Measure Applications Partnership (MAP) FAQs

The Measure Applications Partnership (MAP) will play a valuable role in improving the quality and value of healthcare.

MAP Basics

1. What is MAP?

The Measure Applications Partnership (MAP) is a public-private partnership convened by the National Quality Forum. MAP was created for the explicit purpose of providing input to the Department of Health and Human Services on the selection of performance measures for public reporting and performance-based payment programs.

2. Why is MAP important?

The choice of measures for gauging and rewarding progress is so important that no one perspective is adequate to inform the task. MAP is a unique voice in healthcare, blending the views of diverse groups who all have a vested interest in improving the quality of healthcare.

Through MAP activities, a wide variety of stakeholders will be able to provide input into HHS's selection of performance measures for public reporting and payment reform programs, which will allow for greater coordination of performance measures across programs, settings, and payers. MAP's balance of interests—representing consumers, businesses and purchasers, labor, health plans, clinicians and providers, communities and states, and suppliers—ensures that HHS will receive well-rounded input on performance measure selection.

3. How will MAP determine on which priorities and goals to focus?

The MAP Coordinating Committee will compile a decision-making framework, which will include priorities from a number of different sources, including the newly released National Quality Strategy, the upcoming National Patient Safety Initiative and National Prevention and Health Promotion Strategy, the high-priority Medicare and child health conditions, and the patient-focused episodes of care model. Additionally, the committee will develop measure selection criteria to help guide their decision making.

4. Will MAP recommend only NQF-endorsed measures for government public reporting and payment reform programs? Will part of this effort point out measurement gaps and include those gaps in recommendations?

MAP will recommend the best measures available for specific uses, giving first consideration to NQF-endorsed measures. If MAP is seeking a type of measure currently not represented in the portfolio of NQF-endorsed measures, it will look outside for other available measures. When non-endorsed measures are used, the measure developer will be asked to submit the measure to

an NQF endorsement project for consideration. Gaps identified in the endorsed measures available will be captured to inform subsequent measure development.

MAP Structure

5. How will MAP be structured?

MAP will be composed of a two-tiered structure. MAP's overall strategy will be set by the Coordinating Committee, and this committee will provide final input to HHS. Working directly under the Coordinating Committee will be four advisory workgroups—three that are settings-based and one that focuses on the dual eligible beneficiary population. The workgroups are flexible and can be changed as the work in the program evolves. More than 60 organizations representing major stakeholder groups, 40 individual experts, and nine federal agencies are represented in the Coordinating Committee and workgroups.

6. How will the Coordinating Committee and workgroups be appointed?

MAP's Coordinating Committee and workgroups were selected based on NQF Board-adopted selection criteria, which included nominations and an open public commenting period. Balance among stakeholder groups was paramount. Due to the complexity of MAP's tasks, it was also imperative that individual subject matter experts were included in the groups. Other considerations included adding individuals with expertise in health disparities and vulnerable populations, state representation, and individuals with experience in health IT. Federal government *ex officio* members are non-voting because federal officials cannot advise themselves.

A Nominating Committee, composed of seven NQF Board members, oversaw the appointment of the members of the Coordinating Committee through a public nominations process that was required by statute. The nomination period remained open for one month each for the Coordinating Committee (Sept. 29-Oct. 28, 2010) and the workgroups (Jan. 10-Feb. 7, 2011). The Nominating Committee proposed a roster for each group, which was vetted publicly, as required by statute. After careful consideration of public comments, the rosters were given final approval by the full NQF Board for the Coordinating Committee on Jan. 24, 2011, and for the workgroups on March 31, 2011. MAP members will serve staggered three-year terms, with the initial members drawing one-, two-, or three-year terms at random, allowing additional opportunities to serve to be available annually.

7. To whom will the committees report?

The Coordinating Committee will be overseen by the NQF Board, which was responsible for establishing MAP and selecting its members. The Board will review any procedural questions that arise about MAP's structure or function and will periodically evaluate MAP's structure, function, and effectiveness. The NQF Board will not review the MAP Coordinating Committee's input to HHS.

The Coordinating Committee will provide its input directly to HHS, while the workgroups will be charged by and report directly to the Coordinating Committee.

MAP: How NQF and HHS Work Together

8. Why did HHS choose NQF for this project?

The Affordable Care Act specifies the involvement of a neutral convener to manage engagement and coordination and to take a leadership role in the quality measurement field. With a wealth of measure endorsement experience, a deep network of members and partners, sufficient analytic support to assist in decision making, its relationship with HHS as a consensus-based entity, as well as its experience in convening the National Priorities Partnership, NQF is uniquely structured to meet these criteria. NQF's independence is also critical in filling this important advisory capacity.

9. Why can't HHS do this on its own?

Choosing measures for gauging and rewarding progress is so important that no one perspective is adequate to inform the task.

NQF's organizational structure and independent nature makes it uniquely positioned to be a neutral convener and to act as an additional resource to provide coordinated expertise into the HHS decision-making process.

10. Are HHS and CMS required to accept and implement NQF's recommendations?

HHS is required to take into consideration any input from MAP in its selection of quality measures for various uses, but final decisions about implementation are solely at HHS's discretion.

The Administrative Procedures Act requires that HHS's decisions be made through routine rulemaking processes. MAP is not a subregulatory process. Should HHS via its decision making decide to select a measure that is not NQF endorsed, it must publish a rationale for its decision.

11. How does all of this relate to the National Quality Strategy?

The National Quality Strategy (NQS) was released on March 21, 2011, by the Secretary of HHS. The NQS is very important to MAP, as it represents the primary basis not only for the MAP decision-making framework developed by the Coordinating Committee, but also for the overall MAP strategy designed to guide the workgroups. The MAP decision-making framework will remain somewhat fluid to allow it to evolve along with the NQS.

12. How quickly will MAP provide input, and how quickly thereafter do you predict the government will implements any or all of its recommendations?

The MAP Coordinating Committee will begin providing input to HHS in fall 2011, and HHS will begin utilizing this input in calendar year 2012.

MAP Impact on the General Public

13. How will the public benefit from this project?

MAP is designed to support broader national efforts to create better, more affordable care. Its work will strengthen public reporting, which has been demonstrated to improve quality, and will give people more and better information when making healthcare choices and help providers improve their performance. MAP recommendations also will help shape payment programs, creating powerful financial incentives to providers to improve care. Consumer and purchaser stakeholders will have a place and a voice in every discussion. Lastly, measure selection decisions made in public programs often have a spillover effect in private insurance markets, so choices made by HHS may have a much broader impact over time.

14. Will the public have input into the MAP process? How will MAP achieve transparency?

MAP's overriding goal in intent and in statute is to maintain transparency for the public and encourage public engagement throughout MAP's work.

The public has been involved in the MAP process from early on, starting with two rounds of public comment on the NQF Board's establishment of MAP to another two rounds of public nominations and public vetting of the rosters for both the MAP Coordinating Committee and its workgroups. All MAP meetings will be open to the public, and meeting summaries and conclusions will be posted on the NQF website. MAP will seek public comment on all input to HHS.

15. What might be the ultimate implication of MAP's work?

The Measure Applications Partnership has real potential to enact positive change in our nation's healthcare system and build on a decade of remarkable work to develop measures that can help bring greater value into healthcare. We now have hundreds of measures, but MAP can help users pick the right ones for their applications.

Some outcomes we hope to see from the project include a defragmentation of care delivery, heightened accountability of clinicians and providers, better and more information for consumer decision making, higher value for spending by aligning payment with performance, a reduced data collection burden through the alignment of measurement activities, and an improvement in the consistent provision of evidence-based care across measured domains.