure and make determination on a recommendation for implementation of this measure in HRRP as part of its role of providing final input to HHS.

Overview of Recommendations for Hospital Programs

MAP reviewed program measure sets and measures under consideration for nine hospital and facility programs: Hospital Inpatient Quality Reporting (IQR), Hospital Value-Based Purchasing (HVBP), Meaningful Use for Hospitals and Critical Access Hospitals, Hospital Readmissions Reduction Program (HRRP), Hospital-Acquired Condition Payment Reduction Program, PPS-Exempt Cancer Hospital Quality Reporting (PCHQR), Inpatient Psychiatric Facility Quality Reporting (IPFQR), Hospital Outpatient Quality Reporting (OQR), and Ambulatory Surgical Center Quality Reporting (ASCQR). MAP's pre-rulemaking recommendations for measures for these hospital programs reflect the MAP Measure Selection Criteria and build on prior NQF work.

Hospital Inpatient Quality Reporting

MAP reviewed 11 measures under consideration for the IQR program, a pay-for-reporting program for acute care hospitals (see Appendix X; Table X). While the MAP Measure Selection Criteria note a strong preference for NQF-endorsed measures, MAP supported or conditionally supported a number of measures that were not endorsed as they address critical program objectives and previously identified gaps. MAP encouraged further development of these important concepts where applicable and reiterated that the measures should be submitted for NQF endorsement. MAP also discussed the need to balance potential advancement and innovation that can be achieved through the application of eMeasures with the implementation challenges hospitals face in extracting data from electronic health records to support measurement.

MAP supported a number of measures under consideration to help fill previously identified gaps. Two measures under consideration, Hepatitis B Vaccine Coverage Among All Live Newborn Infants Prior to Hospital or Birthing Facility Discharge and PC-02 Cesarean Section are NQF-endorsed and help fill the previously identified gap of maternal/child care. MAP cautioned that C-section rates can be misleading and recommended CMS work with others to ensure that consumers understand publicly reported results and why the measure is important.

MAP supported two measures under consideration that help address the previously identified gap of affordability and overall cost, Hospital-level, risk-standardized 30-day episode-of-care payment measure for heart failure and Hospital-level, risk-standardized 30-day episode-of-care payment measure for pneumonia. MAP noted the need for condition-specific cost information, while recognizing the attribution challenges inherent in measuring episodes of care that involve post-discharge care. Additionally, MAP reiterated the need for the cost measures to be submitted for NQF endorsement.

Two measures under consideration could serve as replacements for one of the HAC rates previously removed from the IQR program. These measures are Adverse Drug Events – Hypoglycemia and Adverse Drug Events – Hyperglycemia. MAP conditionally supported these measures. MAP expressed concern about the feasibility of these measures as they have only been tested using electronic data and not all hospitals participating in IQR have capacity to report eMeasures. MAP noted that the NQF endorsement process should resolve this issue.

MAP also provided input on another measure addressing adverse drug events and medication safety, Appropriate Monitoring of patients receiving an Opioid via an IV Patient Controlled Analgesia Device. While this measure is no longer under consideration by HHS, MAP reiterated the importance of opioid monitoring as an important gap area. In particular, high-risk patients should be continually monitored and sedation outcomes should be tracked. MAP also expressed concern that this measure is limited to patient-controlled analgesia (PCA) and could result in the negative unintended consequence of avoidance of PCA in favor of older, more dangerous therapies. MAP encourages the development of a measure that addresses opioid safety more broadly.

MAP conditionally supported two condition-specific readmission measures for coronary artery bypass graft surgery and vascular procedures, pending NQF-endorsement. MAP reiterated the need for condition-specific readmission measures to help drive quality improvement but noted concerns about risk adjustment for socioeconomic status. Finally, MAP conditionally supported two measures addressing mortality: Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following Coronary Artery Bypass Graft (CABG) surgery and Hospital 30-day Risk-standardized Acute Myocardial Infarction (AMI) Mortality eMeasure. MAP noted the AMI eMeasure is a promising concept but expressed concerns that some hospitals may have difficulties implementing it because of current limitations of EHR systems.

MAP reiterated the importance of filling the gaps that have been previously identified for the IQR program. Specifically, members called for new measures to address pediatrics, maternal/child health, cancer, behavioral health, affordability/cost, care transitions, patient education, and palliative and end-of-life care. MAP is also interested in additional safety measures for medication reconciliation, a hospital's culture of patient safety, pressure ulcers, and adverse drug events. MAP advises HHS to focus on filling gaps where measures already exist, such as the adoption of current measures used in the PCHQR, IPFQR, or Hospice Quality Reporting program rather than gaps with significant needs for measure development.

To keep the IQR measure set parsimonious, MAP identified six finalized measures within the program for phased removal (see Appendix X; Table X). MAP favored removing measures that are no longer NQF-endorsed or endorsed in reserve status, indicating that performance is very high and there is not significant opportunity to improve. MAP acknowledged the potential burden of retaining topped-out measures but cautioned that the removal of such measures could create gaps in the program or take focus away from important topics. MAP advised careful monitoring to prevent a decline in performance after measures are removed.

Hospital Value-Based Purchasing

MAP reviewed 14 measures under consideration for the HVBP program, a pay-for-performance program. In this program, hospitals receive a payment associated with the higher of two scores: one based on their performance relative to other hospitals and the other reflecting their improvement over time (see Appendix X; Table X). MAP reinforced its previous recommendations that 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.

MAP supported four measures under consideration addressing stroke care, noting that stroke is a high-impact condition and the need to promote processes closely tied to better outcomes. MAP did not support the other stroke care measures under consideration because performance on those measures is already high, in congruence with MAP's previous recommendation that the program measure set should be parsimonious to avoid diluting HVBP payment incentives.

MAP reiterated its desire to see additional outcome measures in the HVBP measure set. Noting that measures in the HVBP program must be drawn from the IQR measure set, MAP identified current IQR measures that should be prioritized for inclusion in the HVBP program as potential ways to fill gaps in the program and include more outcome measures. MAP recommended the prioritization of:

- NQF #0469 Elective delivery prior to 39 completed weeks of gestation
- NQF #0351 PSI–4 Death among surgical inpatients with serious treatable complications
- NQF #1550 Hip/Knee Complication: Hospital-level Risk-Standardized Complication Rate (RSCR) following Elective Primary Total Hip Arthroplasty
- NQF #1893 COPD 30-day mortality rate
- AMI Payment per Episode of Care

Additionally, MAP supported CMS's previously stated intention to propose NQF #1716 NHSN Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure and NQF #1717 NHSN Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure for the HVBP program.

Finally, MAP noted additional gap areas, including acute renal failure acquired in the hospital, a hospital's culture of patient safety, and emergency department throughput.

Medicare and Medicaid EHR Incentive Program for Hospitals and Critical Access Hospitals

MAP conditionally supported all six measures under consideration for the Meaningful Use for Hospitals and Critical Access Hospitals program, a pay-for-reporting program (see Appendix X; Table X). Five of the measures under consideration were either under consideration or finalized for the IQR program. While MAP supports alignment across programs and HHS's attempts to minimize reporting burden, members cautioned that the Hospital Meaningful Use program is complex. Hospitals have had difficulty understanding and implementing the program requirements; thus, it may be appropriate to have different measures for the IQR and Meaningful Use programs.

MAP noted the need to continue development of electronic specifications for NQF #0500 Severe Sepsis and Septic Shock: Management Bundle. While some MAP members challenged the feasibility and evidence behind the measure, MAP deferred to the recent endorsement review of this measure and conditionally supported it for the Meaningful Use program.

Hospital Readmissions Reduction Program

The Hospital Readmissions Reduction Program is a pay-for-performance program that adjusts payments for hospitals found to have an excessive number of readmissions based on a national average. MAP reviewed three measures under consideration for this program (see Appendix X; Table X). Two measures under consideration address specific conditions and one addresses all-cause readmissions. MAP considered the balance between all-cause measures and condition-specific measures of readmissions and reiterated the importance of both.

MAP conditionally supported one measure, Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following Coronary artery Bypass Graft (CABG) Surgery, noting the need for additional condition-specific measures in the program. The measure should be submitted for NQF endorsement. MAP did not support the inclusion of Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following an acute ischemic stroke hospitalization, wanting more experience with the measure before it is used for payment purposes. In addition, MAP voiced concerns about the reliability, validity, and risk adjustment of the measure.

With a vote of 13 to 10 in favor of conditional support, the Hospital Workgroup did not reach consensus on a recommendation on including NQF #1789 Hospital-Wide All-Cause Unplanned Readmission Measure in the HRRP program set. As noted above, the workgroup struggled to balance the need to drive improvement for all patients with the risk of unintended consequences for safety net hospitals that may be more likely to experience payment reduction. MAP also urged CMS to develop a methodology for how all-cause and condition-specific measures would be used together in the HRRP program and across programs to avoid duplication.

Regarding gaps in the HRRP program measure set, MAP noted the need for additional condition-specific measures. In particular, MAP recommends the inclusion of measures addressing behavioral/mental health, cancer, percutaneous intervention, and additional medical/surgical conditions beyond cardiovascular conditions.

Hospital-Acquired Condition Payment Reduction Program

MAP reviewed four measures under consideration (see Appendix X; Table X) for the HAC Reduction program, a pay-for-performance program that reduces Medicare payments for hospitals that have rates

of HACs in the top quartile compared to the national average. 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 receive a score for each measure within the two domains. Domain scores will also be calculated, with Domain 1 weighted at 35 percent and Domain 2 weighted at 65 percent to determine a total score under the program.

The four measures under consideration for the HAC Reduction Program are AHRQ PSI measures. MAP supported the inclusion of two NQF-endorsed measures, NQF #0349 Transfusion Reaction (PSI 16) and NQF #0533 Postoperative Respiratory Failure Rate (PSI 11). MAP emphasized that these HACs are devastating to patients and are very costly. MAP did not support the inclusion of PSI 10: Postoperative Physiologic and Metabolic Derangement Rate in the program set, noting the measure is vague and covers too many conditions. The Hospital Workgroup split on the inclusion of PSI 9: Perioperative Hemorrhage or Hematoma Rate. PSI 9 addresses perioperative hemorrhage or hematoma cases with control of perioperative hemorrhage, drainage of hematoma, or a miscellaneous hemorrhage- or hematoma-related procedure following surgery; however the measure is not NQF-endorsed. The Coordinating Committee will make a decision on this measure.

MAP noted a number of gaps for the HAC Payment Reduction Program. MAP suggested the use of PSI-5 to address foreign bodies retained after surgery. Additionally, MAP supported the development of measures to address wrong site/wrong side surgery and sepsis beyond post-operative infections.

PPS-Exempt Cancer Hospital Quality Reporting

MAP reviewed six measures under consideration for the PCHQR program, a quality reporting program for PPS-Exempt Cancer Hospitals (see Appendix X; Table X). While the program does not currently include an incentive or penalty for failing to report, CMS has indicated that the agency plans to address incentives in future rulemaking.

Two of the measures under consideration are process measures addressing cancer treatment. MAP supported one of these measures, NQF #1822 External Beam Radiotherapy for Bone Metastases, noting the importance of this therapy in controlling pain for patients with advanced cancer. MAP conditionally supported a measure addressing the initiation of osteoclast inhibitors for patients with multiple myeloma or bone metastases associated with breast cancer, prostate cancer, or lung cancer. MAP requested that this measure be submitted for NQF endorsement to review its concordance with current evidence and the potential unintended consequence of measuring use of one class of medication.

MAP conditionally supported one measure under consideration related to pain screening, NQF #1628 Patients with Advanced Cancer Screened for Pain at Outpatient Visits. While MAP supports the implementation of patient-reported outcome measures of pain, the group expressed concern that this measure would be especially burdensome and costly to implement. A sampling methodology may be more feasible than collecting data on all patients at all visits. MAP also noted that this measure may be redundant with NQF #0383 and NQF #0384; two measures related to pain that are already finalized for the program. MAP encourages CMS to be parsimonious when selecting measures for the program.

MAP supported NQF #0450 Postoperative Pulmonary Embolism or Deep Vein Thrombosis Rate (PSI 12) for the PCHQR program. This is an NQF-endorsed measure that is included in the MAP Safety Family of

Measures and addresses an important patient safety concern. MAP conditionally supported Potentially Avoidable Admissions and Emergency Department Visits Among Patients Receiving Outpatient Chemotherapy, noting that the measure should be submitted for NQF endorsement.

MAP conditionally supported Overuse of Imaging for Staging Breast Cancer at Low Risk of Metastasis, noting that preventing overuse is important to addressing waste in the system and improving patient safety. The measure should be submitted and receive NQF endorsement. MAP focused on the importance of patient-centered care for this program, noting that overuse should be more closely tied to shared decision-making. The evidence-base for cancer care evolves quickly, and patients should have the opportunity to discuss treatment options and their care plans with their providers.

Previously, MAP had noted palliative care measurement gaps in its hospital programs, particularly in the PCHQR program. With guidance from the PAC/LTC Workgroup, the Hospital Workgroup considered four palliative care measures for inclusion in the PCHQR program that were not on HHS' list of measures under consideration for the program. Two measures, NQF #1634 and NQF #1637, help address pain screening and assessment. Additionally, they are in two MAP families of measures, therefore promoting alignment across settings and programs. The remaining two measures, NQF #0326 Advanced Care Plan and NQF #1641 Treatment Preferences, are currently in the Hospice and Palliative Care Family of Measures and address the previously identified gap of supportive social services for patients. MAP recommended that HHS consider all four of these measures for inclusion in the PCHQR program and that they be considered for the IQR program at a later date, when EHRs have been more widely implemented. The MAP Dual Eligible Beneficiaries Workgroup voiced additional support for these recommendations.

Inpatient Psychiatric Facility Quality Reporting

MAP reviewed ten measures under consideration for the IPFQR program, a pay-for-reporting program (see Appendix X; Table X). The majority of the measures under consideration address screening, and MAP found that the measures did not adequately meet the needs of the program. While MAP agreed that requirement to conduct screening for risk of violence, risk of suicide, and alcohol, tobacco, and substance abuse within a day was an improvement over other measures with a three-day screening window, members expressed concern that the measures set a low bar. As alternatives to the measures under consideration, MAP encouraged the inclusion of measures from The Joint Commission's tobacco, substance abuse, and hospital-based inpatient psychiatric services suites, noting these are currently used in the field and they are in the final stages of the NQF endorsement process. The Dual Eligible Beneficiaries Workgroup supported this recommendation.

MAP conditionally supported two measures addressing influenza vaccination for the IPFQR program, noting that influenza monitoring is important for healthcare personnel and patients and is an important public health concern. However, MAP cautioned that CDC and CMS need to collaborate on adjusting specifications for reporting and implementation before these measures can be included in the reporting program.

As a first step to address the previously identified gap in measures for person-centered psychiatric care, MAP supported the Inpatient Psychiatric Facility Routinely Assesses Patient Experience of Care measure for inclusion in this program. MAP encouraged the rapid replacement of this measure with use of a patient-reported measure of experience of care.

MAP did not support one measure under consideration addressing IPF use of an electronic health record meeting Meaningful Use Criteria. Psychiatric hospitals were excluded from the Meaningful Use EHR Incentive program and imposing these criteria may not be realistic. MAP also expressed concerns about using quality reporting programs to collect data on systems and infrastructure and suggested that the American Hospital Association's survey of hospitals may be a better source for this type of data.

Finally, MAP reviewed measure gaps in the IPFQR program measure set. MAP recognized that outcome measures take time to develop but reiterated the need for this type of measure in the IPFQR program. Gaps identified for this program include patient and family engagement, patient-reported outcomes, medical errors, fear of violence at home, death by suicide within 30 days of admission, and timely access to psychiatric facilities for patients that present to emergency departments.

Hospital Outpatient Quality Reporting

MAP reviewed four measures under consideration for the OQR program, a pay-for-reporting program (see Appendix X; Table X).

MAP did not support three of the measures under consideration for the OQR program. While MAP generally favors the inclusion of readmission measures as part of a broader approach to measuring performance and improving care, MAP did not have enough information on the 30-Day Readmissions measure under consideration to support its use. MAP did not support two measures under consideration related to psychotherapy: No Individual Psychotherapy and Group Therapy. MAP members wanted evidence on the relative value of individual versus group therapy and recommended that these measures be submitted for NQF endorsement to better understand their merit before they are implemented in the OQR program. The Dual Eligible Beneficiaries Workgroup also provided input on the application of these measures for the OQR program. The Dual Eligible Beneficiaries Workgroup stated that individualized psychotherapy services are needed and these measures conceptually have face validity; however, the measures have more to do with previously identified billing abuses than they do with quality of care or patient outcomes.

The Hospital Workgroup split in its decision about the High-Acuity Care Visits after Outpatient Colonoscopy Procedure measure for the OQR program. Workgroup members agreed that the measure addresses an important quality and safety issue, but some members pointed out that incidence of complications following this type of procedure may be very low. Workgroup members also expressed concern that this measure may be difficult to implement because patients are often not tracked by hospitals after procedures. The measure requires further development, particularly of its exclusion criteria. The MAP Coordinating Committee will resolve the split decision on this measure.

MAP identified shared decision-making and patient experience reporting beyond CAHPS as gaps in the OQR program measure set. In addition, MAP identified wrong site or wrong person surgery, a potential adverse event in outpatient facilities, as a measure gap.

Ambulatory Surgical Center Quality Reporting

MAP reviewed one measure under consideration for the ASCQR program, a pay-for-reporting program (see Appendix A; Table A20). The proposed colonoscopy measure was also under consideration for the OQR program, and the Hospital Workgroup was unable to determine the path to take with this measure, reiterating concerns about attribution of a clinician-level measure to a facility and the facility's ability to track patients after procedures. As for the OQR program, the Coordinating Committee will resolve the split decision on this measure.

While questions about the feasibility of the finalized measures related to cataract surgery and endoscopy/polyp surveillance were raised, MAP ultimately supported retaining these measures in the program, noting the important role they play in promoting share accountability.

MAP identified a number of priority measure gap areas for the ASCQR program, including shared decision-making and infections. Infection data could be collected through post-surgical infection surveys and data from hospital admissions and emergency department visits.

Post-Acute Care and Long-Term Care Performance Measurement Programs

This section presents key issues related to performance measurement in PAC/LTC settings that MAP identified during pre-rulemaking activities, and an overview of MAP's pre-rulemaking recommendations for the Inpatient Rehabilitation Facility (IRF) Quality Reporting Program, Long-Term Care Hospital (LTCH) Quality Reporting Program, End Stage Renal Disease Quality Incentive Program (ESRD-QIP), and Home Health (HH) Quality Reporting Program.

This year, MAP was not asked to provide input on measures under consideration for the Nursing Home (NH) Quality Initiative and NH Compare programs, or for the Hospice Quality Reporting (HQR) Program. MAP typically reviews the finalized program measure set when there are no measures under consideration; however, the Nursing Home quality measure set has not changed since MAP's 2013 review. Additionally, HHS updated the Hospice Quality Reporting Program measure set to reflect MAP's 2013 recommendations. Accordingly, MAP did not review these programs as part of this pre-rulemaking cycle.

Key Issues

MAP reiterated several key issues related to the selection of measures for PAC/LTC programs during this pre-rulemaking cycle, including the importance of measure alignment, care coordination, and shared accountability across settings.

MAP emphasized the need to align performance measurement across PA/LTC settings as well as with other settings. When recommending measures for inclusion in the programs, MAP considered harmonization of measures to promote patient-centered care across the healthcare continuum. Recognizing the heterogeneity of populations served in each setting, MAP recommended that measures be specified and applicable to specific populations. For example, MAP noted that falls are more important in long-term care and typically associated with other conditions such as dementia and delirium. However, to encourage harmonization across settings, MAP recommended inclusion of a falls measure in the IRF Quality Reporting Program once the measure has been tested and re-specified for IRFs.

MAP has repeatedly recommended that care transition measures, including setting-specific admission and readmission measures that address the unique needs of the heterogeneous PAC/LTC population, are needed to promote coordination and shared accountability across the care continuum. Last year, MAP conditionally supported admission/readmission measures that were not NQF-endorsed but were under consideration for the PAC/LTC programs, noting that the measures should be appropriately risk-adjusted to account for various population characteristics. Through HHS rulemaking in 2013, four of those measures were implemented in several PAC/LTC programs: two measures of 30-day all cause post discharge readmission for IRFs and LTCHs, and two measures of rehospitalization during first 30 days

and emergency department use without readmission for HH. MAP noted the importance of identifying attribution issues and unintended consequences when further refining these measures.

Highlighting the importance of providing preventive care for patients seen in PAC/LTC settings, MAP encouraged care coordination, better communication, and shared accountability among acute care providers and PAC/LTC facilities to ensure the timely receipt of appropriate services. MAP acknowledges the challenges associated with providing preventive care for vulnerable populations such as dual eligible beneficiaries and patients with multiple chronic conditions, as it is often unclear which provider is responsible for monitoring their complex care needs. For example, ESRD patients spend more time in dialysis facilities and visit their primary care clinicians less frequently; regardless, it is crucial that ESRD patients receive timely vaccinations.

Application of Prior Coordination Strategies to Pre-Rulemaking Decisions

In addition to the MAP Measure Selection Criteria, MAP's Coordination Strategy for Post-Acute Care and Long-Term Care Performance Measurement and Performance Measurement Coordination Strategy for Hospice and Palliative Care served as guides for MAP's pre-rulemaking review of measures for the PAC/LTC programs.

In the PAC/LTC coordination strategy, MAP defined high-leverage areas for performance measurement and identified 13 core measure concepts to address each of the high-leverage areas.

Table X. PAC/LTC Highest-Leverage Measurement Areas and Core Measure Concepts

Highest-Leverage Areas for Performance Measurement	Core Measure Concepts
Function	• Functional and cognitive status assessment • Mental Health
Goal Attainment	• Establishment of patient/family/caregiver goals • Advanced care planning and treatment
Patient Engagement	• Experience of care • Shared decision making
Care Coordination	• Transition planning
Safety	• Falls • Pressure ulcers • Adverse drug events
Cost/Access	• Inappropriate medicine use • Infection rates • Avoidable admissions

In the hospice coordination strategy, MAP identified 28 high-leverage measurement opportunities that are important for hospice and palliative care. Further, MAP prioritized 13 measurement opportunities: seven for hospice and palliative care, three specific to hospice care, and three specific to palliative care. The opportunities specific to hospice care reflect patients' needs for increased access and communication and include timeliness/responsiveness of care, access to the healthcare team on a 24-hour basis, and avoiding unwanted treatments.

This year, MAP emphasized the importance of filling the critical measure gaps (i.e., the core concepts not addressed in the programs) across PAC/LTC programs and expressed strong desire to revisit the PAC/LTC coordination strategy outside of the pre-rulemaking process with a focus on identifying opportunities to make progress on filling key measure gaps. The PAC/LTC core measure concepts that MAP found would greatly enhance the current measure sets include: goal attainment; medication management, medication reconciliation, and adverse drug events; functional and cognitive status; patient and family experience of care and engagement in care; shared decision-making; and transitions in care.

Overview of Recommendations for Post-Acute and Long-Term Care Programs

INPATIENT REHABILITATION FACILITY QUALITY REPORTING PROGRAM

MAP reviewed the five measures currently finalized for the IRF Quality Reporting Program measure set and eight measures under consideration for the program (see MAP PAC-LTC Program Measure Tables). MAP reiterated its previous recommendation that the program measure set is too limited and could be enhanced by addressing core measure concepts not currently addressed in the set. Recognizing that there has been progress in the area of patient safety with HHS' adoption of vaccination and readmission measures for the FY 2016 and 2017 IRF PPS annual payment increase factor, MAP noted that the program measure set still has gaps in high-priority measurement areas for IRFs. Accordingly, MAP supported one NQF-endorsed measure under consideration that addresses *C. difficile*, a high incidence health care acquired condition in IRFs that can affect patients' ability to participate in rehabilitation programs.

MAP conditionally supported the remaining measures under consideration, noting that they all address PAC/LTC core measure concepts but need further modification or development. MAP conditionally supported a measure of falls with injury, stating that the measure needs modification to clarify the scale of the injury, where the falls occur in the facility, and distinction between assisted falls and unassisted falls. MAP also conditionally supported two measures addressing *methicillin-resistant Staphylococcus aureus* (MRSA) and pain, stating that management of these conditions would enable patients to participate fully in their treatment, and thus are valuable. Similarly, MAP conditionally supported four functional status outcome measures, noting that the measures are important indicators for this setting but are still in development.

LONG-TERM CARE HOSPITAL QUALITY REPORTING PROGRAM

MAP reviewed the nine measures currently finalized for the LTCH Quality Reporting Program measure set and three measures under consideration for the program (see MAP PAC-LTC Program Measure Tables). MAP conditionally supported two measures that address the core concept of functional and cognitive assessment. MAP agreed that functional status is a critical area of measurement, and that functional status assessment should cover a broad range of mobility issues, such as position changes, locomotion, poor mobility, picking up objects, and chair-to-bed transfers. MAP expressed concern that these measures are limited to patients requiring ventilator support, which is a fairly small percentage of patients in LTCH facilities. Increased attention should be given to pain, agitation, and delirium among the ventilated population, as these factors are the biggest impediments to mobility.

MAP also supported a measure addressing Ventilator-Associated Events, which addresses complications that have developed from ventilator use as well as infections as a subset of those complications. MAP

agreed although this measure is not NQF-endorsed, it provides useful information for healthcare facilities to help them monitor ventilator use and identify improvements for preventing complications.

END STAGE RENAL DISEASE QUALITY INCENTIVE PROGRAM

MAP reviewed the fifteen measures currently finalized for the ESRD Quality Incentive Program measure set and twenty one measures under consideration for the program (see MAP PAC-LTC Program Measure Tables). MAP previously recommended that the measure set expand beyond dialysis procedures to include non-clinical aspects of care such as care coordination, medication reconciliation, functional status, patient engagement, pain, falls, and measures covering comorbid conditions such as depression.

MAP supported seven measures under consideration, addressing several cross-cutting areas previously noted as gaps and other important measurement topics for the ESRD population. These measures address areas ranging from counseling on physical activity, depression, pain, and health behaviors (substance use treatment) to safety issues such as vaccination among healthcare personnel and testing for Hepatitis C, which is a prevalent comorbid condition in the ESRD population. MAP also noted that depression is a common condition among dialysis patients and has been correlated with mortality, and that pain is important to assess for quality of life because it can signal other problems.

MAP conditionally supported nine measures, deeming them conceptually important but in need of further development. These included vaccination measures and clinical quality measures that address the ESRD program's statutory requirements, including dialysis adequacy and bone mineral metabolism.

MAP did not support five measures, including NQF #0260 Assessment of Health-related Quality of Life, noting that dialysis facilities annually collect and report this data to CMS through the Kidney Disease Quality of Life (KDQOL) survey. Similarly, MAP did not support the comorbidity reporting measure under consideration, as facilities are required to update and annually report the comorbidity data to CMS. Finally, MAP did not support additional vaccination measures under consideration because the measure specifications are not aligned with the Center for Disease Control and Prevention's (CDC) recommendations.

HOME HEALTH QUALITY REPORTING PROGRAM

MAP reviewed the 82 measures finalized for the Home Health Quality Reporting Program measure set and four measures under consideration for the program (see MAP PAC-LTC Program Measure Tables). Two measures under consideration addressed the PAC/LTC core concept of avoidable admissions, and MAP reinforced the important role measures of readmissions play in promoting shared accountability across the care continuum. These measures, Rehospitalization during the First 30 Days of Home Health and Emergency Department Use without Hospital Readmission during the First 30 Days of Home Health, were adopted for the HHQR program in the CY 2014 Rule, but HHS asked MAP to provide input on revisions to the risk adjustment methodology for the measures. MAP supported the revised measures, noting that applying a hierarchical risk adjustment model would be an improvement, but raised concerns that the measures still do not adjust for all factors that could influence a patient's likelihood of readmission to the hospital or emergency department.

MAP also reviewed two new measures under consideration. One measure under consideration addresses the PAC/LTC core concept of mental health. MAP supported this measure, Depression Screening Conducted and Follow-Up Plan Documented, noting that it includes an element of follow up, better promoting person- and family-centered care. MAP noted this measure would be preferable to the

depression screening measure currently in the HHQR set and recommended that this improved measure replace the current measure. Finally, MAP supported one measure under consideration that addresses the PAC/LTC core concept of pressure ulcers; however, the group expressed concern about patient and family compliance and proper risk adjustment for the measure.

HOSPICE QUALITY REPORTING PROGRAM

There were no measures under consideration for the Hospice Quality Reporting Program this year, so MAP used the opportunity to consider alignment of the HQR program with hospital programs by identifying finalized hospice measures that could be incorporated into hospital programs. Accordingly, the MAP PAC/LTC Workgroup provided input to the MAP Hospital Workgroup (see the Hospital section for additional information). During this discussion, MAP expressed concern that NQF #0209 Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment had been finalized for removal from the HRQ program set and stated support for further measure development in this area recognizing that implementation issues for hospice patients who may not be able to respond within 48 hours need to be addressed.

NATIONAL QUALITY FORUM

Issue Brief: MAP Assessment of the Potential Impact of Measures Under Consideration

Overview of the Issue

The Affordable Care Act requires HHS to assess the impact of quality and efficiency measures used in federal healthcare programs, and to provide the findings in a report to Congress every three years. The first such report, the National Impact Assessment of Medicare Quality Measures, was released in March 2012. CMS convened a Technical Expert Panel (TEP) to advise the agency on subsequent reports.

In addition, HHS requested that MAP provide input on the potential impact of quality measures under consideration that MAP recommends for future use in federal programs. In collaboration with HHS, MAP will continue to refine the approach for these assessments based on the data and resources available. More sophisticated analysis and assessment of potential measure impact presents an opportunity for MAP to provide better guidance to HHS on the selection of measures having the highest potential to achieve programmatic goals, and ultimately improve health outcomes. A comparison of the roles of the CMS TEP and MAP is summarized below.

Complementary Roles of CMS Technical Expert Panel and MAP in Assessing Impact

	CMS TEP	**MAP**
Perspective	Retrospective evaluation	Prospective evaluation
Composition	Primarily academic and technical experts	Broad multi-stakeholder group with diverse backgrounds
Primary Anticipated Output	Detailed analyses of impact, which may be at the individual measure level	Broad assessment of the potential impact of adding new measures under consideration to measure sets
Cross-Effort Representation	George Isham – TEP co-chair; Karen Adams and Allen Leavens – TEP members; CMS staff	George Isham – Coordinating Committee co-chair; Karen Adams and Allen Leavens – NQF staff; CMS staff
Funding	CMS contract with HSAG	No separate funding beyond CMS funding of MAP pre-rulemaking activities

Progress to Date

The MAP Measure Selection Criteria and Impact Task Force discussed issues related to assessment of potential measure impact during two task force conference calls in July and August 2013. A summary of the task force's findings was subsequently presented to the MAP Coordinating Committee at their October 3 in-person meeting. Key recommendations agreed upon by the committee included clearly defining "impact" and leveraging existing approaches for assessing impact.

Both CMS and MAP have used the National Quality Strategy as a guiding framework. One simplified definition of impact is therefore: "The extent to which a program measure set addresses the aims and accelerates progress on the priorities of the National Quality Strategy."

One approach to evaluating potential impact is determining the extent to which new measures help program measure sets better meet the MAP Measure Selection Criteria (MSC). In particular, strong emphasis can be placed on increasing alignment and filling important measure gaps. Another approach stems from the RE-AIM (Reach, Effectiveness, Adoption, Implementation, Maintenance) framework being used by the CMS TEP to determine measure impact. Use of RE-AIM promotes a broad assessment of impact by focusing attention on the multiple dimensions of an intervention that influence whether outcomes are successful.

While the Coordinating Committee agreed that the existing approaches provide a starting point, they indicated that these approaches do not go far enough. Coordinating Committee recommendations included:

- Seek and utilize additional quantitative and qualitative information on measures.
- Ensure that both potential positive and negative impacts are evaluated.
- Consider a stronger focus on measures that address upstream health determinants of large populations.
- Look beyond general impact to variations in impact for different populations that may signal disparities.
- For selected measures, develop explicit hypotheses and/or estimates on the range of impact that can be evaluated against outcomes at a later time.

Following the October Coordinating Committee meeting, a small group of MAP members with extensive experience in research methods and evaluation met via teleconference to further discuss the Coordinating Committee recommendations and potential next steps. The group generally agreed that assessing potential measure impact is a complex challenge, and that many factors beyond measurement can influence care and health outcomes. However, the group determined that a logic model would provide more clarity on potential future directions.

Recommendations to the Coordinating Committee

1) Evaluate the draft logic model capturing existing steps in the pre-rulemaking process and related efforts for assessing potential measure impact (see attached diagram).
   a. One key potential addition to current processes would involve the development of explicit hypotheses of expected changes in health and cost outcomes as a result of

implementing certain measures under consideration. The expected hypothetical outcomes could then be compared to actual outcomes over time.

b. The draft logic model includes new initiatives or partnerships that may facilitate more advanced analytic methods, specifically predictive modeling.

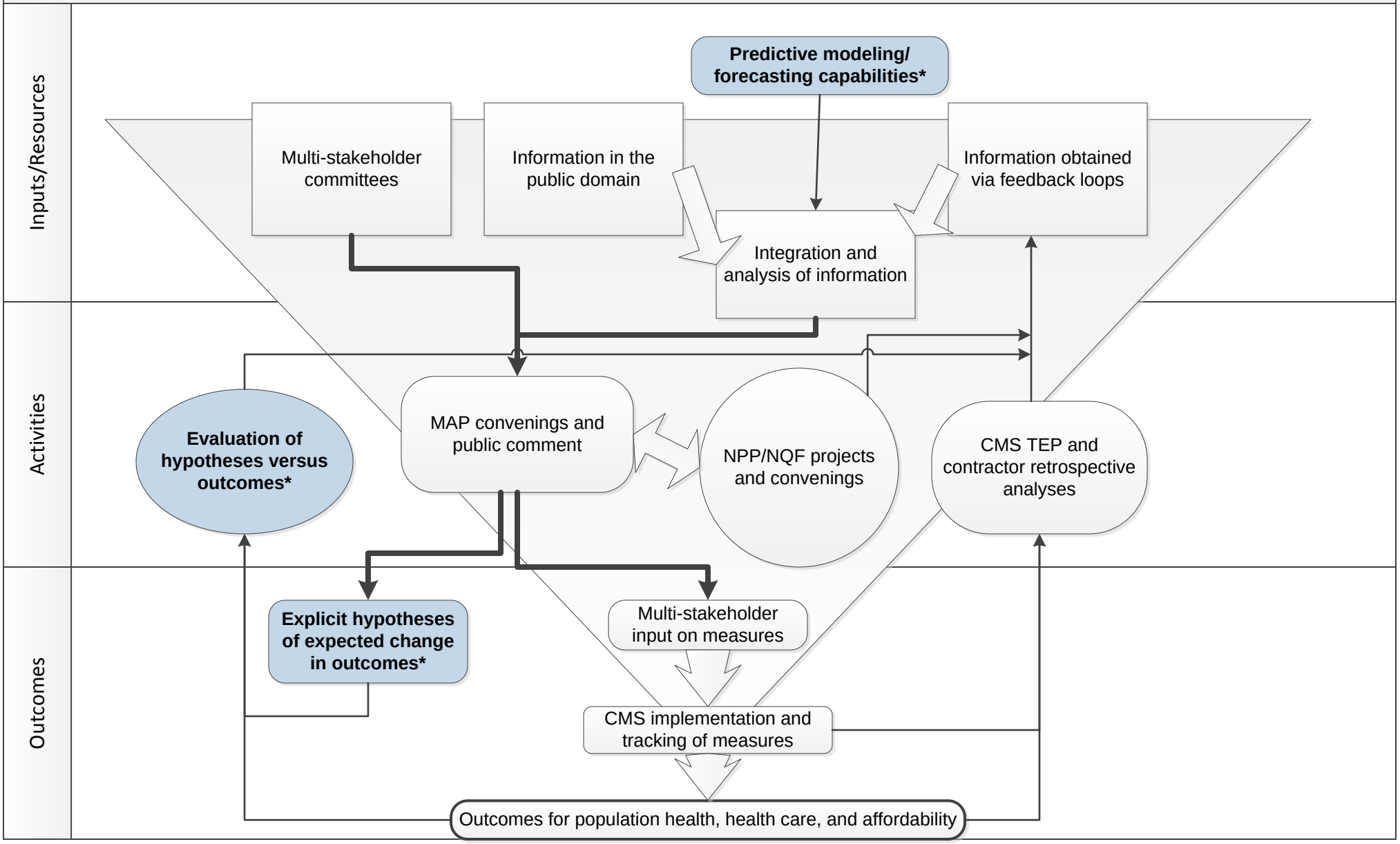
2) Take a consumer-oriented approach to provide an additional lens for assessing potential impact, with consideration for outcomes that matter most to consumers – such as quality of life and pain management.

3) Consider a stratified approach to impact assessment.

a. Examining expected impact by program and reviewing changes in measured results over time may be most feasible and meaningful.

b. Consistent with a consumer-oriented approach, give higher priority to impacts for programs that are more relevant to consumers.

A Logic Model for MAP Assessment of the Potential Impact of Measures Under Consideration



Key Assumptions: 1) Multi-stakeholder input significantly influences CMS measure selection; 2) Implementation of specific quality measures significantly affects outcomes.

*Proposed

NATIONAL QUALITY FORUM

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

DRAFT REPORT

December 23, 2013

This report is funded by the Department of Health and Human Services under contract HHSM-500-2012-00009I task order #3.

Introduction

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

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

MAP convened a time-limited Health Insurance Exchange-Quality Rating System (HIX-QRS) Task Force, drawn from the membership of the MAP Coordinating Committee and workgroups, to advise the MAP Coordinating Committee on recommendations for the QRS (see MAP Coordinating Committee and HIX-QRS Task Force Rosters—Appendix B). The 26-member HIX-QRS Task Force convened via three web meetings and one two-day in-person meeting to develop its input to the Coordinating Committee. All MAP meetings are open to members of the public; the agendas and materials for the task force and Coordinating Committee meetings can be found on the NQF website.

On November 15, 2013, HHS released the Notice with Comment on the Patient Protection and Affordable Care Act; Exchanges and Qualified Health Plans, Quality Rating System (QRS), Framework Measures and Methodology. HHS provided MAP with supporting documentation on the proposed QRS hierarchical structure, organization, and measures for the family and child core sets.

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

[1] ACA 1311(c)(3) http://housedocs.house.gov/energycommerce/ppacacon.pdf

Vision for Enabling Consumer Choice in the Health Insurance Marketplaces

MAP defined its vision for the Quality Rating System for the Health Insurance Marketplaces taking into consideration the characteristics of the Marketplace population (see population profile—Appendix C). As a primary focus of the QRS is to enable consumer choice of health plans, MAP's vision articulates how information can be most accessible to consumers (i.e., how information is structured in the QRS), what information is most meaningful to consumers (i.e., the performance measures that support consumer decision-making), and how the QRS should be implemented over time. MAP's Quality Rating System Guiding Principles (Appendix D) summarize MAP's vision and serve as guidance for providing input on HHS' proposed structure and measures for the QRS.

Making Information Accessible to Consumers

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

The QRS represents a unique opportunity to educate the public on quality of care and how this information can inform health care decisions, as many consumers entering the Marketplaces will have minimal experience with the health care system. Accordingly, the QRS should use plain language to explain quality information and provide consumer decision-support tools. To ensure that information can be easily digested, the QRS should provide an overall score for each QHP, summary scores of meaningful topic areas for each QHP, and the ability to drill down to performance scores for individual measures. Recognizing that consumers will become more accustomed to using quality information over time, MAP recommends that the QRS include feedback loops; that is, systematic mechanisms for collecting information on the use and usefulness of information used in the QRS. This information would provide insight into new strategies for reporting quality information in increasingly meaningful ways.

Making Information Meaningful for Consumers

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

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

In considering the information consumers desire, MAP identified and prioritized high-leverage opportunities for measurement and determined how best to organize the opportunities. The high-leverage opportunities represent areas of consumer interest and improvement gaps, and areas of greatest cost and prevalence. MAP defined the five highest priority measurement areas as: (1) patient and family experience or satisfaction, (2) cost (including total out of pocket costs, costs for specific medical services and prescription medications, shared financial responsibility, and affordability), (3) care coordination and case management, (4) medication management, and (5) quality of providers in the health plan. Similarly, when considering how best to organize information in the QRS, MAP identified three overarching categories that are most important to consumers—experience, cost and quality.

Measures in the QRS should address both plan and provider performance

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

Regardless of the approach for including provider performance, MAP noted that the experience and quality high-leverage opportunities for measurement are similar for plans and providers; however, the specific measures to assess these high-leverage opportunities may vary. Ideally, MAP envisions aligned measurement across plans and providers; for example, a care coordination measure for health plans may assess plans' efforts to provide patient information to multiple providers; whereas, a care coordination measure for providers may assess providers' timeliness in transferring information to the plan or other sites of care. Regarding cost, MAP emphasized that cost should be addressed from the consumer's perspective—providing relevant information on out of pocket cost of services, prescription costs, and premiums.

Phased Approach to Implementation

MAP recognizes that many aspects of its vision for the QRS might not be feasible for initial implementation in 2016. As initial implementation may be limited to health plan reporting on existing quality measures, MAP sought to define the structure and types of measures that are feasible in the first two years of implementation. MAP considered alignment among measurement activities as a critical aspect of feasibility.

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

MAP's recommended initial structure (Appendix F) presents high-leverage opportunities for measurement organized by experience, cost, and quality.

Input on Proposed Marketplaces QRS

Hierarchical Structure for the Quality Rating System

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

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

MAP recommends enhancements to HHS' proposed structure, specifically:

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

Measures for the Quality Rating System

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

MAP reviewed 42 measures HHS proposed for inclusion in the family core set and 25 measures proposed for inclusion in the child core set. For each proposed measure, MAP provided rationale for one of the following recommendations:

- Support: Indicates measures under consideration that should be added to the QRS.

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

Overall, the task force supported the use of most of the measures in HHS' proposed family and child core sets for the Marketplaces QRS (27 for the family core set and 25 for the child core set). MAP conditionally supported measures (9 for the family core set and 4 for the child core set) that were found to be not ready for implementation and need further experience or testing before being added to the QRS. Additionally, MAP conditionally supported measures where HHS proposed a single rate within an NQF-endorsed measure, preferring use of complete endorsed measures instead. MAP did not support certain measures for the QRS that should be assessed at the provider level of analysis or could be better addressed by other measures (6 for the family core set and 2 for the child core set). See Appendix H for individual measure recommendations.

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

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

Table 1: MAP's Recommendation for the QRS Structure: Organization of High-Leverage Opportunities and Supported Proposed Measures

Summary Indicator	Domain	Subdomain	High-Leverage Opportunity/Proposed Measures Supported by MAP
Experience	Plan Experience	Experience with Health Plan	• Patient and Family Experience/Satisfaction o CAHPS – Customer Service o CAHPS – Global Rating of Health Plan • *Shared Decision-Making* • *Quality of Providers* • *Member Complaints and Grievances*

Summary Indicator	Domain	Subdomain	High-Leverage Opportunity/Proposed Measures Supported by MAP
		Access to Plan Resources	• Member Access to Information o CAHPS – Plan Information on Costs • *Member Education* • Cultural Competency o CAHPS – Cultural Competency • *Access to Health Plan Resources, Medical Records*
		Access to Care	• Access to Care, Specialists, and Network Adequacy o CAHPS – Getting Care Quickly o CAHPS – Getting Needed Care o Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life o Well-Child Visits in the First 15 Months of Life (Child Core Set Only) o Children and Adolescents' Access to Primary Care Practitioners (Child Core Set Only) • *Covered Services/Benefits*
	Provider Experience	Provider Experience	• Patient and Family Experience/Satisfaction o CAHPS – Rating of All Health Care o CAHPS – Rating of Personal Doctor o CAHPS – Rating of Specialist Seen Most Often • *Shared Decision-Making* • *Access to Medical Records*
Cost	Cost	Cost	• Out of pocket costs • Premiums • Efficient Resource Use o Appropriate Testing for Children With Pharyngitis o Appropriate Treatment for Children with Upper Respiratory Infection o Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (Family Core Set Only) o Relative Resource Use for People with Cardiovascular Conditions – Inpatient Facility Index (Family Core Set Only) o Relative Resource Use for People with Diabetes – Inpatient Facility Index (Family Core Set Only) o Use of Imaging Studies for Low Back Pain (Family Core Set Only)

Summary Indicator	Domain	Subdomain	High-Leverage Opportunity/Proposed Measures Supported by MAP
Quality	Health Plan Quality	Staying Healthy	• Maternal Health o Prenatal and Postpartum Care: Postpartum Care (Family Core Set Only) o Prenatal and Postpartum Care: Timeliness of Prenatal Care (Family Core Set Only) • Well-Infant, Child, Adolescent Care o Childhood Immunization Status o Immunizations for Adolescents • Behavioral/Mental Health o Antidepressant Medication Management (Family Core Set Only) o Follow – Up After Hospitalization for Mental Illness: 7 days (Family Core Set Only) o Follow – Up Care for Children Prescribed ADHD Medication: Initiation Phase o Follow-Up Care for Children Prescribed ADHD Medication: Continuation Phase (Child Core Set Only) • Screening, Immunization, and Treatment of Infectious Disease o CAHPS – Flu Shots for Adults (Family Core Set Only) o Chlamydia Screening in Women (Ages 16-20) (Child Core Set Only) o HPV Vaccination for Female Adolescents (Child Core Set Only) • Cancer Screening o Breast Cancer Screening (Family Core Set Only) o Cervical Cancer Screening (Family Core Set Only) o Colorectal Cancer Screening (Family Core Set Only) • Tobacco, Alcohol and Substance Use o CAHPS – Medical Assistance With Smoking and Tobacco Use Cessation (Family Core Set Only) • Weight Management and Wellness Counseling o Weight Assessment and Counseling for Nutrition and Physical Activity Children and Adolescents: BMI Percentile Documentation • Dental and Vision Care o Annual Dental Visit

Summary Indicator	Domain	Subdomain	High-Leverage Opportunity/Proposed Measures Supported by MAP
		Living with Chronic Illness	• Cardiovascular Care o Controlling High Blood Pressure (Family Core Set Only) • Diabetes Care o Diabetes Care: Eye Exam (Retinal) Performed Screening (Family Core Set Only) o Diabetes Care: Hemoglobin A1c (HbA1c) Control <8.0% Screening (Family Core Set Only) • *Asthma and Respiratory Care* o Medication Management for People with Asthma • *Cancer Treatment*
		Coordination	• Care Coordination and Case Management o CAHPS – Coordination of Members' Health Care Services • Medication Management o Annual Monitoring for Patients on Persistent Medications (Family Core Set Only) • *Advanced Illness Care* • *Care for Older Adults* • Readmissions o Plan All – Cause Readmissions (Family Core Set Only)
	Provider Quality	Staying Healthy	• *Maternal Health* • *Well-Infant, Child, Adolescent Care* • *Behavioral/Mental Health* • *Screening, Immunization, and Treatment of Infectious Disease* • *Tobacco, Alcohol and Substance Use* • *Weight Management and Wellness Counseling* • *Dental and Vision Care*
		Living with Chronic Illness	• *Cardiovascular Care* • *Diabetes Care* • *Asthma and Respiratory Care* • *Cancer Screening and Treatment*
		Coordination	• *Care Coordination and Case Management* • *Medication Management* • *Advanced Illness Care* • *Care for Older Adults* • *Readmissions*

Path Forward

The Quality Rating System for the new Health Insurance Marketplaces is an opportunity to engage consumers across the country in innovative and dynamic ways. MAP encourages continual progression in the QRS and has identified several opportunities for its enhancement. Specifically, MAP recommends that HHS:

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

Test the QRS with consumers prior to initial implementation. While the existing measures have been previously used in public reporting systems, the structure and measures may not resonate with the anticipated Marketplace population. Additionally, testing can help refine consumer-friendly language, explanations, and displays needed throughout the QRS.

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

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

Appendix A: MAP Background

Purpose

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

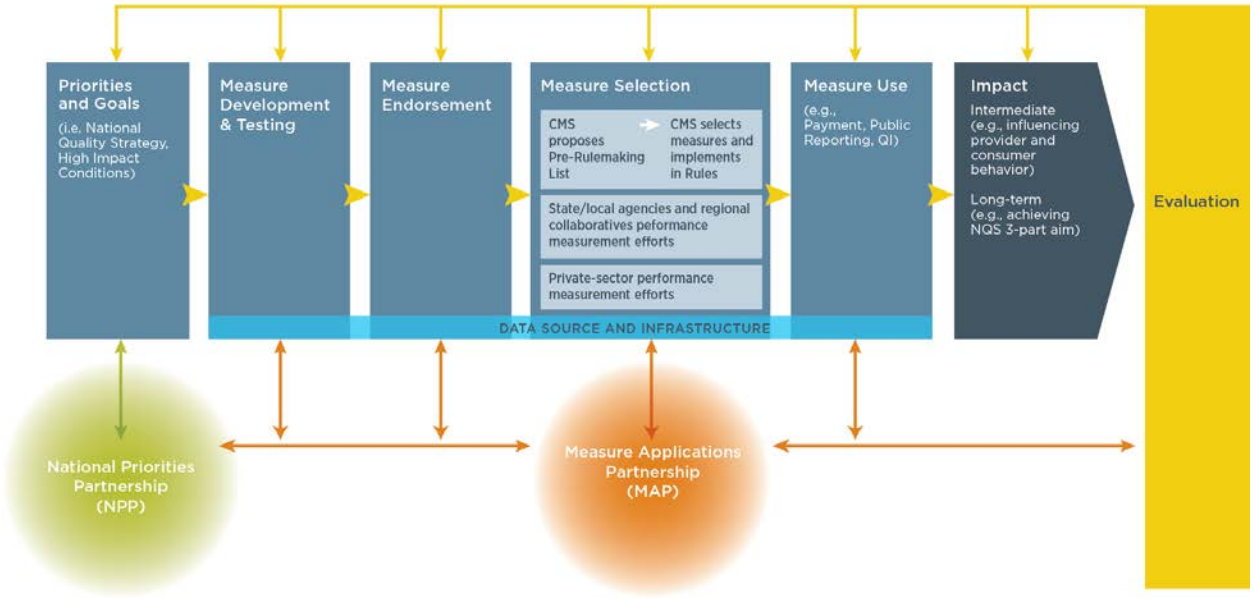
MAP activities are designed to coordinate with and reinforce other efforts for improving health outcomes and healthcare quality. Key strategies for reforming healthcare delivery and financing include publicly reporting performance results for transparency and healthcare decision-making, aligning payment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

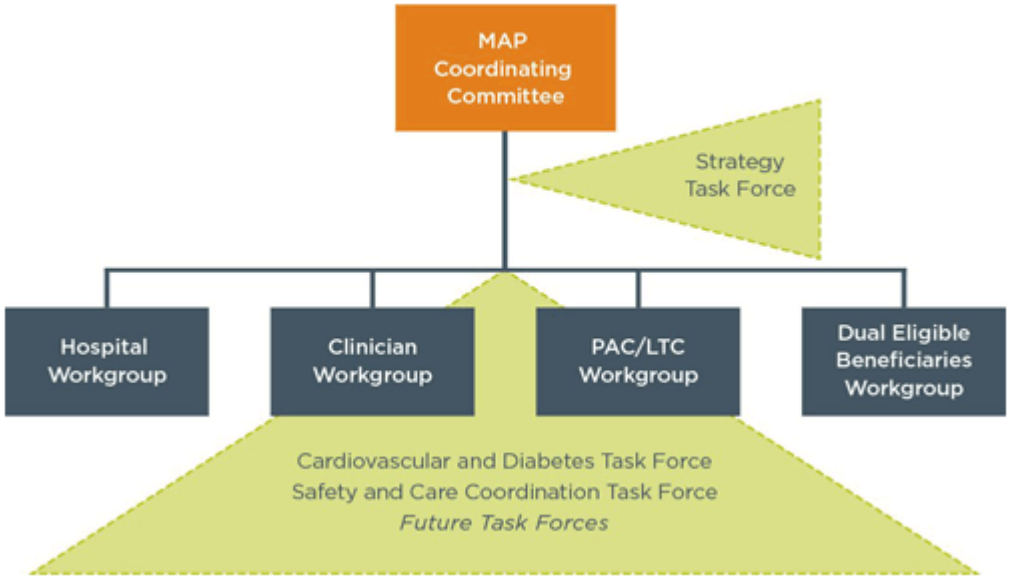
Figure 1. Functions of the Quality Enterprise.



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

Appendix B: Measure Applications Partnership Rosters

MAP Coordinating Committee Roster

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

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

EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Child Health	Richard Antonelli, MD, MS
Population Health	Bobbie Berkowitz, PhD, RN, CNAA, FAAN
Disparities	Marshall Chin, MD, MPH, FACP
Rural Health	Ira Moscovice, PhD
Mental Health	Harold Pincus, MD

EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Post-Acute Care/ Home Health/ Hospice	Carol Raphael, MPA

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

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

MAP Health Insurance Exchange-Quality Rating System Task Force Roster

CHAIR (VOTING)
Elizabeth Mitchell

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

EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Child Health	Richard Antonelli, MD, MS
Health IT	Thomas Von Sternberg, MD
Measure Methodologist	Debra Saliba, MD, MPH
Medicaid ACO	Ruth Perry, MD
Nursing	Gail Stuart, PhD, RN

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVES
Centers for Medicare & Medicaid Services (CMS)	Deborah Greene, MPH
Health Resources and Services Administration (HRSA)	Terry Adirim, MD, MPH

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

Appendix C: Health Insurance Marketplace Population Description

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

- Approximately 17 million people will be newly insured in 2014.[9]
- 90% of individual marketplace enrollees will receive federal subsidies.
- The total marketplace population is projected to reach 29 million in 2021 (25 million in the individual marketplace and 4 million through the SHOP marketplace).[10]
- More than 50% of the marketplace population is expected to be unmarried adults, with a median age of 33.

Geography

Americans throughout the country will make up the marketplace population.

- Individuals in the South and West regions of the United States are most likely to be uninsured.
- Approximately 40% of the expected individual marketplace enrollees will come from five states: California, Texas, Florida, New York, and Illinois.[11][12]

Race and Ethnicity

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

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

Family Status

The newly insured are more likely to be unmarried adults.

- The current insurance market is made up of 40% married and 29% single adults, and 31% children.
- The proportion of the newly insured that is made up of single adults is expected to be 52%.
- Children are currently the least likely to be uninsured because they are more likely to qualify for Medicaid or the Children's Health Insurance Program (CHIP).[13]

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[9] http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf

[10] http://pwchealth.com/cgi-local/hregister.cgi/reg/pwc-health-insurance-exchanges-impact-and-options.pdf

[11] HRI Analysis; US Census Bureau, Current Population Survey, March 2011 Supplement; CBO, "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision," July 2012.

[12] http://www.census.gov/hhes/www/hlthins/data/historical/HIB_tables.html

- 90% children in the US have either public or private health insurance coverage.
- Children enrolled in Medicaid and CHIP are more likely to have a usual source of care, had a well-child visit in the past year, and been seen by a specialist in the past year, and less likely to have had their medical care delayed than uninsured children.[14]
- Rates of young adults without insurance have recently decreased due to early ACA provisions allowing them to remain on a parent's private health plan until age 26, but the uninsured rates continue to remain high compared to other age groups.

Education

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

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

Employment

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

- The anticipated marketplace population has a median income of 166% of the federal poverty level (FPL), compared to the currently insured population medium income of 333% of the FPL.[15]
- 59% of individuals in the current insurance market have full-time employment, compared to 42% of the newly insured.
- Across industries, more than 80% of uninsured workers are in blue-collar jobs; the gap in rates of coverage between blue- and white-collar workers is two-fold or greater.
- More than 50% of currently uninsured individuals have at least one full-time worker in their family, and only 15% have only part-time workers in their family.
- Most uninsured workers are either self-employed or work for small firms less likely to offer health benefits.[16]
- Partially employed individuals are expected to cycle coverage between Medicaid and the marketplaces, a phenomenon known as "churn."

Health Status

The marketplace population is less likely to report excellent or very good health than the traditional market.[17]

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

[14] http://www.nashp.org/sites/default/files/keeping.children's.coverage.strong.pdf

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

[16] http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7806-05.pdf

[17] HRI Analysis 2012

- 26% of the newly insured population is estimated to report being in excellent health, and 29% is estimated to report being in very good health, compared to 37% and 33% of the currently insured population, respectively.
- 16% of people with a disability in the US are estimated to be uninsured.
- Leading causes of death in the US for non-elderly adults include malignant neoplasms, diseases of the heart, unintentional injuries, suicide, chronic lower respiratory diseases, chronic liver disease, diabetes mellitus, and homicide.[18]
- Lack of insurance increases mortality rate by 25%. Risk of death from some preventable and treatable diseases (including heart disease and certain types of cancer) is also higher for people without health insurance.[19]

Access to Care

In 2011, 75% of the non-elderly uninsured population was without insurance for more than a year, during which 43% report having no health care visits within the past 12 months, compared to 12% of the continuously insured population who report having no health care visits.

- More than 25% of uninsured adults forgo needed care each year, and they are less likely than those with insurance to receive preventative care and services for major health conditions and chronic conditions.[20]

[18] CDC/NCHS, National Vital Statistics System, 2012

[19] http://www.urban.org/UploadedPDF/411588_uninsured_dying.pdf

[20] CDC/NCHS, National Vital Statistics System, 2012

Appendix D: MAP's Quality Rating System Guiding Principles

The MAP Health Insurance Exchange (HIX) Quality Rating System (QRS) Task Force developed these principles to serve as guidance for applying performance measures to support consumer decision-making in Qualified Health Plans (QHPs). The principles are not absolute rules; rather, they are meant to guide measure selection decisions. The principles are intended to complement the statutory requirements for QHPs in the Affordable Care Act (ACA) and the MAP Measure Selection Criteria.

- QRS structure should focus on consumer needs by providing information that is:
    - Usable and of interest to consumers in comparing plan performance
    - Accessible and can be easily and quickly interpreted by consumers
    - Interactive and customizable, allowing consumers to emphasize their values

- Measures within the QRS should:
    - Focus on cost, experience, clinical quality outcomes, and patient-reported outcomes
    - Address core plan functions, including quality of providers, managing costs, additional benefits
    - Drive improvement for plans and providers by measuring quality at the proper level of accountability (i.e., attributable and actionable by plans, attributable and actionable by providers)
    - Be NQF-endorsed, or build on existing structural information
    - Be aligned and parsimonious, taking into consideration existing plan reporting requirements

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

Appendix E: 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)

Appendix F: MAP's Recommended Structure for the QRS and High-Leverage Opportunities for Measurement

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

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

Appendix G: MAP's Recommended and HHS' Proposed Structure- Side by Side Comparison

EXPERIENCE

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

COST

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

QUALITY – HEALTH PLAN QUALITY

Tier 1	Proposed QRS Indicator	Tier 2	Proposed QRS Domain	High-Leverage Opportunity	Proposed QRS Composite
Quality	Clinical Quality Management	Health Plan Quality (Identical HLOs to Provider Quality)	Care Coordination	Coordination • Care Coordination and Case Management • Medication Management • Advanced Illness Care • Readmissions	No Composite • CAHPS – Coordination of Members' Health Care Services
			Patient Safety (Not on Child Structure)		No Composite • Annual Monitoring for Patients on Persistent Medications • Plan All – Cause Readmissions

Tier 1	Proposed QRS Indicator	Tier 2	Proposed QRS Domain	High-Leverage Opportunity	Proposed QRS Composite
			Prevention	<u>Prevention/Staying Healthy</u> • Maternal Health • Well-Infant, Child, Adolescent Care • Behavioral/Mental Health • Screening, Immunization, and Treatment of Infectious Disease • Tobacco, Alcohol and Substance Use • Weight Management and Wellness Counseling • Dental and Vision Care <u>Chronic Management</u> • Cardiovascular Care • Diabetes Care • Asthma and Respiratory Care • Cancer Screening and Treatment	<u>Checking for Cancer (Not on Child Structure)</u> • Breast Cancer Screening • Cervical Cancer Screening • Colorectal Cancer Screening <u>Maternal Health (Not on Child Structure)</u> • Prenatal and Postpartum Care: Postpartum Care • Prenatal and Postpartum Care: Timeliness of Prenatal Care <u>Staying Healthy Adult (Not on Child Structure)</u> • Adult BMI Assessment • CAHPS – Aspirin Use and Discussion • CAHPS – Flu Shots for Adults • CAHPS – Medical Assistance With Smoking and Tobacco Use Cessation <u>Staying Healthy Child</u> • Annual Dental Visit • Childhood Immunization Status • Immunizations for Adolescents • Weight Assessment and Counseling for Nutrition and Physical Activity Children and Adolescents: BMI Percentile Documentation

Tier 1	Proposed QRS Indicator	Tier 2	Proposed QRS Domain	High-Leverage Opportunity	Proposed QRS Composite
			Clinical Effectiveness		Behavioral Health • Antidepressant Medication Management • Follow – Up After Hospitalization for Mental Illness: 7 days • Follow – Up Care for Children Prescribed ADHD Medication: Initiation Phase Cardiovascular Care (Not on Child Structure) • Cholesterol Management for Patients With Cardiovascular Conditions: LDL-C Control (<100 mg/Dl) • Cholesterol Management for Patients With Cardiovascular Conditions: LDL-C Screening • Controlling High Blood Pressure Diabetes Care (Not on Child Structure) • Diabetes Care: Eye Exam (Retinal) Performed • Diabetes Care: Hemoglobin A1c (HbA1c) Control <8.0% No Composite • Medication Management for Asthma

QUALITY – PROVIDER QUALITY

Tier 1	Proposed QRS Indicator	Tier 2	Proposed QRS Domain	High-Leverage Opportunity	Proposed QRS Composite

Tier 1	Proposed QRS Indicator	Tier 2	Proposed QRS Domain	High-Leverage Opportunity	Proposed QRS Composite
Quality	Clinical Quality Management	Provider Quality (Identical HLOs to Health Plan Quality)	Care Coordination	<u>Coordination</u> • Care Coordination and Case Management • Medication Management • Advanced Illness Care • Readmissions	<u>No composite</u> • CAHPS – Coordination of Members' Health Care Services
			Patient Safety (Not on Child Structure)		<u>No Composite</u> • Annual Monitoring for Patients on Persistent Medications • Plan All – Cause Readmissions

Tier 1	Proposed QRS Indicator	Tier 2	Proposed QRS Domain	High-Leverage Opportunity	Proposed QRS Composite
			Prevention	<u>Prevention/Staying Healthy</u> • Maternal Health • Well-Infant, Child, Adolescent Care • Behavioral/Mental Health • Screening, Immunization, and Treatment of Infectious Disease • Tobacco, Alcohol and Substance Use • Weight Management and Wellness Counseling • Dental and Vision Care <u>Chronic Management</u> • Cardiovascular Care • Diabetes Care • Asthma and Respiratory Care • Cancer Screening and Treatment	<u>Checking for Cancer (Not on Child Structure)</u> • Breast Cancer Screening • Cervical Cancer Screening • Colorectal Cancer Screening <u>Maternal Health (Not on Child Structure)</u> • Prenatal and Postpartum Care: Postpartum Care • Prenatal and Postpartum Care: Timeliness of Prenatal Care <u>Staying Healthy Adult (Not on Child Structure)</u> • Adult BMI Assessment • CAHPS – Aspirin Use and Discussion • CAHPS – Flu Shots for Adults • CAHPS – Medical Assistance With Smoking and Tobacco Use Cessation <u>Staying Healthy Child</u> • Annual Dental Visit • Childhood Immunization Status • Immunizations for Adolescents • Weight Assessment and Counseling for Nutrition and Physical Activity Children and Adolescents: BMI Percentile Documentation

Tier 1	Proposed QRS Indicator	Tier 2	Proposed QRS Domain	High-Leverage Opportunity	Proposed QRS Composite
			Clinical Effectiveness		<u>Behavioral Health</u> • Antidepressant Medication Management • Follow – Up After Hospitalization for Mental Illness: 7 days • Follow – Up Care for Children Prescribed ADHD Medication: Initiation Phase <u>Cardiovascular Care (Not on Child Structure)</u> • Cholesterol Management for Patients With Cardiovascular Conditions: LDL-C Control (<100 mg/Dl) • Cholesterol Management for Patients With Cardiovascular Conditions: LDL-C Screening • Controlling High Blood Pressure <u>Diabetes Care (Not on Child Structure)</u> • Diabetes Care: Eye Exam (Retinal) Performed • Diabetes Care: Hemoglobin A1c (HbA1c) Control <8.0% <u>No Composite</u> • Medication Management for Asthma

Appendix H: MAP's Recommendations and Rationale on HHS' Proposed Family and Child QRS Measures

Proposed QRS Set	Measure # and NQF Status	Measure Title	MAP Task Force Recommendation and Rationale	MAP Additional Findings
Family and Child Core Sets	NQF# 0006 *Endorsed*	CAHPS - Customer Service	**Support** NQF-endorsed measure Addresses program goals/requirements Promotes alignment across programs, settings, and public and private sector efforts	
Family and Child Core Sets	NQF# 0006 *Endorsed*	CAHPS - Global Rating of Health Plan	**Conditional Support** Not ready for implementation; measure needs further experience or testing before being used in the program	Task force recommends delaying implementation of this measure until there is additional testing. While this information highly valued by consumers, testing needs to determine what factors (e.g., cost) consumers consider when rating their health plan.
Family and Child Core Sets	NQF# 0006 *Endorsed*	CAHPS - Plan Information on Costs	**Support** NQF-endorsed measure Addresses program goals/requirements Promotes alignment across programs, settings, and public and private sector efforts	
Family and Child Core Sets	Not Endorsed	CAHPS - Cultural Competency	**Conditional Support** Not ready for implementation; measure needs further experience or testing before being used in the program	Task force expressed concerns that this measure assesses provider performance rather than health plan performance
Family and Child Core Sets	NQF# 0006 *Endorsed*	CAHPS - Getting Care Quickly	**Support** NQF-endorsed measure Addresses program goals/requirements Promotes alignment across programs, settings, and public and private sector efforts	
Family and Child Core Sets	NQF# 0006 *Endorsed*	CAHPS - Getting Needed Care	**Support** NQF-endorsed measure Promotes alignment across programs, settings, and public and private sector efforts Promotes person- and family-centered care	

Proposed QRS Set	Measure # and NQF Status	Measure Title	MAP Task Force Recommendation and Rationale	MAP Additional Findings
Family and Child Core Sets	*Not Endorsed*	Adolescent Well-Care Visits	**Do Not Support** Measure does not adequately address any current needs of the program	This measure assesses if adolescents have an annual visit; however, evidence does not exist to support annual visits for adolescents.
Family and Child Core Sets	NQF# 1516 *Endorsed*	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	**Support** NQF-endorsed measure Addresses National Quality Strategy aim or priority not adequately addressed in program measure set Promotes alignment across programs, settings, and public and private sector efforts	
Child Core Set	NQF# 1392 *Endorsed*	Well-Child Visits in the First 15 Months of Life	**Support** NQF-endorsed measure Addresses National Quality Strategy aim or priority not adequately addressed in program measure set Addresses program goals/requirements	
Family Core Set	*Not Endorsed*	Adults' Access to Preventive and Ambulatory Health Services	**Do Not Support** Measure does not adequately address any current needs of the program	This measure assesses if adults over 20 have an annual visit; however, evidence does not exist to support annual visits for adults.
Child Core Set	Not Endorsed	Children and Adolescents' Access to Primary Care Practitioners	**Do Not Support** Measure does not adequately address any current needs of the program A 'Supported' measure under consideration addresses as similar topic and better addresses the needs of the program	The task force prefers NQF# 1516 Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life. This measure assesses if children had any visit with a primary care practitioner--evidence supports PCP visits for children under 6, that care will be captured in NQF# 1516.
Family and Child Core Sets	NQF# 0006 *Endorsed*	CAHPS - Rating of All Health Care	**Support** NQF-endorsed measure Addresses program goals/requirements Promotes alignment across programs, settings, and public and private sector efforts	

Proposed QRS Set	Measure # and NQF Status	Measure Title	MAP Task Force Recommendation and Rationale	MAP Additional Findings
Family and Child Core Sets	NQF# 0006 *Endorsed*	CAHPS - Rating of Personal Doctor	**Support** NQF-endorsed measure Promotes alignment across programs, settings, and public and private sector efforts Promotes person- and family-centered care	The task force suggested that the measure be revised to account for the entire health care team, rather than just the doctor.
Family and Child Core Sets	NQF# 0006 *Endorsed*	CAHPS - Rating of Specialist Seen Most Often	**Support** NQF-endorsed measure Promotes alignment across programs, settings, and public and private sector efforts Promotes person- and family-centered care	
Family and Child Core Sets	NQF# 0002 *Endorsed*	Appropriate Testing for Children With Pharyngitis	**Support** NQF-endorsed measure Addresses National Quality Strategy aim or priority not adequately addressed in program measure set Promotes alignment across programs, settings, and public and private sector efforts	
Child Core Set	NQF# 0069 *Endorsed*	Appropriate Treatment for Children with Upper Respiratory Infection	**Support** NQF-endorsed measure Addresses National Quality Strategy aim or priority not adequately addressed in program measure set Addresses a measure type not adequately represented in the program measure set	
Family Core Set	NQF# 0058 *Endorsed*	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	**Support** NQF-endorsed measure Addresses National Quality Strategy aim or priority not adequately addressed in program measure set Promotes alignment across programs, settings, and public and private sector efforts	

Proposed QRS Set	Measure # and NQF Status	Measure Title	MAP Task Force Recommendation and Rationale	MAP Additional Findings
Family Core Set	NQF# 1558 *Endorsed*	Relative Resource Use for People with Cardiovascular Conditions - Inpatient Facility Index	**Conditional Support** Use complete NQF-endorsed measure	The measure should be used as endorsed; the measure cannot be reported without considering outpatient costs. The task force expressed caution using this measure for consumer decision-making; consumer education is needed so that consumers can interpret resource use measures.
Family Core Set	NQF# 1557 *Endorsed*	Relative Resource Use for People with Diabetes - Inpatient Facility Index	**Conditional Support** Use complete NQF-endorsed measure	The measure should be used as endorsed; the measure cannot be reported without considering outpatient costs. The task force expressed caution using this measure for consumer decision-making; consumer education is needed so that consumers can interpret resource use measures.
Family Core Set	NQF# 0052 *Endorsed*	Use of Imaging Studies for Low Back Pain	**Support** NQF-endorsed measure Addresses National Quality Strategy aim or priority not adequately addressed in program measure set Promotes alignment across programs, settings, and public and private sector efforts	
Family Core Set	NQF# 1517 *Endorsed*	Prenatal and Postpartum Care: Timeliness of Prenatal Care	**Support** NQF-endorsed measure Addresses National Quality Strategy aim or priority not adequately addressed in program measure set Promotes alignment across programs, settings, and public and private sector efforts	

Proposed QRS Set	Measure # and NQF Status	Measure Title	MAP Task Force Recommendation and Rationale	MAP Additional Findings
Family Core Set	NQF# 1517 *Endorsed*	Prenatal and Postpartum Care: Postpartum Care	**Support** NQF-endorsed measure Addresses National Quality Strategy aim or priority not adequately addressed in program measure set Promotes alignment across programs, settings, and public and private sector efforts	
Family and Child Core Sets	NQF# 0038 *Endorsed*	Childhood Immunization Status	**Support** NQF-endorsed measure Addresses National Quality Strategy aim or priority not adequately addressed in program measure set Promotes alignment across programs, settings, and public and private sector efforts	
Family and Child Core Sets	NQF# 1407 *Endorsed*	Immunizations for Adolescents	**Support** NQF-endorsed measure Addresses National Quality Strategy aim or priority not adequately addressed in program measure set Promotes alignment across programs, settings, and public and private sector efforts	
Family Core Set	NQF# 0105 *Endorsed*	Antidepressant Medication Management	**Support** NQF-endorsed measure Addresses National Quality Strategy aim or priority not adequately addressed in program measure set Promotes alignment across programs, settings, and public and private sector efforts	
Family Core Set	NQF# 0576 *Endorsed*	Follow - Up After Hospitalization for Mental Illness: 7 days	**Support** NQF-endorsed measure Addresses National Quality Strategy aim or priority not adequately addressed in program measure set Included in a MAP family of measures	

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

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

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

Proposed QRS Set	Measure # and NQF Status	Measure Title	MAP Task Force Recommendation and Rationale	MAP Additional Findings
Family Core Set	NQF# 0575 *Endorsed*	Diabetes Care: Hemoglobin A1c (HbA1c) Control <8.0%	**Support** NQF-endorsed measure Addresses National Quality Strategy aim or priority not adequately addressed in program measure set Promotes alignment across programs, settings, and public and private sector efforts	
Family and Child Core Sets	*NQF# 1799 Endorsed*	Medication Management for People With Asthma	**Support** NQF-endorsed measure Addresses National Quality Strategy aim or priority not adequately addressed in program measure set Promotes alignment across programs, settings, and public and private sector efforts	
Family and Child Core Sets	*Not Endorsed*	CAHPS - Coordination of Members' Health Care Services	**Support** Addresses program goals/requirements Promotes alignment across programs, settings, and public and private sector efforts Addresses National Quality Strategy aim or priority not adequately addressed in program measure set	
Family Core Set	D0021 *Endorsement Withdrawn*	Annual Monitoring for Patients on Persistent Medications	**Conditional Support** Not ready for implementation; should be submitted for and receive NQF endorsement	The measure is undergoing updates and will be submitted for endorsement; implementation should be delayed until the measure is endorsed.
Family Core Set	NQF# 1768 *Endorsed*	Plan All - Cause Readmissions	**Support** NQF-endorsed measure Addresses National Quality Strategy aim or priority not adequately addressed in program measure set Promotes alignment across programs, settings, and public and private sector efforts	

MAP Off-Cycle Review of Measures

Introduction

HHS has asked MAP to perform "off-cycle" (previously called "ad hoc") reviews of measures outside of the usual pre-rulemaking process in exceptional circumstances. As required under NQF's contract with HHS, off-cycle reviews are on expedited timelines and must be accomplished within an eight-week period. The timelines and budgets for these off-cycle reviews are extremely tight, which did not allow time for MAP's typical multi-level review and public comment processes during the initial off-cycle review. **How can MAP's workflows be adapted for future off-cycle reviews to maintain MAP's relevance and increase its efficiency, while ensuring the integrity of MAP processes?**

Background

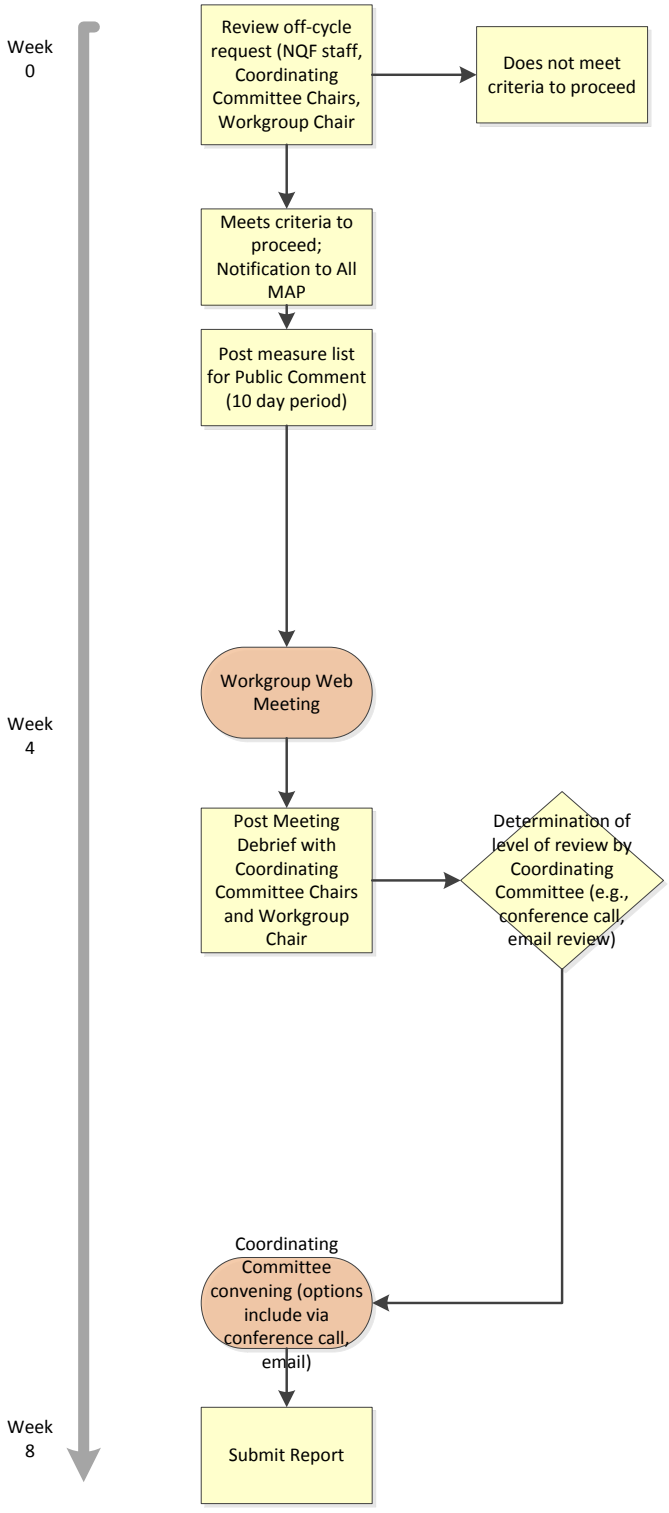
At its October 3 meeting, the MAP Coordinating Committee discussed the process for off-cycle review of measures. Coordinating Committee members commented on the importance of maintaining the integrity of the process and of delivering high quality recommendations to HHS. Coordinating Committee members also emphasized the importance of preserving the opportunity for MAP member and public comment on measures undergoing off-cycle review.

This document presents draft principles and a draft process for conducting an off-cycle review.

Draft Principles

- Off-cycle reviews are not intended to replace MAP's annual pre-rulemaking process, and will only be conducted in exceptional circumstances. Criteria for accepting an off-cycle review include:
    - The measures address a previously identified gap area of high impact.
    - A year delay would prevent HHS from meeting a statutory or regulatory requirement.
    - The measure would promote alignment and reduce measurement burden.
- A decision to conduct an off-cycle review will carefully balance the opportunity to provide multi-stakeholder input with maintaining the integrity of MAP's processes.
- Clear and transparent notification that MAP will be undertaking an off-cycle review will be provided to MAP Coordinating Committee and workgroup members and the public.

Draft Process



Notes: Workgroups and task forces will perform off-cycle reviews of measures under consideration for their usual programs.