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Agenda

Measure Applications Partnership

Health Insurance Exchange Quality Rating System Task Force Meeting

November 20-21, 2013

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

Remote Participation Instructions:

Streaming Audio Online

- Direct your web browser to: http://nqf.commpartners.com
- Under "Enter a Meeting" type the meeting number for Day 1: **888669** or for Day 2: **150212**
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Teleconference

- Dial (888) 802-7237 for task force members and (877) 303-9138 for public audience
- Use conference ID code for Day 1: **93673143** and use conference ID code for Day 2: **93688641** to access the audio platform.

Meeting Objectives:

- Finalize task force's decision-making framework for the Health Insurance Exchange Quality Rating System (QRS).
- Provide input on the proposed measures for the family and child QRS.
- Provide input on the proposed domains, hierarchical structure, and organization of measures for the QRS.
- Define MAP's vision for the QRS and a pathway for achieving MAP's vision.

Day 1: Wednesday, November 20, 2013

8:30 am **Breakfast**

9:00 am **Welcome and Review of Meeting Objectives**
Elizabeth Mitchell, Task Force Chair

9:15 am **Health Insurance Exchange QRS Task Force Decision-Making Framework**
Elizabeth Mitchell
Aisha Pittman, Senior Director, NQF

- Review the MAP Measure Selection Criteria (MSC) and discuss approach for MAP's input on the QRS
- Finalize task force guiding principles for selection of measures for the QRS

- Review and discuss results of high-leverage opportunity prioritization exercise

10:15 am **Define Ideal Organization of the QRS: Literature Review and Focus Group Experience**
Elizabeth Mitchell
Megan Duevel Anderson, Project Analyst, NQF
Panel Members: Marissa Schlaifer and Lance Roberts

- Review literature on organizing information to support consumer decision-making
- Panel discussion on the use of health care quality information for consumer decision-making

11: 15 am **Define Ideal Organization of the QRS: Breakouts**

- Review and discuss options for organization of high-leverage opportunities
- Define ideal structure for the QRS for consumer decision-making

12:15 pm **Lunch**

12: 45 pm **Define Ideal Organization of the QRS: Report-Outs and Finalize**
Elizabeth Mitchell

1:45 pm **Opportunity for Public Comment**

2:00 pm **Review of Proposed QRS Structure and Measures**
Elizabeth Flow-Delwiche

2:30 pm **Input on Proposed QRS Measures**
Elizabeth Mitchell
Aisha Pitman

- Input on proposed measures for the family and child QRS
- Identification of measure gaps

4:00 pm **Opportunity for Public Comment**

4:15 pm **Summary of Day**
Elizabeth Mitchell

4:30 pm **Adjourn**

Day 2: Thursday, November 21, 2013

8:00 am **Breakfast**

8:30 am **Review Previous Day's Themes**
Elizabeth Mitchell

9:00 am **Measure Aggregation**
Elizabeth Mitchell
Karen Pace, Senior Director, NQF

- Review measure methodological considerations likely to be raised during the review of the proposed structure

9:30 am **Input on Proposed QRS Structure**
Elizabeth Mitchell

10:30 am **QRS Path Forward: Functionality to Enhance Consumer Decision-Making**
Elizabeth Mitchell
Exchange Reactors: Jeff Rideout and Jay Himmelstein
Rachel Grob and Robert Krughoff

- Patient Experience and Direct Consumer Comment
- Customizing Information for Consumers

11:30 pm **Lunch**

12:00 pm **QRS Path Forward: Additional Information to Enhance Consumer Decision-Making**
Elizabeth Mitchell
Exchange Reactors: Jay Himmelstein

- Cost Information for Consumers
- Structural Information into the QRS
- Provider-Level Quality Information in the QRS

1:00 pm **Revisit and Revise Task Force Decision-Making Framework**
Elizabeth Mitchell

1:30 pm **Opportunity for Public Comment**

1:45 pm **Wrap Up/Next Steps**
Elizabeth Mitchell

2:00 pm **Adjourn**

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MAP Health Insurance Exchange Quality Rating System Task Force DRAFT 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 plan and provider improvement
    - 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

MAP MEASURE SELECTION CRITERIA

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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)

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Health Insurance Exchange Quality Rating System High-Leverage Opportunities for Measurement

The table below identifies high-leverage opportunities for measurement of qualified health plans in the Health Insurance Exchanges/Marketplaces. For each high-leverage measurement opportunity, the health plan function and National Quality Strategy (NQS) priority addressed is noted. To demonstrate how the high-leverage measurement opportunities could be addressed, examples of available NQF-endorsed measures and structural elements (i.e., accreditation standards, health plan design information) are provided. The examples listed are not exhaustive of all tools to evaluate the high-leverage opportunities.

High-Leverage Opportunity for Measurement	Health Plan Function	NQS Priority	Example Available NQF-Endorsed Quality Measures	Example Structures (e.g., accreditation standards, health plan design information)
Patient Experience/ Satisfaction	Customer Service	Person- and Family-Centered Care	• 0006: CAHPS Health Plan Survey v 4.0 - Adult questionnaire • 0007: NCQA Supplemental items for CAHPS® 4.0 Adult Questionnaire (CAHPS 4.0H)	• URAC HP-13: Call Center Performance • URAC HP-16: Complaint Response Timeliness • NCQA: Satisfaction with Physician; Satisfaction with Health Plan Services
Quality of Providers	Customer Service, Provider Payment, Network Management	Person- and Family-Centered Care, Prevention and Treatment of the Leading Causes of Mortality	• Multiple Clinician Level Quality Measures Available	• URAC HP-2: Provider Network Adequacy: Number of Specialists Accepting New Patients At End of Reporting Period by Specialist Type • URAC HP-11: Provider Network Adequacy: Number of Primary Care Providers (PCP) accepting new patients at end of reporting period by PCP type. • NCQA: Assessment of Organizational of Providers • eValue8: Provider Network Management and Board Certification

High-Leverage Opportunity for Measurement	Health Plan Function	NQS Priority	Example Available NQF-Endorsed Quality Measures	Example Structures (e.g., accreditation standards, health plan design information)
Cost	Benefit Design, Customer Service, Provider Payment	Affordable Care	• 1557: Relative Resource Use for People with Diabetes (RDI) • 1558: Relative Resource Use for People with Cardiovascular Conditions	• US News: Completeness of Coverage and Cost-Sharing • eValue8: Relative Cost Information Provided to Members and Relative Efficiency Available to Providers
Utilization Management	Network Management	Affordable Care		• NCQA: Mental Health Utilization, Antibiotics Utilization • NCQA: Utilization Management (UM) • eValue8: Quality and Utilization Data Reporting to Purchasers for Improvement Strategies
Screening, Immunization, and Treatment of Infectious Disease	Care Management	Prevention and Treatment of Leading Causes of Disease	• 0038: Childhood Immunization Status • 0150: Pneumococcal vaccination • 0227: Influenza Immunization • HIV Screening: Members at High Risk of HIV • 0475: Hepatitis B Vaccine Coverage Among All Live Newborn Infants Prior to Hospital or Birthing Facility Discharge	• URAC HIX-7: Preventive Services: Percentage of Enrolled Members Ages Less than or Equal to 18 years Who have had Preventive Services, Recommended Risk Factor Reductions and Behavioral Health Change Interventions, Appropriate Screenings and Immunizations • Consumer Reports/NCQA: Other Treatment Measures
Cancer Screening and Treatment	Care Management	Prevention and Treatment of Leading Causes of Disease	• 0031: Breast Cancer Screening • 0032: Cervical Cancer Screening • 0034: Colorectal Cancer Screening •	• URAC HIX-5: Preventive Care and Screening: Percentage of Female Patient Who Had A Mammogram Performed During The Two-year Measurement Period • URAC HIX-8: Colorectal Cancer Screening

High-Leverage Opportunity for Measurement	Health Plan Function	NQS Priority	Example Available NQF-Endorsed Quality Measures	Example Structures (e.g., accreditation standards, health plan design information)
Weight Management and Wellness Counseling	Care Management, Benefits Design, Customer Service	Health and Well-Being, Prevention and Treatment of Leading Causes of Disease	• 0023: Body Mass Index (BMI) in adults > 18 years of age • 0024: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents • 0029: Counseling on physical activity in older adults - a. Discussing Physical Activity, b. Advising Physical Activity	• eValue8: Capabilities to Address Obesity • URAC HIX-7: Preventive Services: Percentage of Enrolled Members Ages Less than or Equal to 18 years Who have had Preventive Services, Recommended Risk Factor Reductions and Behavioral Health Change Interventions, Appropriate Screenings and Immunizations • URAC HIX-10: Prevention and Management of Obesity in Mature Adolescents and Adults • URAC HIX-20: Health Risk Assessment Completion Rate • NCQA: Health Appraisals
Cardiovascular Care	Care Management	Prevention and Treatment of Leading Causes of Disease	• 0018: Controlling High Blood Pressure • 0071: Persistence of Beta-Blocker Treatment After a Heart Attack	
Diabetes Care	Care Management	Prevention and Treatment of Leading Causes of Disease	• 0731: Comprehensive Diabetes Care (0055, 0057, 0059, 0061, 0062, 0064, 0575) • 0603: Adult(s) taking insulin with evidence of self-monitoring blood glucose testing. • 0604: Adult(s) with diabetes mellitus that had a serum creatinine in last 12 reported months.	• URAC HP-10: Diabetes: All or None Process Measure (Optimal Testing: HbA1c, LDL-C, nephropathy) • URAC HP-18: Diabetes: All or None Process Measure: Optimal Results for HbA1c, LDL-C, and BP

High-Leverage Opportunity for Measurement	Health Plan Function	NQS Priority	Example Available NQF-Endorsed Quality Measures	Example Structures (e.g., accreditation standards, health plan design information)
Asthma and Respiratory Care	Care Management	Prevention and Treatment of Leading Causes of Disease	• 0283: Adult asthma (PQI 15) • 0036: Use of appropriate medications for people with asthma • 0069: Appropriate treatment for children with upper respiratory infection (URI)	
Maternal Health	Care Management	Health and Well-Being, Patient Safety	• 1391: Frequency of Ongoing Prenatal Care • 1517: Prenatal & Postpartum Care	• eValue8: Pregnancy and Early Child Care Initiatives • US News: Maternity and newborn care
Well-Infant, Child, and Adolescent Care	Care Management	Health and Well-Being, Prevention and Treatment of Leading Causes of Disease	• 0010: Young Adult Health Care Survey (YAHCS) • 0011: Promoting Healthy Development Survey (PHDS) • 1392: Well-Child Visits in the First 15 Months of Life • 1516: Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	• URAC HIX-7: Preventive Services: Percentage of Enrolled Members Ages Less than or Equal to 18 years Who have had Preventive Services, Recommended Risk Factor Reductions and Behavioral Health Change Interventions, Appropriate Screenings and Immunizations • eValue8: Pregnancy and Early Child Care Initiatives
Dental and Vision Care	Care Management, Network Management, Benefit Design	Health and Well-Being	• 1388: Annual Dental Visit • 1419: Primary Caries Prevention Intervention as Part of Well/Ill Child Care as Offered by Primary Care Medical Providers • 1412: Pre-School Vision Screening in the Medical Home	• US News: Scope of Covered Benefits

High-Leverage Opportunity for Measurement	Health Plan Function	NQS Priority	Example Available NQF-Endorsed Quality Measures	Example Structures (e.g., accreditation standards, health plan design information)
Behavioral Health/ Mental Health	Care Management	Health and Well-Being, Person- and Family Centered Care, Prevention and Treatment of Leading Causes of Disease	• 0008: Experience of Care and Health Outcomes (ECHO) Survey (behavioral health, managed care versions) • 0108: Follow-Up Care for Children Prescribed ADHD Medication (ADD) • 0580: Bipolar antimanic agent • 0544: Use and Adherence to Antipsychotics among members with Schizophrenia	• eValue8: Plan ability to Track and Guide Members to Behavioral Health Treatment Options and Support Programs; Screening Members for Behavioral Health Issues; Integration of Behavioral Health and Other Medical Care; Support for Behavioral Health and Non-Behavioral Health Clinicians; Timely Emergency Clinical Support 24/7 • NCQA: Continuity and Coordination Between Medical and Behavioral Health Care; Triage and Referral for Behavioral Health Care • US News: Mental health and substance abuse services • Consumer Reports/NCQA: Mental and Behavioral Health
Tobacco, Alcohol, and Substance Use	Care Management, Benefit Design	Prevention and Treatment of Leading Causes of Disease, Health and Well-Being	• 0027: Medical Assistance With Smoking and Tobacco Use Cessation • 0028: Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	• eValue8: Follow-Up after Treatment in ER for Alcohol-Related Injuries; Efficacy of Programs to Prevent and Reduce Tobacco Use • US News: Mental health and substance abuse services

High-Leverage Opportunity for Measurement	Health Plan Function	NQS Priority	Example Available NQF-Endorsed Quality Measures	Example Structures (e.g., accreditation standards, health plan design information)
Care for Older Adults (Osteoporosis, Arthritis, Dementia, Alzheimer's, Falls, Incontinence)	Care Management	Health and Well-Being, Patient Safety	• 0029: Counseling on physical activity in older adults - a. Discussing Physical Activity, b. Advising Physical Activity • 0030: Urinary Incontinence Management in Older Adults - a. Discussing urinary incontinence, b. Receiving urinary incontinence treatment 0036: Osteoporosis testing in older women • 0035: Fall Risk Management • 0053: Care for Older Adults – Medication Review • 0054: Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis • 1959: Antipsychotic Use in Persons with Dementia	
Advanced Illness Care (Hospice, End-of-Life, and Palliative Care)	Care Management, Provider Payment, Benefit Design	Person- and Family-Centered Care, Affordable Care	• 0211: Proportion with more than one emergency room visit in the last days of life • 0215: Proportion not admitted to hospice • 0210: Proportion receiving chemotherapy in the last 14 days of life	

High-Leverage Opportunity for Measurement	Health Plan Function	NQS Priority	Example Available NQF-Endorsed Quality Measures	Example Structures (e.g., accreditation standards, health plan design information)
Medication Management	Care Management, Provider Payment	Effective Communication and Care Coordination, Affordable Care, Patient Safety	• 0022: Use of High Risk Medications in the Elderly • 0105: Antidepressant Medication Management • 0541: Proportion of Days Covered (PDC): 5 Rates by Therapeutic Category	• URAC HP-4: Drug-Drug Interactions • eValue8: Plan Monitoring Medication Compliance • US News: Prescription drugs
Care Coordination and Case Management	Care Management, Provider Payment	Effective Communication and Care Coordination, Person- and Family-Centered Care, Patient Safety	• 0004: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment • 1937: Follow-Up After Hospitalization for Schizophrenia (7- and 30-day)	• URAC HP-15: Case Management: Contacting Consumer • eValue8: Care Coordination; Promoting Adherence to Prescription Regimens
Readmissions	Care Management, Provider Payment	Patient Safety, Care Coordination	• 0505: Hospital 30-day all-cause risk-standardized readmission rate (RSRR) following acute myocardial infarction (AMI) hospitalization.	
Member Access to Information	Customer Service	Effective Communication and Care Coordination, Person- and Family-Centered Care	• 0006: CAHPS Health Plan Survey v4.0 – Adult questionnaire • 0007: NCQA Supplemental Items for CAHPS Adult Questionnaire v4.0 • 0009: CAHPS Health Plan Survey v 3.0 children with chronic conditions supplement	• URAC HP-13: Call Center Performance • URAC HP-16: Complaint Response Timeliness • NCQA: Medicaid Benefits and Services, Health Information Line; Self-Management Tools
Member Education	Customer Service, Benefit Design	Person- and Family-Centered Care, Health and Well-Being		• eValue8: Patient Support; Availability of Counseling

High-Leverage Opportunity for Measurement	Health Plan Function	NQS Priority	Example Available NQF-Endorsed Quality Measures	Example Structures (e.g., accreditation standards, health plan design information)
Access to Care, Specialists, and Network Adequacy	Network Management, Provider Payment	Person- and Family-Centered Care, Patient Safety	• 0006: CAHPS Health Plan Survey v4.0 – Adult questionnaire • 0007: NCQA Supplemental Items for CAHPS Adult Questionnaire v4.0 • 0009: CAHPS Health Plan Survey v 3.0 children with chronic conditions supplement • 0477: Under 1500g infant Not Delivered at Appropriate Level of Care	• URAC HP-2: Provider Network Adequacy: Number of Primary Care Providers (PCP) accepting new patients at end of reporting period by PCP type. • URAC HP-11: Provider Network Adequacy: Number of Specialists Accepting New Patients At End of Reporting Period by Specialist Type • eValue8: Timely Emergency Clinical Support 24/7
Cultural Competency	Network Management, Benefit Design, Customer Service	Person- and Family-Centered Care	• 0006: CAHPS Health Plan Survey v4.0 – Adult questionnaire • 1919: Cultural Competency Implementation Measure	• eValue8: Culturally-, Racially-, and Language-Sensitive Services • Medicare Star: Cultural Competency • NCQA: Quality Management Program Structure; Availability of Practitioners; Policies and Procedures for Complaints and Appeals; Self-Management Tools
Access to Health Plan Resources, Medical Records	Customer Service	Person- and Family-Centered Care	• 0006: CAHPS Health Plan Survey v4.0 – Adult questionnaire	• NCQA: Health Information Line; Privacy and Confidentiality • eValue8: Electronic Personal Health Records
Shared Decision-Making	Customer Service, Benefit Management, Provider Payment	Person- and Family-Centered Care		• eValue8: Decision Support Tools for Members

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MAP Health Insurance Exchange Quality Rating System Task Force High-Leverage Opportunity Exercise Results

The MAP Health Insurance Exchange Quality Rating System Task Force completed an exercise to rank high-leverage opportunities for measurement of Qualified Health Plans (QHPs) in the Health Insurance Exchanges/Marketplace. Task force members were asked to rank each high leverage opportunity on a scale of 1-5, 5 meaning highest and 1 meaning lowest priority; 13 task force members completed the exercise. The measurement opportunities are listed in rank order, based on their average ranking.

High-Leverage Opportunities for Measurement by Average Score	Average Ranking (Highest Priority=5, Lowest Priority=1)	Number of Respondents Ranking High (4 or 5) Priority
1. Patient Experience/Satisfaction	**4.8**	13
2. Cost	**4.7**	11
3. Care Coordination and Case Management	**4.2**	10
4. Medication Management	**4.2**	9
5. Quality of Providers	**4.1**	10
6. Cardiovascular Care	3.9	9
7. Diabetes Care	3.9	9
8. Shared Decision-Making	3.9	8
9. Access to Care, Specialists, and Network Adequacy	3.9	8
10. Maternal Health	3.8	9
11. Well-Infant, Child, and Adolescent Care	3.8	7
12. Member Access to Information	3.8	7
13. Behavioral Health/Mental Health	3.7	7
14. Readmissions	3.7	8
15. Asthma and Respiratory Care	3.6	7
16. Member Education	3.6	6
17. Cancer Screening and Treatment	3.5	7
18. Cultural Competency	3.5	7
19. Screening, Immunization, and Treatment of Infectious Disease	3.5	7
20. Tobacco, Alcohol, and Substance Use	3.5	6
21. Advanced Illness Care (Hospice, End-of-Life, and Palliative Care)	3.5	6
22. Care for Older Adults (Osteoporosis, Arthritis, Dementia, Alzheimer's, Falls, Incontinence)	3.3	5

High-Leverage Opportunities for Measurement by Average Score	Average Ranking (Highest Priority=5, Lowest Priority=1)	Number of Respondents Ranking High (4 or 5) Priority
23. Weight Management and Wellness Counseling	3.3	7
24. Dental and Vision Care	3.2	5
25. Access to Health Plan Resources, Medical Records	3.2	4
26. Utilization Management	2.8	4

Task force members also offered additional opportunities for measurement in the QRS. They are:

- Burden of illness (e.g., missed work dates/school days) due to illness
- Compensation practices affiliated with quality metrics
- Consumer incentives
- Family experience/satisfaction
- Family planning
- Self-care education
- Internal and external benchmarks of care and process
- Member complaints and grievances
- Narrative comments
- Quality strategy
- Quality activities
- Organized system of coordinated care
- Provider shared financial responsibility and accountability
- Use of interoperable HIT and evidence-based medicine

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Organization of Measurement Information in Public Reporting Systems

Public reporting systems for health plans generally organize measurement information into these common groups:

- Summary or Overall Quality of Plan
- Scope of Benefits and Coverage
- Customer and Patient Experience, Access to Information or Satisfaction
- Customer Service or Complaints Management
- Prevention or Health Promotion Programs
- Management or Treatment of Chronic Conditions
- Cost and Efficiency

Each reporting system has a unique approach for how information is presented to consumers, varying by how information is prioritized and presented. Some of the variation can be attributed to the purpose of the reporting system and the population covered. For example, evalu8 is intended to support employers in choosing health plans to offer in employee benefit programs, so the reporting system emphasizes benefit management information. Similarly, the Medicare Health Plan Star Ratings assess Medicare plans, so the reporting system does not include measures assessing the quality of care for children, adolescents, and maternal care. The table below describes how several reporting systems organize measurement information into groups, with the high-leverage measurement opportunities listed for each group.

Reporting System	**Organization Structure- Groups of Information**	**High-Leverage Opportunities for Measurement**
Consumer Reports/NCQA	Customer Satisfaction (CAHPS) data	Getting Care Satisfaction with Physicians Satisfaction with Health Plan Services
	Prevention	Children and Adolescents Well-Care Women's Reproductive Health Cancer Screening Other Preventative Services
	Treatment	Asthma Diabetes Care Heart Disease Mental and Behavioral Health Other Treatment Measures

Reporting System	Organization Structure- Groups of Information	High-Leverage Opportunities for Measurement
	Accreditation by NCQA	Quality Management and Improvement (QI) Utilization Management (UM) Credentialing and Recredentialing (CR) Members' Rights and Responsibilities (RR) Standards for Member Connections (MEM) Medicaid Benefits and Services (MED) HEDIS/CAHPS Performance Measures
eValue8	Plan Profile	Plan Design Plan Accreditation IT Infrastructure Provider Network Management and Board Certification Culturally-, Racially-, and Language-Sensitive Services Quality and Utilization Data Reporting to Purchasers for Improvement Strategies
	Consumer Engagement	Information and Provider Choice Tools Web-based Visits and E-Mail Contact with Providers Decision Support Tools for Members Electronic Personal Health Records Relative Cost Information Provided to Members and Relative Efficiency Available to Providers
	Provider Measurement and Rewards	Use of Clinical Performance, Relative Efficiency, and Other Data Use of Reimbursement Strategies and Contractual Terms to Motivate Hospitals to Avoid Serious Errors and Infections Incentive and Benefit Design for High Performing Doctors and Hospitals Physicians Leveraging Potential of Health IT Health Plan Collaboration with other Plans to Measure and Improve Performance
	Pharmaceutical Management	Promoting Adherence to Prescription Regimens Promotion of Generic Drugs and Appropriate Use of Specialty Pharmaceuticals Formulary/Benefit Designs with Comparative Effectiveness and Member Adherence

Reporting System	Organization Structure- Groups of Information	High-Leverage Opportunities for Measurement
	Prevention and Health Promotion	Supporting Employers' On-Site Health Promotion Health Risk Assessments for Members Use of Health Risk Assessments to Guide Members Cancer Screening Rates Immunization Programs Efficacy of Programs to Prevent and Reduce Tobacco Use Capabilities to Address Obesity Pregnancy and Early Child Care Initiatives
	Chronic Disease Management	Member Identification and Support Care Coordination Patient Support Response to Gaps in Care (Missed Tests or Prescription Refills) Availability of Counseling Physician and Practice Support Member Disease Management Program Engagement Efficacy of Disease Management Programs Offered
	Behavioral Health	Plan ability to Track and Guide Members to Behavioral Health Treatment Options and Support Programs Screening Members for Behavioral Health Issues Follow-Up after Treatment in ER for Alcohol-Related Injuries Timely Emergency Clinical Support 24/7 Plan Monitoring Medication Compliance Integration of Behavioral Health and Other Medical Care Support for Behavioral Health and Non-Behavioral Health Clinicians
Medicare Star (Health Plan)	Summary Rating of Health Plan Quality	Overall score on the plan's quality on 36 different topic areas in 5 categories: Staying Healthy, Managing Chronic Conditions, Member Experience, Member Complaints, Problems Getting Services, Improvements in Plan's Performance, and Health Plan Customer Service

Reporting System	Organization Structure- Groups of Information	High-Leverage Opportunities for Measurement
	Staying Healthy	Cancer Screening Screening for Patients with Heart Disease and Diabetes Vaccinations Improving and Maintaining Physical and Mental Health Weight Management and Physical Activity
	Managing Chronic Conditions	Osteoporosis Management Diabetes Management Blood Pressure Management Arthritis Management Preventing Falls Reducing Readmissions
	Member Experience with Health Plan	Getting Needed Care and Appointments Getting Information Member's Health Plan and Health Care Quality Ratings
	Member Complaints, Problems Getting Services, and Improvement in the Health Plan's Performance	Complaints Members Leaving Plan Health Plan Performance Improvement
	Health Plan Customer Service	Appeals Cultural Competency
US News and World Report	Scope of Covered Benefits	Prescription Drugs Hospital Charges Outpatient Surgery Charges Emergency Services Mental Health and Substance Abuse Services Rehabilitation and Habilitation Services Preventive Care Medical Devices and Equipment Maternity and Newborn Care Selected Pediatric Services

Reporting System	Organization Structure- Groups of Information	High-Leverage Opportunities for Measurement
	Completeness of Coverage and Cost-Sharing	Weighted Points for Completeness of Financial Coverage of Benefits Copay Coinsurance Cost Shifting Out-of-Pocket Spending Capitation Limits on Annual Payout of Benefits Truth in Labeling and Transparency

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MAP Health Insurance Exchange Quality Rating System Task Force Organization of High-Leverage Opportunities Options

Task force breakout groups are asked to define the ideal organization of the Health Insurance Exchange Quality Rating System (QRS). NQF staff has compiled three options for organizing the high-leverage opportunities.

The first option draws from structures that are currently in use to organize health plan measurement information (see background document Organization of Measurement Information). The second option uses the organizing structure from HHS' proposed rule. The third approach employs a framework to communicate about health care quality by Judy Hibbard.

Option 1

Benefits/Coverage

- Utilization Management
- Access to Care, Specialists, and Network Adequacy

Experience

- Patient Experience/Satisfaction
- Advanced Illness Care (Hospice, End-of-Life, and Palliative Care)
- Cultural Competency
- Shared Decision-Making

Complaints/Customer Service

- Member Access to Information
- Member Education
- Access to Health Plan Resources, Medical Records

Prevention/Health Promotion

- Screening, Immunization, and Treatment of Infectious Disease
- Cancer Screening and Treatment
- Weight Management and Wellness Counseling
- Well-Infant, Child, and Adolescent Care
- Dental and Vision Care
- Behavioral Health/Mental Health
- Tobacco, Alcohol, and Substance Use
- Maternal Health
- Care for Older Adults (Osteoporosis, Arthritis, Dementia, Alzheimer's, Falls, Incontinence)

Management/Treatment of Conditions

- Care Coordination and Case Management
- Cancer Screening and Treatment
- Cardiovascular Care
- Diabetes Care
- Dental and Vision Care
- Screening, Immunization, and Treatment of Infectious Disease
- Behavioral Health/Mental Health
- Asthma and Respiratory Care
- Maternal Health
- Care for Older Adults (Osteoporosis, Arthritis, Dementia, Alzheimer's, Falls, Incontinence)
- Medication Management

Cost/Efficiency

- Cost
- Readmissions

Option 2

Clinical Quality Management

- Care Coordination
- Clinical Effectiveness
  - Behavioral Health/Mental Health
  - Screening, Immunization, and Treatment of Cancer Screening and Treatment
  - Infectious Disease
  - Cardiovascular Care
  - Diabetes Care
  - Maternal Health
  - Dental and Vision Care
  - Asthma and Respiratory Care' Advanced Illness Care (Hospice, End-of-Life, and Palliative Care)
- Patient Safety
  - Medication Management
  - Readmissions
- Prevention
  - Screening, Immunization, and Treatment of Infectious Disease
  - Weight Management and Wellness Counseling
  - Cancer Screening and Treatment
  - Well-Infant, Child, and Adolescent Care
  - Maternal Health
  - Dental and Vision Care
  - Care for Older Adults (Osteoporosis, Arthritis, Dementia, Alzheimer's, Falls, Incontinence)
  - Tobacco, Alcohol, and Substance Use

Member Experience

- Access
  - Member Access to Information
  - Access to Care, Specialists, and Network Adequacy
  - Access to Health Plan Resources, Medical Records
- Doctor and Care
  - Quality of Providers
  - Patient Experience/Satisfaction
  - Care Coordination and Case Management
  - Advanced Illness Care (Hospice, End-of-Life, and Palliative Care)
  - Cultural Competency

Cost and Efficiency

- Efficiency and Cost Reduction
  - Cost
  - Utilization Management
- Plan Service
  - Patient Experience/Satisfaction
  - Member Education
  - Shared Decision-Making

Option 3

Effective

- Quality of Providers
- Cost
- Utilization Management
- Screening, Immunization, and Treatment of Infectious Disease
- Cancer Screening and Treatment
- Weight Management and Wellness Counseling
- Cardiovascular Care
- Diabetes Care
- Asthma and Respiratory Care
- Maternal Health
- Well-Infant, Child, and Adolescent Care
- Dental and Vision Care
- Behavioral Health/Mental Health
- Tobacco, Alcohol, and Substance Use
- Care for Older Adults (Osteoporosis, Arthritis, Dementia, Alzheimer's, Falls, Incontinence)

Safe

- Medication Management
- Readmissions

Patient-Focused

- Patient Experience/Satisfaction
- Quality of Providers
- Advanced Illness Care (Hospice, End-of-Life, and Palliative Care)
- Care Coordination and Case Management
- Member Access to Information
- Member Education
- Access to Care, Specialists, and Network Adequacy
- Cultural Competency
- Access to Health Plan Resources, Medical Records
- Shared Decision-Making

National Quality Forum (NQF) Health Insurance Exchange Task Force Support Documentation

November 14, 2013

Centers for Medicare & Medicaid Services
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1. Executive Summary

1.1 Purpose

The purpose of this document is to provide more detailed information to the National Quality Forum (NQF) Health Insurance Exchange Task Force about the Quality Rating System (QRS) for Qualified Health Plans (QHPs) operating in the Affordable Insurance Exchanges (also known as Health Insurance Marketplaces or Marketplaces). This document provides background about the development of the QRS, the approach and criteria used in measure selection, and how the measures are organized to create the QRS ratings.

A QRS Technical Expert Panel (TEP), subject matter experts, stakeholder listening sessions and results from the initial methodology testing were used to inform the QRS development. This document supplements the Excel file named *QRS_NQFBriefing_20131104_Final.xlsx,* which accompanies this document.

CMS will evaluate feedback from the NQF Health Insurance Exchange Task Force and the QRS public comment period occurring between November 8, 2013 and January 8, 2014 to determine if revisions to the QRS measure sets are needed.

1.2 The Quality Rating System

The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act or the ACA) establishes a Marketplace within each state. Marketplaces will assist qualified individuals in each state with obtaining affordable health insurance.

CMS holds primary responsibility for establishing guidelines for the Marketplaces. Each state may create and operate its own Marketplace (State-based Marketplace) or a hybrid, called a State Partnership Marketplace, in which the state oversees certain functions. If a state elects not to establish a State-based Marketplace or if a state will not have a Marketplace that is operational by January 1, 2014, pursuant to section 1321(c)(1) of the Affordable Care Act, the Secretary will establish and operate a Federally-facilitated Marketplace in those states.

The Affordable Care Act requires the Secretary of the Department of Health and Human Services (HHS) to develop the standards and guidelines for the Marketplaces. Specifically, sections 1311(c)(3) and (c)(4) of the Affordable Care Act direct the Secretary to develop – (1) a system that rates qualified health plans (QHPs) based on quality and price, and (2) an enrollee satisfaction survey system that assesses consumer experience with QHPs. Because the QHP consumer experience is an important part of rating the overall quality of a QHP, CMS will use some of the information collected from the Enrollee Satisfaction Survey in the Quality Rating System (QRS).

The QRS is a rating system, similar to CMS' Medicare Stars, designed to inform consumer and employer selection of QHPs offered through the Marketplaces. The QRS is designed to provide ratings of QHPs based on health care quality, health outcomes, consumer experience, and cost of care. The intent is for all QHP issuers to report data at the product level for the initial years of QRS implementation (for example, at the Health Maintenance Organization level or Preferred Provider Organization level). QHPs are expected to provide product-level quality performance data for the QRS in general topic areas such as clinical effectiveness of care, patient safety, care coordination, prevention of disease and illness, access to care, member experience, plan service, and efficiency and affordability. The QRS ratings should demonstrate sound, reliable, and meaningful information on the performance of QHPs to support consumers in making informed decisions.

QHPs offered in the Marketplace may provide family/adult self-only coverage or child-only coverage. Therefore, the QRS consists of two measure sets: the QRS measure set (for family and adult self-only coverage) and a Child-only QRS measure set (for child-only coverage). The proposed QRS measure set consists of 42 measures: 29 clinical measures which encompass health care topics of clinical effectiveness, prevention, access and efficiency and 13 Consumer Assessment of Healthcare Providers and Systems® (CAHPS) survey measures which encompass topics such as member experiences with the QHP, providers, and health care services, including preventive care. The QRS measure set addresses the essential health benefits (EHBs) for which health plan measures are currently available. The majority of the measures (76%) are presently NQF-endorsed. The proposed QRS measure set addresses all six National Quality Strategy (NQS) priorities. Approximately 83 percent of the QRS measures are included in at least one of the reviewed Federally-established measure sets (for example, the Office of Personnel Management [OPM] Federal Employee Health Benefits [FEHB], CMS Medicare Stars, CMS Initial Adult Medicaid Core Set, CMS Initial Children's Core Set, Medicare Part C&D Plan Reporting).[1] The remaining measures are used in other State-based and private sector health plan reporting programs such as Consumer Reports Health Plan Rankings[2] or through accreditation. QHPs offering family or adult self-only coverage would be required to report on all 42 measures in the QRS measure set.

The proposed Child-only QRS measure set consists of 25 measures: 15 clinical measures and 10 CAHPS measures. The Child-only QRS measure set includes a combination of process and outcome measures. The Child-only QRS measure set addresses many EHBs. The majority of the measures (84%) are NQF-endorsed. The proposed Child-only QRS measure set addresses the majority of the six NQS priorities. Approximately 80 percent of the measures are included in

[1] Initial Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid (Initial Medicaid Adult Core Set). February 2013.
[2] http://www.consumerreports.org/health/insurance/health-insurance-plans.htm

either the OPM FEHB Set or the CMS Initial Children's Core Set.[3] As with the QRS measure set, the remaining measures in the Child-only set are used State-based and private sector health plan reporting programs. Child-only QHPs would be required to report on all 25 measures in the Child-only QRS measure set.

The QRS will organize measures using multiple constructs:

- Individual indicators or measures – The fundamental building blocks of the QRS structure
- Composites – The combination of two or more individual indicators or measures that results in a single score
- Domains – Eight categories representing unique and important aspects of quality
- Summary Indicators – Three broad categories that aggregate the measure domains
- Global Rating – A single score that summarizes all measures, composites, and domains

In some instances, the QRS includes one or more, but not all, individual indicators within a measure. Indicators were removed from the measure sets if there was redundancy with other measures, weaker psychometric properties including the need for large sample sizes, or limited opportunities for improvement due to high scores with less variation.

In future rulemaking, CMS intends to propose requirements for QHPs and Marketplaces regarding the collection and submission of specific quality-related information. In addition, CMS intends to provide future technical guidance for QHP Issuers and Marketplaces related to QRS measure specifications, detailed rating methodology guidelines, and data reporting and procedures.

2. Goal and Guiding Principles of the QRS

The overarching goal of the QRS is based on two fundamental tenets: (1) providing comparable and useful information regarding the quality of QHPs offered through the Marketplaces to inform consumer and employer choice and (2) facilitating regulatory oversight of QHPs with regard to the quality standards set forth in the Affordable Care Act. Consequently, the QRS should provide QHP ratings based on health care quality and outcomes, consumer experience and cost. Five general QRS principles serve as the guidelines for QRS design and construction and support the overall achievement of the proposed goal to design the QRS:

[3] SHO: # 13-002. Letter to State Health Official and State Medicaid Director. Re: 2013 Children's Core Set of Health Care Quality Measures. January 24, 2013.

- The QRS should produce QHP quality performance information to encourage the delivery of higher-quality health care services, expand access to care, and improve health outcomes for QHP enrollees.

- The QRS should provide sound, reliable, and meaningful quality-related QHP information, which could be used by consumers when comparing health plans, by QHPs for quality improvement, as well as by Marketplaces and CMS for QHP certification and regulatory oversight activities.

- The QRS should reflect the goals of the National Strategy for Quality Improvement in Health Care priorities,[4] which includes reporting cross-cutting performance areas (that is, patient safety, prevention, population health, patient engagement, patient experience, and efficient resource use). The QRS should also facilitate reporting on conditions or procedures of significant prevalence and importance (for example, heart disease or breast cancer screening).

- The QRS measure set should be evidence-based and align, to the maximum extent possible, with priority measures currently implemented in federal, state, and private sector programs to minimize QHP issuer burden. The development and evolution of the QRS should be public and transparent and allow for flexibility to incorporate changes in measures and methodologies as medical treatments and technology evolve and the Marketplaces mature.

3. QRS Framework

The QRS Framework provides direction for creating, implementing, maintaining, and revising the QRS. The overall framework consists of the following two components that are guided by the QRS goals and principles:

- Performance Information
- Rating Methodology

In total, there are ten associated elements that further clarify the Performance Information and Rating Methodology components (see Exhibit 1 below).

[4] See Report to Congress: National Strategy for Quality Improvement in Health Care available at http://www.healthcare.gov/law/resources/reports/quality03212011a.html.

Exhibit 1. QRS Framework

	QRS Component	Element
Goals and Principles	Performance Information	▪ Measures Selection ▪ Hierarchical Structure ▪ Organization of Measures ▪ Data Strategy
	Rating Methodology	▪ Aggregation Rules ▪ Sampling and Attribution ▪ Scoring ▪ Performance Classification Values ▪ Population and Other Adjustments ▪ Peer Groups

The goals and principles for the QRS serve as the common thread throughout the QRS framework. The Performance Information component consists of four elements: (1) Measures Selection, (2) Hierarchical Structure, (3) Organization of Measures, and (4) Data Strategy. The Measures Selection element represents the process for selecting and evaluating the measures sets of the QRS. The Hierarchical Structure element establishes how the QRS measure sets are organized for scoring, rating, and reporting. The Organization of Measures element establishes the approach to create composites, domains, and summary indicators ratings. The Data Strategy element refers to the procedures for how the measures data will be collected, calculated, and submitted and will help to inform how data will be displayed.

The Rating Methodology component aims to define how QHPs will be scored and compared, and as proposed, consists of six elements:

- Aggregation Rules are used to determine how measures should be combined to create useful quality information on health care areas such as diabetes care or preventive health care.
- Sampling and Attribution establish the selection criteria for determining appropriate population samples that yield reliable and valid information.
- Scoring provides the process for converting the raw QRS measures data to points or percentiles on a common numeric scale.
- Performance Classification is used to assign values to the QHP scores; these values would then be used to categorize the QHP's performance.
- Population and other adjustments refer to changes made to raw data or measures to remove potential bias introduced by factors that are not modifiable by the QHP.

- Peer Groups are used to establish a benchmark dataset for comparison of the individual QHP in the performance classification work, most often based on the geographic and time period considerations (for example, current annual distribution of all plans nationally).

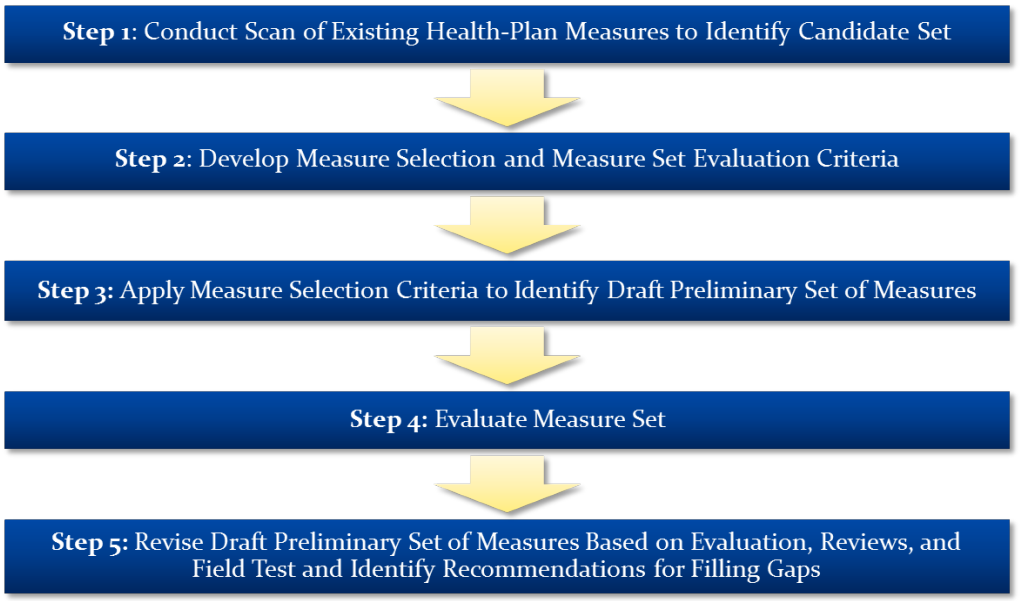
The purpose of this document is to provide details on the Performance Information Component of the QRS, specifically, the measure selection process, the proposed QRS measures, and the organization of measures using a hierarchy.

4. Performance Information Component

4.1 Measure Selection Process

The Project Team's process in identifying and selecting measures for the proposed QRS measure sets included the following five steps (Exhibit 2):

Exhibit 2. Measure Selection Process



4.1.1 Conduct Scan of Existing Health Plan Measures to Identify Candidate Set

In the first step of the process, the team conducted a scan of existing health plan measures to maintain consistency across CMS and ensure alignment with both government and private-sector reporting efforts. The team identified candidate measure sets using the following three criteria:

- Measures specified at the health plan level: The QRS is a health plan accountability program. The performance information shall be used by consumers to select health plans and by plans to improve the performance targeted by the measure set.

- Measure sets used in accountability and accreditation programs that CMS identifies as important resources for the QRS development: CMS seeks to harmonize the many measure sets in use today across its programs and activities and across other significant measurement programs. The QRS development should be informed by measure sets sponsored or used by CMS and others.

- Measure sets whose use is aligned with the QRS: The QRS will be used for consumer choice and QHP monitoring, plan management, and re-certification. Other QRS uses (and other measure sets aligned with these uses) may be implemented over time.

While CMS' accountability programs were of paramount interest, measures were also selected from other accountability and accreditation programs, State-based monitoring programs, and State-based Marketplace programs.[5] Exhibit 3 summarizes the accountability and accreditation programs the team selected for the scan.

Exhibit 3. Measure Scan Programs

Type of Program	Program
Accreditation Programs	▪ NCQA – Medicare – Medicaid – Commercial ▪ URAC ▪ Accreditation Association for Ambulatory Health Care (AAAHC)
CMS Programs	▪ Initial Adult Medicaid Core Set of Health Care Quality Measures ▪ Initial Core Set of Children's Health Care Quality Measures ▪ Medicare Stars and Medicare Part C & Part D Plan Reporting
State Health Plan Monitoring Programs	▪ Maryland HealthChoice Consumer Report Card ▪ California Health Care Quality Report Card ▪ New York Electronic Quality Assurance Reporting Requirements ▪ Maryland Health Plan Report ▪ California Medi-CAL Health Plan Quality Ratings
State-based Marketplaces/ Exchanges	▪ Oregon Health Insurance Exchange ▪ New York State Health Benefit Exchange ▪ California Health Benefit Exchange

[5] Based on a review conducted in 4th quarter of 2012

Type of Program	Program
Other	▪ Office of Personnel Management (OPM) Federal Employee Health Benefit Program (FEHB) – Health Maintenance Organization (HMO) – Fee For Service (FFS) ▪ Consumer Reports Health Plan Rankings – Medicare – Medicaid – Commercial ▪ eValue8

4.1.2 Develop Measure Selection and Measure Set Evaluation Criteria

The Project Team developed measure selection and measure set evaluation criteria using the frameworks for the NQF Measure Evaluation Criteria and the Measures Application Partnership (MAP) Measure-Selection Criteria.[6, 7] The measure selection criteria were applied to individual measures while the measure set criteria were applied to the preliminary QRS measure sets.

4.1.2.1 QRS Measure Selection Criteria

Exhibit 4 shows the areas addressed by the QRS Measure Selection Criteria. Full descriptions of the measure selection criteria and sub-criteria are provided in Appendix A. Alignment, which is not explicitly a NQF endorsement criterion, was included in the QRS Measure Selection Criteria because stakeholders were particularly interested in measures currently included in CMS and private sector accountability programs. The criteria represent industry-tested measure selection criteria, which were further informed by discussions with stakeholders and by public comment received from a Request for Information.[8]

Exhibit 4. QRS Measure Selection Criteria

Criteria	Definition
Importance	The extent to which the measure has a high impact and is relevant to the Marketplace population. High impact aspects of care may include a leading cause of morbidity/mortality, high resource use, severity of consequences of poor quality, number of people at risk, effectiveness of care, and the opportunity for improvement.
Performance Gap	The extent to which the measure shows opportunities for improvement based on current health plan performance. The topic area or measure focus should be evaluated relative to being a quality problem (i.e., there must be an opportunity or gap between actual and potential performance).

[6] National Quality Forum. "Measure Evaluation Criteria, November 2012." accessed January 23, 2013, http://www.qualityforum.org/docs/measure_evaluation_criteria.aspx

[7] Measure Applications Partnership. "MAP Working Measure Selection Criteria and Working Guide." National Quality Forum, December 2012.

[8] Request for Information Regarding Health Care Quality for Exchanges: http://www.gpo.gov/fdsys/pkg/FR-2012-11-27/pdf/2012-28473.pdf

Criteria	Definition
Reliability and Validity	Reliability: The extent to which the measure, as specified, produces consistent results within health plans. Validity: The extent to which the measure, as specified, produces credible results.
Feasibility	The extent to which the required measure data are readily available to Marketplace QHPs or could be captured without undue burden.
Alignment	The extent to which the measure is included in one or more priority CMS and private-sector measurement programs (e.g., CMS Medicare Stars, CMS Initial Adult Medicaid Set, CMS Initial Children's Core Set, OPM FEHB Set, Accreditation Programs) and supports ACA reporting requirements for mandated essential health benefits.

4.1.2.2 QRS Measure Sets Evaluation Criteria

The QRS Measure Set Evaluation Criteria were applied to the preliminary QRS measure sets with particular attention to any significant gaps requiring the evaluation of additional measures. The evaluation criteria included the dimensions described in Exhibit 5. The full QRS Measure Set Evaluation Criteria and sub-criteria are described in Appendix B.

Exhibit 5. QRS Measure Sets Evaluation Criteria

Criteria	Definition
NQF endorsement	Percent of measures that are NQF-endorsed.
NQS priorities	Distribution of measures across the NQS priorities.
Relevance	Percent of measures that addressed clinical conditions of moderate to high prevalence, high disease burden, or consumer information needs.
Alignment	Percent of measures that were included in priority measure sets (i.e., Medicare Stars Ratings, Initial Medicaid Adult Core Set, Initial Core Set of Children's Health Care Quality Measure, and Medicare Part C&D Plan Reporting), aligned with other QHP reporting requirements (plan management measures), and addressed essential health benefits (clinical care measures).
Comprehensiveness	Percent of measures by measure type, including structure, process, outcome, experience of care, and cost/resource use/appropriateness.
Sensitivity to health care disparities	Percent of measures that assessed health care disparities or were sensitive to disparities.
Parsimony	Percent of measures that demonstrated parsimony (measures that are readily available through automated data or are publicly reported or currently in use as contractual or regulatory performance standards/requirements).
Usability	Percent of measures that showed significant opportunities for improvement based on current health plan performance.

4.1.3 Apply Measure Selection Criteria to Draft Preliminary Set of Measures

The QRS Measure Selection Criteria was applied to each measure and evaluated to determine the extent that the measure met the criteria. Measures that performed well against the criteria overall were included in the draft preliminary set of measures. The team also included any measures that were deemed important because of their relevance to the QRS (e.g., measures that were sensitive to health care disparities).

4.1.4 Evaluate Measure Set

The draft of preliminary set of measures was then evaluated using the QRS Measure Set Evaluation Criteria. Overall, the QRS preliminary measure set performed well against the criteria. However, gaps were unable to be addressed in some performance areas due to the lack of available health plan measures. These include the Patient Safety and Care Coordination domains as well as the Essential Health Benefits (EHB) categories of emergency department services and rehabilitative/habilitative services.

The proposed measure set was evaluated and reviewed internally by CMS, externally by industry and stakeholders and in a field test using historical health plan data. Listening sessions were also conducted for insurers, states, and consumer groups.

4.1.5 Revise Draft Preliminary Set of Measures Based on Evaluation, Reviews, and Field Test, and Identify Recommendations for Filling Gaps

The measure sets underwent a series of evaluations and reviews since initial development. To balance the information needs with the reporting effort, the overall size of the measure sets were reduced by applying the following criteria. Measures were considered for removal if they:

- Were redundant with other measures based on clinical condition and intent;
- Showed weaker psychometric properties, including reliability, contribution to the quality construct represented by a composite, and measure mean scores and variation;
- Exhibited a smaller opportunity for improvement due to positive measure results with less variation;
- Were less clinically relevant when selecting between indicators for a given measure;
- Had no or little impact on the QRS hierarchical structure, if removed;
- Did not align with CMS programs or the 2013 OPM Federal Employees Health Benefits (FEHB) measure sets; or
- Exhibited low prevalence of the measured condition or topic in the general population.

In some instances, the QRS measure sets include one or more, but not all, individual indicators within a measure. Indicators that adhered most closely to the criteria identified above were retained. Finally, to balance the size of the QRS measure set and the comprehensiveness of the Child-only QRS, many of the child measures removed from the QRS measure set remain in the Child-only QRS measure set.

In addition to reducing the clinical measure sets, the team removed a set of measures reflecting quality of plan management, which included the following five measures:

- Call Center – Foreign Language Interpreter and TTY/TDD Availability
- Complaints about the Health Plan
- Reviewing of Appeals Decisions
- Health Plan Makes Timely Decisions about Appeals
- Members Choosing to Leave the Plan

CMS' ability to obtain data for these measures is limited because the data sources (e.g., complaints tracking module and centralized contract with an independent review entity) are only applicable to Federally-facilitated Marketplaces (FFMs)/State Partnership Marketplaces (SPMs). Obtaining standardized data from State-based Marketplaces (SBMs) for these specific measures will be difficult and may not be feasible in the short-term.

4.2 Individual Measures for the QRS Measure Sets

The proposed QRS measure set consists of a total of 42 measures: 29 clinical measures which encompass clinical effectiveness, prevention, access, and efficiency topics and 13 Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures which encompass member experience and plan service topics. The proposed Child-only QRS measure set consists of a total of 25 measures: 15 clinical measures and 10 CAHPS measures. The Child-only QRS measure set includes a combination of process and outcome measures. Exhibit 6 shows the measures contained in both the QRS and Child-only QRS measure sets.

Although the measures contained in the QRS are consistent with the state-of-science for measuring health care quality, science and technology do not yet allow us to measure or represent the quality of all care delivered through the QHPs. Therefore, the QRS measure set should not be viewed as representative of all care delivered by QHPs.

The Excel file, named *QRS_NQFBriefing_20131104_Final.xlsx*, which accompanies this document, provides detailed information about each measure contained in the QRS and Child-only QRS measure sets. In addition, Appendix C and Appendix D provide the attributes of the QRS Measure Set and Child-only QRS Measure Set, respectively.

Exhibit 6. Measures in QRS and Child-only QRS

Measure Title	NQF ID[9]	QRS	Child-only QRS
Adolescent Well-Care Visits	Not currently endorsed; access is a particularly important aspect of QHP performance	X	X
Adult BMI Assessment	Not currently endorsed; good properties and characteristics per the measure selection criteria	X	
Adults' Access to Preventive and Ambulatory Health Services	Not currently endorsed; access is a particularly important aspect of QHP performance	X	
Annual Dental Visit	1388	X	X
Annual Monitoring for Patients on Persistent Medications	Not currently endorsed; included due to the limited number of ambulatory patient safety measures available at plan-level	X	
Antidepressant Medication Management	0105	X	
Appropriate Testing for Children With Pharyngitis	0002	X	X
Appropriate Treatment for Children With Upper Respiratory Infection	0069		X
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	0058	X	
Breast Cancer Screening	Not currently endorsed; good properties and characteristics per the measure selection criteria	X	
CAHPS – Aspirin Use and Discussion	Not currently endorsed; represents an important aspect of preventive care for at-risk patients that can be collected via CAHPS	X	
CAHPS – Coordination of Members' Health Care Services	Not currently endorsed; included due to the limited number of care coordination measures available at the plan-level[10]	X	X
CAHPS – Cultural Competency	Not currently endorsed[11]; represents a particularly important aspect of QHP performance	X	X
CAHPS – Customer Service	0006	X	X
CAHPS – Flu Shots for Adults	0039	X	
CAHPS – Getting Care Quickly	0006	X	X

[9] Definitions of NQF-endorsed measures can be found here: http://www.qualityforum.org/Home.aspx
[10] Only one question within the CAHPS Coordination of Members' Health Care Services composite is currently endorsed (#0007): "Did your personal doctor seem informed and up-to-date about the medical care you got?". The remaining questions in the composite are new for the Enrollee Satisfaction Survey and have not yet been endorsed.
[11] One of the questions within this CAHPS composite was modified from CAHPS Clinician and Group 2.0, Adult Supplemental (NQF #1904) and the other question(s) is new.

Measure Title	NQF ID[9]	QRS	Child-only QRS
CAHPS – Getting Needed Care	0006	X	X
CAHPS – Global Rating of Health Plan	0006	X	X
CAHPS – Medical Assistance With Smoking and Tobacco Use Cessation	0027	X	
CAHPS – Plan Information on Costs	0006	X	X
CAHPS – Rating of All Health Care	0006	X	X
CAHPS – Rating of Personal Doctor	0006	X	X
CAHPS – Rating of Specialist Seen Most Often	0006	X	X
Cervical Cancer Screening	0032	X	
Child and Adolescent Access to PCPs	Not currently endorsed; access is a particularly important aspect of QHP performance		X
Childhood Immunization Status	0038	X	X
Chlamydia Screening in Women (Ages 16-20)	0033		X
Cholesterol Management for Patients With Cardiovascular Conditions: LDL-C Control (<100 mg/Dl)	Not currently endorsed; good properties and characteristics per the measure selection criteria	X	
Cholesterol Management for Patients With Cardiovascular Conditions: LDL-C Screening	Not currently endorsed; good properties and characteristics per the measure selection criteria	X	
Colorectal Cancer Screening	0034	X	
Controlling High Blood Pressure	0018	X	
Diabetes Care: Eye Exam (Retinal) Performed	0055	X	
Diabetes Care: Hemoglobin A1c (HbA1c) Control <8.0%	0575	X	
Follow – Up After Hospitalization for Mental Illness: 7 days	0576[12]	X	
Follow – Up Care for Children Prescribed ADHD Medication: Initiation Phase	0108[13]	X	X
Follow – Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase	0108		X
HPV Vaccination for Female Adolescents	1959		X
Immunizations for Adolescents	1407	X	X
Medication Management for People With Asthma	1799	X	
Medication Management for People With Asthma (Ages 5-18)	1799		X
Plan All – Cause Readmissions	1768	X	
Prenatal and Postpartum Care: Postpartum Care	1517	X	

[12]Measure includes only one indicator of the NQF-endorsed measure
[13]Measure includes only one indicator of the NQF-endorsed measure for the Child-only QRS

Measure Title	NQF ID[9]	QRS	Child-only QRS
Prenatal and Postpartum Care: Timeliness of Prenatal Care	1517	X	
Relative Resource Use for People with Cardiovascular Conditions – Inpatient Facility Index	1558	X	
Relative Resource Use for People with Diabetes – Inpatient Facility Index	1557	X	
Use of Imaging Studies for Low Back Pain	0052	X	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	0024		X
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents: BMI Percentile Documentation	0024[14]	X	
Well-Child Visits in the First 15 Months of Life	1392		X
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	1516	X	X

4.3 Organization of the QRS Measure Sets

Although rating systems can be comprised of a large collection of measures, the most useful to consumers are organized in a hierarchical structure. The proposed QRS structure organizes the measures in a way that makes the information more accessible and understandable. The measure hierarchy allows consumers to easily use the quality data in the QRS in their health plan comparisons for selection of a QHP in the Marketplace.

The QRS hierarchical structure includes the following:

- Individual indicators or measures – The fundamental building blocks of the QRS structure
- Composites – The combination of two or more individual indicators or measures that results in a single score
- Domains – Eight categories representing unique and important aspects of quality
- Summary Indicators – Three broad categories that aggregate the measure domains
- Global Rating – A single score that summarizes all measures, composites, and domains

The individual indicators or measures serve as the fundamental building blocks of the QRS structure. Similar indicators or measures are combined to form composites, which allow large amounts of information to be streamlined and reported in formats that are easy for consumers to

[14] Measure includes only one indicator of the NQF-endorsed measure

comprehend. Grouping measures into composites also helps to reduce random variability, differentiate performance across health plans and provide meaningful information to the consumer. The composites are then combined to form domains that represent unique and important aspects of quality, which are then aggregated to form summary indicators. The Global Rating summarizes all measures, composites, and domains into a single score.

As the Project Team developed the hierarchical structure, it considered testing results for each domain and composite, as well as the overall QRS goals and vision, to arrive at the recommended structure for organizing measures. The rationale underlying each domain and the composites contained within are provided in Exhibit 7 below.

Exhibit 7: Supporting Information for each Domain Recommended within the Organization of Measures

Domain	Rationale
Clinical Effectiveness	The Clinical Effectiveness domain is represented by measures that address four prevalent chronic condition patient populations: Diabetes Care, Cardiovascular Care, Asthma Care, and Behavioral Health. In addition to a stand-alone asthma measure, the remaining three topics are represented by condition-specific composites. The measures address important clinical competencies including intermediate outcomes, evidence-based therapies to mitigate the progression of disease, and screenings to monitor metabolic and other disease markers.
Patient Safety	Patient Safety is an important aspect of 'right care' across the spectrum of healthcare delivery. Given its importance, this domain is represented in the QRS survey at the outset notwithstanding the limited number of plan-level measures. Ideally, the robustness of this domain will be improved by adapting additional measures for plan-level accountability in future years. There is no composite associated with this domain.
Care Coordination	Care Coordination, for the QRS, is defined as care occurring "across settings" and/or "across providers." The Care Coordination domain represents CAHPS questions under the Coordination of Members' Health Care Services topic, as well as candidate items to be tested in the Qualified Health Plan Enrollee Experience Survey (QHP Enrollee Survey). The proposed questions for this domain include: ▪ Doctor seemed informed and up-to-date about care from other health providers ▪ Doctor has your medical records ▪ Follow up about blood test, x-ray or other test results ▪ Got blood test, x-ray or other test results as soon as you needed them ▪ Doctor talk about prescription drugs you are taking ▪ Doctor's office manage your care among different providers Currently, there is no composite associated with this domain. The construction of any composites within this domain will be assessed in the QHP Enrollee Survey testing.
Prevention	The Prevention domain represents a number of important areas related to early detection of disease, regular health check-ups, and support for healthy behaviors. This domain includes four composites: ▪ Checking for Cancer ▪ Staying Healthy Child ▪ Staying Healthy Adult ▪ Maternal Health Particular elements of this domain include: screening and early detection; avoiding disease through immunization and aspirin use; obtaining regular care during pregnancy; and support to maintain a healthy weight and stop smoking.

Domain	Rationale
Access	Access to care is a distinct dimension of quality that is a particularly important aspect of Marketplace plan performance given the expansion of comprehensive health insurance coverage to a large number of individuals. This domain includes two composites: Access Preventive Visits and Access to Care, which capture access performance through ambulatory care visit frequency and member-reported experiences.
Doctor and Care	Member experience with the Doctor and Care domain is distinct from experiences with the health plan's services. Given the provider network overlap among insurers in many local markets, the QRS distinguishes provider-centric and plan-centric member-reported performance. This domain includes three CAHPS ratings: Global Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist, along with a Cultural Competency question. This domain is comprised of the Doctor and Care composite.
Plan Service	The Plan Service domain represents aspects of member experiences about plan services, such as customer service and getting information about the cost of services. Member experiences with the health plan generally are distinct from those experiences with the provider network and are therefore included in this separate domain. This domain is comprised of the Member Experience with Health Plan composite.
Efficiency and Affordability	The Efficiency and Affordability domain focuses on the overuse of services and reducing costs due to inappropriate services. It supports the HHS National Quality Strategy priority of "Making Care More Affordable," and can be used to support both plan choice and plan oversight. This domain signals the health plan's ability to eliminate waste and avoid harm by minimizing inappropriate services. This domain is comprised of the Efficient Care composite.

4.3.1 QRS Measure Set Structure

The QRS is organized into 42 measures, 12 composites,[15] and a set of eight domains that represent unique and important aspects of quality: Care Coordination, Clinical Effectiveness, Patient Safety, Prevention, Access, Doctor and Care, Efficiency and Affordability, and Plan Service. The domains are grouped into three summary indicators that align with the CMS priority areas: Clinical Quality Management; Member Experience; and Plan Efficiency, Affordability and Management. These three summary indicators further organize the domains into broad categories that the consumer may use in evaluating options. All three indicator summaries are then grouped into a single Global Rating. The Global Rating is a single score that summarizes all measures, composites, and domains in the hierarchical structure of the QRS measure set. Exhibit 8 below provides the organization of the proposed QRS core measure set.

[15] Not all measures in the QRS are a part of a composite.

Exhibit 8. Proposed QRS Structure

QRS Summary Indicator	QRS Domain	QRS Composite	Measure Title
Clinical Quality Management	Care Coordination	▪ No Composite	CAHPS – Coordination of Members' Health Care Services
	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	▪ 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	▪ Diabetes Care: Eye Exam (Retinal) Performed ▪ Diabetes Care: Hemoglobin A1c (HbA1c) Control <8.0%
		▪ No Composite	▪ Medication Management for People With Asthma
	Patient Safety	▪ No Composite	▪ Annual Monitoring for Patients on Persistent Medications ▪ Plan All – Cause Readmissions
	Prevention	▪ Checking for Cancer	▪ Breast Cancer Screening ▪ Cervical Cancer Screening ▪ Colorectal Cancer Screening
		▪ Maternal Health	▪ Prenatal and Postpartum Care: Postpartum Care ▪ Prenatal and Postpartum Care: Timeliness of Prenatal Care
		▪ Staying Healthy Adult	▪ Adult BMI Assessment ▪ CAHPS – Aspirin Use and Discussion ▪ CAHPS – Flu Shots for Adults ▪ CAHPS – Medical Assistance With Smoking and Tobacco Use Cessation
		▪ Staying Healthy Child	▪ Annual Dental Visit ▪ Childhood Immunization Status ▪ Immunizations for Adolescents ▪ Weight Assessment and Counseling for Nutrition and Physical Activity Children and Adolescents: BMI Percentile Documentation

QRS Summary Indicator	QRS Domain	QRS Composite	Measure Title
Member Experience	Access	▪ Access Preventive Visits	▪ Adolescent Well-Care Visits ▪ Adults' Access to Preventive and Ambulatory Health Services ▪ Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
		▪ Access to Care	▪ CAHPS – Getting Care Quickly ▪ CAHPS – Getting Needed Care
	Doctor and Care	▪ Doctor and Care	▪ CAHPS – Cultural Competency ▪ CAHPS – Rating of All Health Care ▪ CAHPS – Rating of Personal Doctor ▪ CAHPS – Rating of Specialist Seen Most Often
Plan Efficiency, Affordability and Management	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
	Plan Service	▪ Member Experience with Health Plan	▪ CAHPS – Customer Service ▪ CAHPS – Global Rating of Health Plan ▪ CAHPS – Plan Information on Costs

4.3.2 Child-only QRS Measure Set Structure

The hierarchical structure for the proposed Child-only QRS is similar to the proposed QRS measure set. The 25 measures of the Child-only QRS provide the basic foundation of the structure. Not all measures in the Child-only QRS are part of a composite. Exhibit 9 below provides the organization of the proposed Child-only QRS measure set. The Child-only QRS is organized into 25 measures, seven composites, and a set of seven domains: Care Coordination, Clinical Effectiveness, Prevention, Access, Doctor and Care, Efficiency and Affordability, and Plan Service. The domains are grouped into the same three summary indicators as the Family QRS: Clinical Quality Management; Member Experience; and Plan Efficiency, Affordability and Management. All three indicator summaries are then grouped into a single Global Rating.

Exhibit 9. Proposed Child-only QRS Structure

Child-only Summary Indicator	Child-only Domain	Child-only Composite	Measure Title
Clinical Quality Management	Care Coordination	▪ No Composite	▪ CAHPS – Coordination of Members' Health Care Services
	Clinical Effectiveness	▪ Behavioral Health Child	▪ Follow – Up Care for Children Prescribed ADHD Medication: Initiation Phase ▪ Follow – Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase
		▪ No Composite	▪ Medication Management for People With Asthma (Ages 5-18)
	Prevention	▪ Staying Healthy Child	▪ Annual Dental Visit ▪ Childhood Immunization Status ▪ Chlamydia Screening in Women (Ages 16-20) ▪ HPV Vaccination for Female Adolescents ▪ Immunizations for Adolescents ▪ Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
Member Experience	Access	▪ Access Preventive Visits Child	▪ Adolescent Well-Care Visits ▪ Well-Child Visits in the First 15 Months of Life ▪ Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life ▪ Children and Adolescents' Access to Primary Care Practitioners
		▪ Access to Care	▪ CAHPS – Getting Care Quickly ▪ CAHPS – Getting Needed Care
	Doctor and Care	▪ Doctor and Care	▪ CAHPS – Cultural Competency ▪ CAHPS – Rating of All Health Care ▪ CAHPS – Rating of Personal Doctor ▪ CAHPS – Rating of Specialist Seen Most Often
Plan Efficiency, Affordability and Management	Efficiency and Affordability	▪ Efficient Care Child	▪ Appropriate Testing for Children With Pharyngitis ▪ Appropriate Treatment for Children With Upper Respiratory Infection
	Plan Service	▪ Member Experience with Health Plan	▪ CAHPS – Customer Service ▪ CAHPS – Global Rating of Health Plan ▪ CAHPS – Plan Information on Costs

Appendix A. QRS Measure Selection Criteria and Sub-Criteria

Measure-Selection Criterion	NQF Criterion	Explanation	Sub-criterion
Importance	Yes	This criterion considers the extent to which the measure has a high-impact and is relevant to the Exchange population. This criterion considers to the extent to which the specific measure focus is evidence-based, important to making significant gains in health care quality, and key to improving health outcomes for a specific high-impact aspect of health care where there is variation in or overall less-than-optimal performance. Exchange population compared to the currently insured: ▪ More likely to be adult and single ▪ Less likely to rank self in "excellent" or "very good" health ▪ Less likely to have a college degree ▪ More likely to be non-white ▪ More likely to speak a language other than English ▪ Less likely to have full-time employment ▪ Likely to cycle between Medicaid and the subsidized Marketplaces[16] The majority of projected Marketplace enrollees will transition from being previously uninsured. Many people expected to enroll in the Marketplaces by 2019 currently experience access barriers. Compared to the currently insured, these enrollees are: ▪ More likely to have gone more than two years without a check-up ▪ Less likely to have usual source of care ▪ More likely to have no interaction with the medical system The most commonly diagnosed chronic conditions among adults in the Exchange are likely to be hypertension (15%), high cholesterol (9%), and depression (9%). [17]	Answer item below as Y, N, or N/A for *all measures:* 1. Measure is NQF-endorsed Answer item below as High, Medium, Low for *clinical measures only* 2. Level of prevalence of condition/ disease in the population is: ▪ High: > 15% ▪ Medium: 5 – 14% ▪ Low: < 5% Answer items below as Y or N for *member experience and plan management measures only (see explanation):* 3. Service being measured is relevant to the Exchange because it responds to known consumer information needs 4. Service being measured is relevant to the Exchange because it is a priority for regulators Answer items below as Y or N for *all measures:* 5. Service or condition being measured is relevant to disparities in care *or access*

[16] PricewaterhouseCoopers Health Research Institute. (October 2012). Health Insurance Exchanges: Long on options, short on time. http://pwchealth.com/cgi-local/hregister.cgi/reg/pwc-health-insurance-exchanges-impact-and-options.pdf

[17] Kaiser Family Foundation. (March 2011). A Profile of Health Insurance Exchange Enrollees. http://www.kff.org/healthreform/upload/8147.pdf

Measure-Selection Criterion	NQF Criterion	Explanation	Sub-criterion
		Services identified as important to the Exchange Population include (Note: we will note in the file if a measure falls into one of these categories): [18] ▪ Financial barriers ▪ Care Coordination ▪ Cost ▪ Covered services ▪ Rules to see a doctor ▪ Doctor in a plan ▪ Doctor quality ratings ▪ Metal-tier	
Performance Gap	Yes	The measure must show performance gaps (i.e., opportunities for improvement exist based on current health plan performance). Measures must reveal true differences among plans where differences exist, and ensure consistency of experience and threshold service expectations across all QHPs.	Answer item below as Y, N or N/A for *all measures:* 1. Measure is NQF-endorsed 2. Measure results indicate low performance (mean < 80 percent) 3. Performance difference is > 15 between the 90th and 10th percentiles
Reliability and Validity	Yes	Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results. Measure result can be confirmed through audit sample.	Answer item below as Y, N, or N/A: 1. Measure is NQF-endorsed If not NQF-endorsed or N/A, answer item below as Y or N 2. Presence of other evidence that indicates that measure Is reliable and valid (e.g., field test report, use in projects)
Feasibility	Yes	This criterion addresses the extent to which the required data are readily available or could be captured without undue burden and can be implemented for performance measurement.	Answer items below as Y, N or N/A: 1. Measure is NQF-endorsed 2. Data readily available through the following data collection sources – claims, administrative, survey, management databases/data streams – versus manual medical record review 3. Measure is publicly reported or currently in use as contractual performance standard/ requirement between plans and public/private purchasers, or as a regulatory requirement

[18] Pacific Business Group on Health. Consumer Choice of Health Plan Decision Support Rules for Health Exchanges. July 2012.

Measure-Selection Criterion	NQF Criterion	Explanation	Sub-criterion
Alignment	No	This criterion addresses extent to which measures are included in one or more priority CMS and private sector measurement programs. More weight will be given to measures that are included in multiple programs. Priority Measure Sets: • Medicare Stars Rating – Part C and Part D • Initial Medicaid Adult Core Set • Initial Core Set of Children's Health Care Quality Measures • OPM FEHB Set (added 8/30/2013) • NCQA Accreditation • URAC Accreditation EHBs: 1. Ambulatory patient services 2. Emergency services 3. Hospitalization 4. Maternity and newborn care 5. Mental health and substance use disorder services, including behavioral health treatment 6. Prescription drugs 7. Rehabilitative and habilitative services and devices 8. Laboratory services 9. Preventive and wellness services and chronic disease management 10. Pediatric services, including oral and vision care	Answer items below as Y or N: 1. Measure is included in 1 or more of the priority sets and programs 2. Measure is included in 2 of the priority sets and programs 3. Measure is included in 3 or more of the priority sets and programs 4. Measure aligns with other ACA QHP reporting requirements (plan management only) 5. Measure addresses essential health benefits (EHBs) (clinical, efficiency, and member experience measures only) 6. Measure is included in at least one CMS program

Measure-Selection Criterion	NQF Criterion	Explanation	Sub-criterion
		Other ACA requirements include:[19] ▪ Claims payment policies and practices ▪ Periodic financial disclosures ▪ Data on enrollment ▪ Data on disenrollment ▪ Data on the number of claims that are denied ▪ Data on rating practices ▪ Information on cost-sharing and payments with respect to any out-of-network coverage. ▪ Information on enrollee and participant rights under this title ▪ Other information as determined appropriate by the Secretary ▪ Issuer Oversight Plan Performance Report Card (will assess alignment once measures are available)	

[19] Affordable Care Act (ACA), Section 2715a, enacted March 23, 2010, and the Health Care and Education Reconciliation Act of 2010, enacted on March 30, 2010.

Appendix B. Measure Set Evaluation Criteria and Sub-Criteria

Criterion	QRS Definitions	Criterion (Adapted from MAP)	Sub-Criterion
NQF-Endorsed Measures	Measures within the program measure set are NQF-endorsed or meet the requirements	Measures within the program measure set are NQF-endorsed	Measure set will be evaluated based on percentage of non-plan management measures that are NQF-endorsed.
NQS Priorities	The QRS core measure set should align with the NQS six priorities to the extent possible: ▪ Making care safer ▪ Person- and family-centered care ▪ Effective communication and care coordination ▪ Prevention and treatment of leading causes of mortality ▪ Health and well-being of communities ▪ Making quality care more affordable	Program measure set adequately addresses each of the NQS priorities, demonstrated by measures addressing each of the National Quality Strategy priorities: ▪ Making care safer ▪ Person- and family-centered care ▪ Effective communication and care coordination ▪ Prevention and treatment of leading causes of mortality ▪ Health and well-being of communities ▪ Making quality care more affordable	Measure set will be evaluated based on the number of non-plan management measures that meet each NQS priority.
Relevance	The QRS core measures set should be relevant to the program's intended population(s) with respect to benefit design/cost-sharing, access, disparities in care, etc. The measure set should address conditions of high prevalence, relevant to the program's intended population(s), including child health conditions and risks. The measure set should include measures that are important to the consumer and employer for making informed decisions about health plans.	Program measure set is relevant to the QRS' intended population(s) (e.g., relatively older, less educated, lower income, racially diverse, experience access barriers and in worse health). This will be demonstrated by the program measure set addressing conditions of high prevalence or high disease burden. Additionally, the measure set should respond to consumer information needs.	Measure set will be evaluated based on percentage of measures that address: ▪ Highly or moderately prevalent conditions (Measure-Selection Criteria- Importance #2 Level of prevalence of condition/disease in the population is: – High: > 15% – Medium: 5 – 14% – Low: < 5% ▪ Consumer information needs (Measure-Selection Criteria – Importance #3 Service being measured is relevant to the Exchange because it responds to known consumer information needs)

Criterion	QRS Definitions	Criterion (Adapted from MAP)	Sub-Criterion
Alignment	The QRS core measures set should be incorporated into and complement other information used by the Exchange for consumer choice of health plan and QHP certification and plan monitoring.	▪ Program measure set contains measures included in priority measure sets (i.e., Medicare Stars Ratings, Initial Medicaid Adult Core Set, Initial Core Set of Children's Health Care Quality Measures, NCQA Accreditation and URAC Accreditation) ▪ Program measure set includes plan management measures that align with ACA QHP reporting requirements and clinical care measures that address essential health benefits. ▪ Program measure set includes measures that are included in at least one CMS program (i.e., Medicare Stars Ratings, Initial Medicaid Adult Core Set, CHIPRA, Clinical Quality Measures, and Medicare Part C&D Plan Reporting).	Measure set will be evaluated based on percentage of measures that: ▪ Address priority measure sets *(Measure-Selection Criteria – Alignment #1 Measure is included in one or more of the priority sets and programs)* ▪ Align with ACA QHP reporting or EHBs *(Measure-Selection Criteria –Alignment #4 Measure aligns with other ACA QHP reporting requirements [plan management only] or #5 Measure addresses essential health benefits (EHBs) [clinical, efficiency, and member experience measures only])* ▪ Are included in CMS programs *(Measure-Selection Criteria – Alignment #6 Measure is included in at least one CMS program)*

Criterion	QRS Definitions	Criterion (Adapted from MAP)	Sub-Criterion
Comprehensive	The QRS core measure set should include an appropriate mix of measure types, including an appropriate mix of process, outcome, experience of care, cost/resource use/ appropriateness, and plan management measures necessary for the specific program attributes. The QRS core measures set should represent a variety of measure domains that address the interests of different member segments and the needs of Exchange management.	Program measure set includes an appropriate mix of measure types. Demonstrated by a program measure set that includes an appropriate mix of process, outcome, member experience of care, efficient resource use, and plan management measures necessary for the specific program attributes. ▪ Outcome measures are adequately represented in the program measure set. ▪ Process measures are adequately represented in the program measure set. ▪ Experience of care measures are adequately represented in the program measure set (e.g., patient, family, caregiver). ▪ Cost/resource use/ appropriateness measures are adequately represented in the program measure set. ▪ Plan management measures are represented in the program measure set.	Measure set will be evaluated based on the number of measures that meet each measure type and category: Measure Types: ▪ Intermediate Outcome ▪ Outcome ▪ Outcome – Patient Experience ▪ Process ▪ Process; Intermediate Outcome Measure Categories: ▪ Clinical care ▪ Efficient resource use ▪ Member experience ▪ Plan management

Criterion	QRS Definitions	Criterion (Adapted from MAP)	Sub-Criterion
Health Care Disparities Sensitive	The QRS core measures set should promote equitable access and treatment by considering health care disparities, capturing data, measuring results and implementing strategies to address variations in care. Factors include addressing race, ethnicity, familial risk factors, socioeconomic status, language, gender, age disparities, or geographical considerations (e.g., urban vs. rural). Program measure set also should address populations at risk for health care disparities (e.g., people with behavioral/mental illness).	Program measure set includes considerations for health care disparities. Demonstrated by a program measure set that promotes equitable access and treatment by considering health care disparities. Factors include addressing race, ethnicity, socioeconomic status, language, gender, age disparities, or geographical considerations (e.g., urban vs. rural). Program measure set also can address populations at risk for health care disparities (e.g., people with behavioral/mental illness). Program measure set includes measures that directly assess health care disparities (e.g., interpreter services). Program measure set includes measures that are sensitive to disparities measurement (e.g., beta blocker treatment after a heart attack).	Measure set will be evaluated based on percentage of measures that are sensitive to health care disparities *(Measure-Selection Criteria – Importance #5 Service or condition being measured is relevant to disparities in care or access):* Program measure set includes measures that directly assess health care disparities (e.g., interpreter services), and/or Program measure set includes measures that are sensitive to disparities measurement (e.g., beta blocker treatment after a heart attack).

Criterion	QRS Definitions	Criterion (Adapted from MAP)	Sub-Criterion
Parsimony	The QRS core measures set should support efficient (i.e., minimum number of measures and the least effort) use of resources for data collection and reporting and supports multiple programs and measurement applications. The program measure set should balance the degree of effort associated with measurement and its opportunity to improve quality, service, or operational performance. The QRS core measures set should include a reasonable number of measures, guided by the number of measures included in other measure sets and programs (i.e., NCQA Accreditation includes 33 measures; the Initial Adult Medicaid Core Set contains 26 measures). This balancing includes ensuring that domain level measure sets accurately reflect key aspects of the pertinent quality/value concept being measured. The QRS core measures set should include assessment of which measures co-vary or overlap to determine if one measure can serve as a surrogate for a larger set.	Program measure set promotes parsimony. Demonstrated by a program measure set that supports efficient (i.e., minimum number of measures and the least effort) use of resources for data collection and reporting and supports multiple programs and measurement applications. The program measure set should balance the degree of effort associated with measurement and its opportunity to improve quality. Measures in the program set can be captured without undue burden and implemented for a performance measure set.	Measure set will be evaluated based on percentage of measures that demonstrate parsimony. ▪ Data is readily available (Measure-Selection Criteria Feasibility #2 Data readily available through the following data collection sources – claims, administrative, survey, management databases/data streams – versus manual medical record review). ▪ Measure is publicly reported or currently in use *(Measure-Selection Criteria Feasibility #3 Measure is publicly reported or currently in use as contractual performance standard/ requirement between plans and public/private purchasers, or as a regulatory requirement*).

Criterion	QRS Definitions	Criterion (Adapted from MAP)	Sub-Criterion
Usability	The QRS core measure set should produce measure results that intended audiences (e.g., consumers, employers and regulators) can understand and are likely to find the measure results useful for decision-making. Additionally, consideration should be given to measure results that are actionable for quality improvement by the QHPs.	Program measure set includes measures that can produce results to facilitate consumer and regulatory decision making and actionable improvement by the QHPs. This would be demonstrated by the measures depicting appropriate performance gaps (i.e., opportunities for improvement exist based on current health plan performance). Measures must reveal true differences among plans where differences exist and ensure consistency of experience and threshold service expectations across all QHPs). Program measure set is applicable to the program's intended level(s) of analysis.	Measure set will be evaluated based on percentage of measures that: ▪ Demonstrate low performance *(Measure-Selection Criteria – Performance Gap #2 Measure results indicate low performance (mean < 80 percent) =High or Medium).* ▪ Demonstrate performance difference *(Measure-Selection Criteria –Performance Gap #3 Performance difference is > 15 between the 90th and 10th percentiles).* ▪ Are applicable to QRS' intended level of analysis (health plan level).

Appendix C. Attributes of the QRS Measure Set

The attributes of the QRS measure set appear below and include NQF endorsement status, measure type, measure category, clinical condition/clinical service, NQS priority, and EHB category.

NQF Endorsement Status	# of QRS Measures
NQF-endorsed	32
Not NQF-endorsed	10
Total	42

Measure Type	# of QRS Measures
Intermediate Outcome	1
Outcome	3
Outcome – Patient Experience	11
Cost/Resource Use	2
Process	23
Process; Intermediate Outcome	2
Total	42

Measure Category	# of QRS Measures
Clinical Care	29
Efficient Resource Use	3
Member Experience	8
Plan Management	2
Total	42

Clinical Condition/Clinical Service	# of QRS Measures
Asthma	1
Behavioral Health	2
Bronchitis	1
Cardiovascular Disease	2
Dental	1
Depression	1
Diabetes	3
Hypertension	1
Immunization	3
Ischemic Heart Disease	2
Low Back Pain	1
None	13
Obesity	2
Perinatal	2
Pharyngitis	1
Screening	3
Tobacco Use	1
Well-Visit	2
Total	42

NQS Priority	# of QRS Measures
Ensuring person- and family-centered care	8
Making care safer	2
Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models	5
Not applicable; member experience with plan management, not care	1
Promoting effective communication and care coordination	2
Promoting the most effective prevention, treatment, and intervention practices for the leading cause of mortality, starting with cardiovascular disease	11
Working with communities to promote wide use of best practices to enable healthy living and well-being	13
Total	42

EHB Categories*	Primary	Secondary	Tertiary
Ambulatory Patient Services	0	18	7
Hospitalization	1	2	1
Laboratory Services	1	0	0
Maternity and newborn care	2	0	0
Mental Health and Substance Use Disorder Treatment	3	0	0
N/A	12**	13	31
Pediatric Services, Including Oral and Vision Care	7	3	0
Prescription Drugs	4	1	0
Preventive and Wellness Services and Chronic Disease Management	12	5	3
Total	42	42	42

* Since many measures are relevant to two or more EHB categories, they have been assigned to secondary and tertiary categories (29 measures have been assigned to a secondary EHB category and 11 to a tertiary).

**Each measure is assigned to a primary EHB, except for the 10 non-clinical CAHPS measures and the two RRU measures.

Appendix D. Attributes of the Child-only QRS

The attributes of the Child-only QRS measure set appear below and include NQF endorsement status, measure type, measure category, clinical condition/clinical service, NQS priority, and EHB category.

NQF Endorsement Status	# of Child QRS Measures
NQF-endorsed	21
Not NQF-endorsed	4
Total	25

Measure Type	# of Child QRS Measures
Outcome – Patient Experience	11
Process	14
Total	25

Measure Category	# of Child QRS Measures
Clinical Care	15
Member Experience	8
Plan Management	2
Total	25

Clinical Condition/Clinical Service	# of Child QRS Measures
Asthma	1
Behavioral Health	2
Dental	1
Immunization	3
None	11
Obesity	1
Pharyngitis	1
Screening	1
Upper Respiratory Infection	1
Well-Visit	3
Total	25

NQS Priority	# of Child QRS Measures
Ensuring person-and family-centered care	8
Making care safer	0
Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models	3
Not applicable; member experience with plan management, not care	1
Promoting effective communication and care coordination	2
Promoting the most effective prevention, treatment, and intervention practices for the leading cause of mortality, starting with cardiovascular disease	1
Working with communities to promote wide use of best practices to enable healthy living and well-being	10
Total	25

EHB Categories*	Primary	Secondary	Tertiary
Ambulatory Patient Services	0	6	8
Hospitalization	0	0	0
Laboratory Services	0	0	0
Maternity and newborn care	0	0	0
Mental Health and Substance Use Disorder Treatment	2	0	0
N/A	10	10	12
Pediatric Services, Including Oral and Vision Care	11	4	0
Prescription Drugs	1	0	0
Preventive and Wellness Services and Chronic Disease Management	1	5	5
Total	25	25	25

*Each measure is assigned to a primary EHB, except for the 10 CAHPS measures. Since many measures are relevant to two or more EHB categories, the team assigned them to secondary and tertiary categories (15 measures have been assigned to a secondary EHB category and 13 to a tertiary category).