Partnership for Applying Measures to Improve Quality

Proposed Member Selection Criteria, Member Responsibilities, and Operating Procedures for Public Comment

The National Quality Forum (NQF) is seeking public comments on the proposed member selection criteria, member responsibilities, and operating procedures for the Partnership for Applying Measures to Improve Quality (PAM) that are presented in this paper. The public comments will inform deliberations of the NQF Board Nominating Committee that will be proposing PAM membership criteria and responsibilities to the whole NQF Board of Directors at its September 23, 2010 meeting. At that meeting, the NQF Board will be considering operating procedures for the Partnership, as well as the PAM membership criteria and responsibilities recommended by the Nominating Committee.

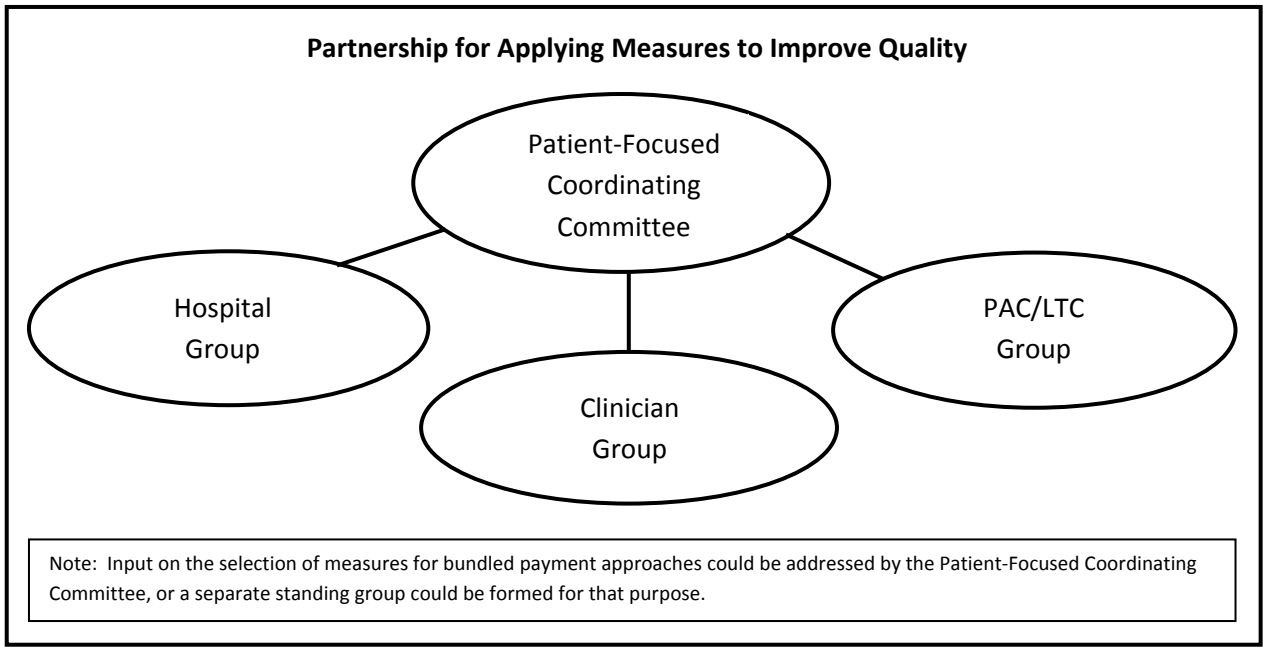
Background

The Affordable Care Act (ACA) establishes new requirements for the Secretary of Health and Human Services to seek multi-stakeholder input on the use of measures and assigns new duties to the consensus-based entity. Among those new duties, the entity is required to convene multi-stakeholder groups to provide input to the Secretary on the selection of quality measures for public reporting and payment programs for use by CMS and potentially other Federal agencies.

NQF, which currently serves as the consensus-based entity under contract with HHS, may be tasked with carrying out this consultative process in its role as neutral convener. In anticipation of the potential need for such a Consultative Partnership, at its May 5, 2010 meeting, the NQF Board adopted a plan for a new Partnership, the PAM, and requested public comments on how to best implement the Partnership. Comments were sought on a paper titled "Establishment of a Partnership for Applying Measures to Improve Quality" (see Attachment A for the paper) that outlined key considerations, including: statutory grounding; Partnership activities; involvement of stakeholder groups; transparency and due process; analytic support for evidence-based decision making; and a flexible, two-tiered structure.

In the plan adopted by the NQF Board, the Partnership structure is comprised of two tiers: (1) a central, multi-stakeholder coordinating group, the Patient-Focused Coordinating Committee, and (2) multi-stakeholder work groups to advise the Coordinating Committee on measures for programs for specific care providers, such as hospitals and clinicians (see below). The Patient-Focused Coordinating Committee will set the overall strategy for the Partnership, provide

direction to the advisory work groups, and be responsible for making recommendations to HHS. This structure will promote alignment of measures, shared accountability, and care coordination among providers, and avoid conflicting recommendations and diffusion of the Partnership's voice. All members of the Partnership, whether of the Coordinating Committee or the work groups, will be appointed by the NQF Board.



Twenty-two public comments were received on the key considerations addressed in the paper (see Attachment B for a summary of the comments). The comments were largely supportive of the plan for establishing the PAM that was adopted by the Board and presented in the paper. No commenters opposed the structure or offered an alternative structure. However, a number of commenters asked for further clarification of member selection criteria, member responsibilities that might affect qualification for membership, and operating procedures. This paper seeks further public comment on those issues.

Member Selection Criteria

Several sources were considered in developing proposed criteria for PAM membership, including the relevant ACA provision, comments received during the previous public comment period on the plan to establish the PAM, selection criteria for the National Priorities Partnership, and background papers and discussion from the December 2009 and May 2010 NQF Board meetings. The relevant ACA provision defines "multi-stakeholder group" as a voluntary collaborative of organizations representing a broad group of stakeholders interested in or affected by the use of quality measures. The membership criteria will apply to the

selection of members for both tiers of the Partnership structure (i.e., the Patient-Focused Coordinating Committee and the advisory work groups), though certain criteria may apply differently at the different levels.

Criteria proposed for the selection of organizations

Organizations selected for the Partnership should be membership entities that represent leading stakeholder groups affected by the use of quality measures. The ACA definition of multi-stakeholder group indicates that affected organizations and broad groups of stakeholders should be represented.

Organizational Partnership members should have structures and processes for setting policy and communicating with their constituencies. Organizations should have a governance structure and have demonstrated success in representing the interests of their constituencies through collaborative policy development and effective communication of their positions.

Organizational Partnership members should contribute to a balance of stakeholder interests. Public comments and NQF Board discussions emphasized that balancing interests is essential and that important interests to consider include: consumers; purchasers; providers; professionals; health plans; public/community health agencies; suppliers/industry; and quality measurement experts/researchers.

Federal government agencies affected by the use of quality measures should be organizational members of the Partnership. Federal agencies are important stakeholders, but government officials typically do not vote on recommendations to the government, so Federal officials will serve as ex-officio, non-voting members.

NQF should be an organizational member of the Partnership, but in its role as neutral convener, will be non-voting.

The majority of Partnership members should be organizations.

Criteria proposed for the selection of individuals

Individual Partnership members should be subject matter experts in a relevant field, such as quality measurement, public reporting, or performance-based payment. Public comments supported the inclusion of individual experts as members.

Individual Partnership members' inherent interests should be considered in balancing stakeholder interests, even though they are not sitting as organizational representatives. Individual subject matter experts should be subject to a high level of scrutiny for potential conflicts of interests.

Criteria proposed for the selection of both organizations and individuals

Members should contribute to the diversity of the Partnership. For organizational members, the organization itself may represent the interests of a vulnerable population. In addition,

organizational members' representatives and individual members should contribute to the diversity of the Partnership, whenever possible. Aspects of diversity to consider include race; ethnicity; gender; geographic area (region of the country, urban/rural, and communities); and representation of lifestages (i.e., child, maternal, adult, and senior health).

Organizational members, as well as individual subject matter experts, should have demonstrated involvement and experience in quality measurement (e.g., development, endorsement, implementation, validation, methodological issues), public reporting, and performance-based payment. Such involvement and experience is relevant to determining an organization's interest in the Partnership's purpose.

Members should be capable of and committed to meeting Partnership member responsibilities (see below).

Member Responsibilities

As a part of the nomination and selection process, the capabilities of nominees and their commitment to meeting member responsibilities will be an important consideration. A variety of sources were reviewed in developing proposed responsibilities for PAM members, including comments received during the previous public comment period on the plan to establish the PAM, the responsibilities of National Priorities Partnership members, general responsibilities from materials developed by the nonprofit organization BoardSource, and background papers and discussion from the December 2009 and May 2010 NQF Board meetings. The relevant ACA provision does not address multi-stakeholder group member responsibilities. The membership responsibilities will apply to members of both tiers of the Partnership structure (i.e., the Patient-Focused Coordinating Committee and the advisory work groups).

The following responsibilities are proposed for PAM members:

- **Strong commitment to advancing the performance measurement and accountability purposes of the Partnership.**
- **Willingness to work collaboratively with other Partnership members, respect differing views, and reach agreement on recommendations.**
- **Ability to volunteer time and make resources available as necessary to accomplish the work of the Partnership, including meeting preparation, attendance and active participation at meetings, completion of assignments, and service on ad hoc groups. Organizational representatives and individuals selected for membership will not be allowed to send substitutes to meetings.**
- **Demonstration of respect for the Partnership's decision making process by not making public statements about issues under consideration until the Partnership has completed its deliberations.**

- **Acceptance of the Partnership's conflict of interest policy. Members will be required to publicly disclose their interests and any changes in their interests over time.**
- **Service in leadership roles, if selected by the NQF Board. The NQF Board will select a chair and a vice-chair from among the members for the Patient-Focused Coordinating Committee and each work group.**
- **Organizational Partnership members will be responsible for identifying an individual to represent them on the PAM.**

Certain responsibilities are reserved for the NQF Board and are not the purview of the PAM membership, including the Partnership charge; structure and processes; appointment of members and leaders; and fiduciary responsibility for resources to support Partnership activities.

Operating Procedures

Procedures governing the activities of the Partnership are necessary to promote transparency, engagement, fairness, efficiency, and continuous improvement in the operations of the Partnership. Sources reviewed in the development of these proposed procedures include the National Priorities Partnership operating procedures, comments received during the previous public comment period on the plan to establish the PAM, and background papers and discussion from the December 2009 and May 2010 NQF Board meetings. The operating procedures will apply to the Patient-Focused Coordinating Committee and the advisory work groups, unless otherwise stated.

The following operating procedures are proposed for the PAM:

- **Public nomination of and public comment on selection of members**. The ACA requires a public call for nominations and the opportunity for the public to comment on the members selected for the multi-stakeholder groups.
- **Conflict of interest**. Members will be required to publicly disclose their interests and any changes in their interests over time. Individual members will be subject to a high level of scrutiny.
- **Openness and transparency**. Meetings will be publicly announced in a timely manner and held in broadcast public session whenever possible. Meeting agendas, background materials, and summaries will be posted online in a timely manner.
- **Public input**. The public will have the opportunity to provide input into matters considered by the Partnership through both oral and written testimony. Public comments will be posted online.
- **Recommendations**. The Patient-Focused Coordinating Committee will have the authority to make recommendations falling within the purview of the Partnership's charge. The work

groups will not make recommendations, rather they will advise the Coordinating Committee. Partnership recommendations are not subject to approval or ratification by the NQF Board.

- **Rules of order**. Sturgis' Standard Code of Parliamentary Procedure (4th Edition) will govern meeting proceedings.
- **Decision making**. A simple majority of voting members of the Patient-Focused Coordinating Committee in attendance will be required to pass a motion.
- **No substitutes**. Organizational representatives and individuals selected for membership will not be allowed to send substitutes to meetings.
- **Evaluation**. The Partnership will provide an annual report on its progress to the NQF Board and this report will be posted for public comment. The Board will have the option of commissioning an independent external evaluation of the Partnership every three years.
- **Complaints and concerns**. A formal complaint process will be established. Issues of concern regarding a substantive recommendation of the Partnership will be resolved by the Patient-Focused Coordinating Committee. Issues of concern regarding the integrity of the Partnership's processes will be resolved by the NQF Board.
- **Procurement**. Engagement of subcontractors will be governed by NQF's procurement policies, which follow appropriate Federal contracting requirements to ensure that the process is open to all qualified entities and is free of conflicts of interest.

Attachment A

Establishment of a Partnership for Applying Measures to Improve Quality

to Provide Input on Measure Selection for Public Reporting and Payment Programs

Introduction

The Patient Protection and Affordable Care Act (PPACA) establishes new requirements for the Secretary of Health and Human Services to seek multi-stakeholder input on measures and assigns new duties to the consensus-based entity.[1] Among those new duties, the entity is required to convene multi-stakeholder groups to provide input to the Secretary on the selection of quality measures for public reporting and payment programs for use by CMS and potentially other Federal agencies.[2] The multi-stakeholder groups, not the consensus-based entity, are charged with making recommendations to the Secretary. The Secretary retains the authority to make final determinations on the selection of measures for public reporting and payment programs, after considering input from other stakeholders through the regular rulemaking process.[3]

NQF, which currently serves as a consensus-based entity under contract with HHS, may be tasked with carrying out this consultative process in its role as neutral convener. To prepare for that potential new responsibility, this paper proposes that the NQF Board establish a new Consultative Partnership, named here the "Partnership for Applying Measures to Improve Quality."

In anticipation of the potential need for such a Consultative Partnership, the NQF Board, at its December 2009 meeting, discussed key policy and operational issues for a Partnership, including objectives, membership, transparency, products, and the need to seek broader input, particularly from existing alliances. An NQF Board work group met January-April 2010 to consider the charge and structure for a potential Partnership for Applying Measures to Improve Quality.

Using the groundbreaking work of the current quality alliances as a foundation, the Board work group developed a range of options to respond to the law and build on the work begun by the quality alliances, assuming the addition of robust analytical capability enabled by an infusion of Federal funding. Recognizing the importance of broad stakeholder input, the Board work group first sought reaction from the AQA Alliance (AQA), the Hospital Quality Alliance (HQA), and the Pharmacy Quality Alliance (PQA), with the ultimate intention of wide-ranging vetting. The results of these interactions are reflected here.

Activities of a Partnership for Applying Measures to Improve Quality

The PPACA assigns the consensus-based entity responsibility for convening multi-stakeholder groups to provide input to the Secretary on the selection of quality measures for public reporting and payment programs.[4] Public reporting and payment programs are construed expansively for this purpose to cover a range of Medicare payment programs, HHS public reporting programs, and other unspecified health

[1] See HR 3590 §§3011 and 3013-15.
[2] HR 3950 §3014, amending Social Security Act §1890(b) by adding (7)-(8), and by adding §1890A.
[3] Ibid.
[4] HR 3590 §3014.

care programs.[5] "Multi-stakeholder group" is defined in statute as a voluntary collaborative of organizations representing a broad group of stakeholders interested in or affected by the use of quality measures.[6]

Some elements of the process for providing the multi-stakeholder input are also defined in statute, and the Secretary will have the discretion to use the multi-stakeholder input more broadly. Not later than December 1 of each year, beginning with 2011, HHS must make available to the public a list of measures that are being considered.[7] Not later than February 1 of each year, beginning with 2012, the entity must transmit the pre-rulemaking input of the multi-stakeholder groups to HHS.[8]

In the near term, key activities of the Partnership for Applying Measures to Improve Quality would include providing pre-rulemaking input on the selection of measures for the Reporting Hospital Quality Data for the Annual Payment Update program (also referred to as RHQDAPU, Hospital Compare, and the hospital pay-for-reporting program) and the Physician Quality Reporting Initiative (also referred to as PQRI and the physician pay-for-reporting program). In the longer term, the Partnership could provide input on new programs like the hospital readmissions reduction program, which begins in fiscal year 2013,[9] and the payment adjustment for conditions acquired in hospitals, which begins in fiscal year 2015.[10] The Partnership could also have input into the selection of measures for emerging programs and demonstrations that are driving away from siloed payment systems toward clinical integration. Some examples of promising payment reforms with stepping stones defined in statute as Medicare demonstrations or pilot programs are medical homes,[11] accountable care organizations,[12] and bundled payment approaches.[13]

In addition to these current and new payment programs, HHS is directed under the statute to publicly report performance information through standardized websites.[14] The information must be tailored to respond to the different needs of hospitals and other institutional health care providers, physicians and other clinicians, patients, consumers, researchers, policymakers, States, and other stakeholders.[15] HHS must ensure that the collection, aggregation, and analysis systems span an increasingly broad range of patient populations, providers, and geographic areas over time.[16] Specifically, HHS must establish a Physician Compare website by January 1, 2011.[17] The Partnership for Applying Measures to Improve Quality would provide input into the selection of measures for these HHS public reporting websites.[18]

[5] HR 3590 §3014(a)(1), amending SSA §1890(b) by adding (7)(B)(i)(I)-(III).
[6] HR 3590 §3014(a)(1), amending SSA §1890(b) by adding (7)(D).
[7] HR 3590 §3014(b), amending SSA §1890A by adding (a)(2).
[8] HR 3590 §3014(a)(1), amending SSA §1890(b) by adding (8) and by adding §1890A(a)(3).
[9] HR 3590 §3025(a), amending SSA §1886 by adding (q)(1).
[10] HR 3590 §3008(a), amending SSA §1866 by adding (p)(1).
[11] See, e.g., HR 3590 §§2703, 3021, and 3502.
[12] See, e.g., HR 3590 §§2706 and 3022.
[13] See, e.g., HR 3590 §§2704 and 3023.
[14] HR 3590 §3015, amending PHSA §399 by adding JJ(a).
[15] Ibid.
[16] HR 3590 §3015, amending PHSA §399 by adding II(a).
[17] HR 3590 §10331(a)(1).
[18] HR 3590 §3015, amending PHSA §399 by adding JJ(c)(1)-(2).

Key Considerations in the Establishment of a Partnership for Applying Measures to Improve Quality

Involvement of stakeholder groups

The Partnership for Applying Measures to Improve Quality is meant to meet the requirements of the PPACA and build on the commitment of many stakeholders to the important work of the current quality alliances. The fact that the PPACA provides for a consultative function around the selection of measures is recognition of the valuable contributions that quality alliances have made in this area. The new Partnership structure must be capable of making measure recommendations across a broad set of public reporting and payment programs, and must comply with legislative requirements pertaining to transparency and due process, but it should also build on the successes of the alliances in this area. With a strong mandate and greater financial resources available to the Partnership, there is also the opportunity to provide stronger analysis for decision-making to support the multi-stakeholder input.

Careful coordination between the ongoing activities of the quality alliances and the new activities of the Partnership for Applying Measures to Improve Quality will be necessary to avoid duplication of effort by the volunteer members of the alliances and the Partnership. The current quality alliances will be key contacts for input and a focus for engagement as the Partnership is being established and begins operations. The alliances will be solicited for nominations of members to serve on the Partnership and for comment on the selected members and comment on recommendations to HHS.

The Federal agencies that are involved in the development and use of quality measures are obviously important stakeholders. Though Federal officials are not typically voting members of groups that make recommendations to the Federal government, the Partnership would benefit greatly from having identified liaisons from the relevant agencies.

Transparency and due process

The PPACA requires that the consultative process for convening multi-stakeholder groups be open and transparent in its initial construction and ongoing operations.[19] Public nominations must be sought for members of the multi-stakeholder groups, and public comment must be sought on member selection.[20] According to NQF policy, nominees for membership will be required to disclose conflicts of interest.

The Partnership for Applying Measures to Improve Quality will operate in a transparent manner. Meetings will be publicly announced and convened in open session, unless specific matters require an executive session. Summaries of deliberations will be publicly available in a timely manner. Public comment will be sought on recommendations, including written comments and verbal comments during meetings.

Analytic support for evidence-based decision making

Federal funding under PPACA will likely be adequate to support some analytic activities. The Partnership for Applying Measures to Improve Quality's multi-stakeholder input should be supported by the best available evidence and analysis. Strong analytical capability will be needed to support Partnership decision making in this fast moving environment. NQF staff will respond to the analytic

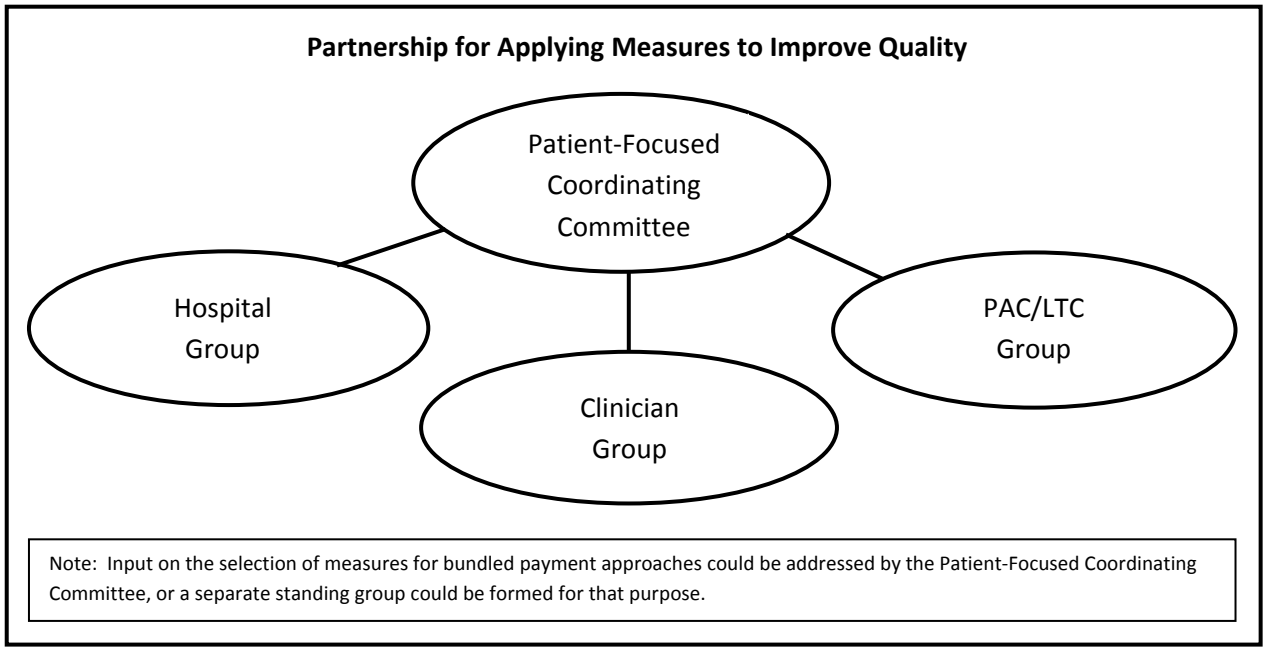
[19] HR 3590 §3014(a)(1), amending SSA §1890(b) by adding (7)(C)(i).
[20] HR 3590 §3014(a)(1), amending SSA §1890(b) by adding (7)(C)(ii).

needs that are identified by the Partnership. For research questions that cannot be answered by evidence available to NQF staff or by subject matter expert members of the Partnership groups, NQF will subcontract with health services research entities for analysis to support decision making.

In-depth analysis will be needed for some issues, while quick turnaround will be needed for others. Three relevant examples of illustrative of processes that provide evidence to support recommendations are discussed in an appendix to this paper. The examples are: (1) an in-depth NQF-RAND project that is currently underway, (2) the ECRI Institute's approach to providing analytical support for technology planning and assessment, and (3) the quick turnaround approach to policy analysis used by the California Health Benefits Review Program. These examples are intended to be illustrative only. In identifying subcontractors, NQF will follow appropriate Federal subcontracting requirements and ensure that the process is open to all types of organizations.

Flexible structure

Initial feedback from the quality alliances about the structure of the Partnership for Applying Measures to Improve Quality indicated preference for a two-tiered approach: (1) a central, multi-stakeholder coordinating group, named here the "Patient-Focused Coordinating Committee," and (2) multi-stakeholder work groups addressing measures for specific care providers like hospitals and clinicians. This structure would be sensitive to the needs of the provider constituencies represented by the current quality alliances, while still providing a strong, unified voice.



The Patient-Focused Coordinating Committee would play a strategic role by focusing on the measures needed for public reporting and payment approaches that cut across individual clinicians and provider sites of care. For example, the Coordinating Committee would consider issues related to the alignment of measures and promotion of shared accountability and care coordination among provider types. In addition to stakeholder representatives, the Coordinating Committee would need members with subject matter expertise in measurement, public reporting to support informed decision making, and performance-based payment approaches. The provider-focused work groups would perform the

narrower utility function of providing immediate input on the selection of measures for current public reporting and payment programs like RHQDAPU and PQRI. The recommendations of the work groups would flow through the Coordinating Committee to HHS to avoid conflicts and diffusion of the voice of the Partnership.

The structure and function of the Partnership for Applying Measures to Improve Quality would be evaluated periodically and would evolve based on the evaluation results. Based on these findings and lessons learned, the Partnership structure would be continually assessed to assure that it is that is patient-focused, efficient to administer, building on prior work, and making efficient use of volunteer members' time.

Relationship between the Partnership for Applying Measures to Improve Quality and the NQF Board

The PPACA calls for the consensus-based entity to convene multi-stakeholder groups to provide input to the Secretary on the selection of measures for public reporting and payment programs. Thus, if NQF is selected as the consensus-based entity, the NQF Board will be responsible for establishing the convening structure and ensuring the integrity of the convening process. The Board's responsibilities will include appointment of the multi-stakeholder members of the Partnership for Applying Measures to Improve Quality and periodic evaluation of the Partnership's structure and processes.

The Partnership for Applying Measures to Improve Quality will regularly report on progress to the NQF Board. A comprehensive assessment of the Partnership's function will be completed annually, and a thorough impact evaluation will be conducted by an independent third party every three years.

The consensus-based entity itself is not charged with making recommendations to the Secretary, so the Partnership for Applying Measures to Improve Quality's substantive recommendations will not flow through the NQF Board for ratification or approval. However, a mechanism for the NQF Board to address issues raised about the Partnership's processes will need to be established.

Appendix
Examples of Processes that Provide Evidence to Support Recommendations

RAND Measurement Implications of Performance-Based Payment Reform Models

NQF has engaged Eric Schneider at RAND to serve as the principal investigator for a two-part project to catalog existing performance-based payment reform models and then to analyze the measurement implications for these new payment approaches. RAND has identified nearly 80 models for the catalog from Federal (i.e., reform legislation, Medicare programs and demonstrations, and MedPAC recommendations), State, and private sector sources. The models will be classified according to typical approaches to performance-based payment (e.g., pay for performance, bundling, global payment, hospital-physician gainsharing, accountable care organizations, medical homes). Each performance-based payment approach will be analyzed for measure needs, methodological measurement issues raised (e.g., attribution, risk adjustment, sample size, data source), and measure gaps. This in-depth analysis will support decision making about measure sets for each approach, as well as measurement implementation issues that need to be overcome and measure gaps that need to be filled.

ECRI Technology Planning and Assessment

The ECRI Institute is a nonprofit organization that performs applied scientific research to determine which medical procedures, devices, drugs, and processes lead to the best outcomes in patient care.[21] ECRI provides clients with evidence-based research, testing, investigations, information, planning, and advice. ECRI's Health Technology Assessment Information Service evaluates healthcare technologies and services along the continuum of evidence from research and development to maturity, to guide coverage and implementation decisions. Their clients receive reports from systematic evidence reviews and trend analysis, and can also submit custom requests for information and for quick consultations tailored to address a particular need. ECRI's multidisciplinary staff includes doctoral-level scientists, clinicians, technologists, medical librarians, and other healthcare professionals.

California Health Benefits Review Program (CHBRP)

The California Legislature established the CHBRP at the University of California to provide independent analysis of the medical, financial, and public health impacts of proposed health insurance benefits mandates and repeals.[22] The CHBRP's small analytic staff leverages faculty from universities across the State, as well as actuarial consultants (CHBRP has contracted with Milliman) and a National Advisory Council. CHBRP produces quick turnaround reports within a strict 60-day production period. The reports summarize the evidence relevant to a proposed mandate, but CHBRP does not make recommendations in deference to State policymakers.

NOTE: These examples are intended to be illustrative only. In identifying subcontractors, NQF will follow appropriate Federal subcontracting requirements and ensure that the process is open to all types of organizations.

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[21] ECRI Institute website, available at: https://www.ecri.org/Products/TechnologyPlanningAssessment/Pages/default.aspx, accessed March 30, 2010.
[22] California Health Benefits Review website, available at: http://chbrp.org/, accessed March 30, 2010.

Attachment B

Summary of Member and Public Comments Received Regarding Establishment of a Partnership for Applying Measures to Improve Quality

The Affordable Care Act (ACA) assigns new duties to the consensus-based entity. Among those new duties, the entity is required to convene multi-stakeholder groups to provide input to the Secretary of HHS on the selection of measures for public reporting and payment programs. The National Quality Forum (NQF), which currently serves as the consensus-based entity under contract with HHS, may be tasked with carrying out this consultative process in its role as neutral convener.

To prepare for that potential responsibility, at its May 5, 2010 meeting, the NQF Board adopted a plan for a Partnership for Applying Measures (PAM) and requested public input regarding its action. In mid-May, NQF posted a call for member and public comments on how to best implement the new Partnership, in the event that HHS contracts with NQF to carry out the new duties for the consensus based entity. Comments were requested regarding the plan adopted by the NQF Board, reflected in a paper titled "Establishment of a Partnership for Applying Measures to Improve Quality to Provide Input on Measure Selection for Public Reporting and Payment Programs."

Specific areas raised as key considerations for comment included:

- Charge and activities;
- Structure;
- Membership, including stakeholder interests, selection criteria, and responsibilities; and
- Operational issues, including procedures, transparency, conflict of interest, NQF role, support for evidence-based decision making, and evaluation.

This paper contains for each of these topics a summary of the comments received and a response.

General

NQF received 22 comments. All of the comments were supportive of the NQF Board's plan for establishing the new Partnership. The effort was described as valuable and important, providing a unique and long-desired opportunity to align and synergize what has been a fragmented quality enterprise. The NQF Board was commended for proactively planning a well-thought-out starting point for improving quality measurement and performance reporting.

Response. We agree that establishing the new Partnership is important and appreciate the commenters support.

Charge and Activities

Commenters agreed that the charge and activities presented in the paper reflected the broad statutory charge required by the ACA. Given the breadth of the charge, two commenters stated that clear goals and priorities should be set, defining the strategic focus of the Partnership as advancing the use of quality information by patients and providers. Commenters also requested that a timeline for Partnership activities be made available as soon as it can be developed.

Commenters noted specific public reporting and payment programs that they wanted to see the Partnership address, including hospital readmissions reduction, payment adjustment for hospital-acquired conditions, medical homes, accountable care organizations, bundled payments, the Hospital Outpatient Data Reporting Program, the End-Stage Renal Disease Quality Incentive Payment program, pharmacy-related programs, and CMS pilots and demonstrations generally. Commenters emphasized the importance of attaining alignment among the measures for these programs and eliminating duplication of effort in quality measurement activities where possible.

Response. We agree that clear goals and priorities should be set for the Partnership and that determining the Partnership's strategic focus will be one of its initial activities. We expect that the scope and timeline of the Partnership's work will be informed by the ACA requirements and defined under contract with HHS. A timeline of Partnership activities will be made publicly available as soon as it is developed. We agree that alignment and minimization of duplication in quality measurement activities are important opportunities for the Partnership to pursue.

Structure

Commenters strongly supported the two-tiered structure presented in the paper. No commenter opposed the structure, and no alternatives were presented. The approach was described as well-structured, efficient, practical, and functional.

Commenters noted the need for the structure to be flexible. One commenter specifically stated that the most likely area where the structure of the Partnership will require some revision over time is the separation of clinicians from hospitals.

Regarding the groups within the structure, some commenters discouraged adopting currently existing groups intact to serve under the new Partnership, while one commenter suggested that existing groups could be incorporated. One commenter suggested that pharmacy should be added as a work group.

Response. We appreciate support for the two-tiered structure. We agree that the structure must evolve based on changes in public reporting and payment programs over time. The structure must be continually assessed to assure that it is patient-focused, efficient to administer, builds on prior work, and makes efficient use of volunteer members' time. The number and focus of the work groups could change over time. The NQF Board will select

members for the multi-stakeholder groups under each tier of the Partnership after a call for nominations.

Membership

Stakeholder interests

Commenters noted that the membership of the Partnership should be broad enough to capture the diverse interests of affected stakeholders, but that the interests should be balanced and the size of the groups must be manageable. Commenters noted that all of the stakeholder groups represented by the NQF council structure should be included. One commenter specifically mentioned the need for representation from communities that face the greatest health disparities. One commenter asked for clarification regarding whether all of the groups under the two-tiered structure would be multi-stakeholder in composition.

Several commenters suggested specific stakeholders that should be included, such as the relevant federal agencies, consumers and consumer groups, large employers and small businesses, payers, specific quality alliances, physicians and physician groups, pharmacists, groups representing the medical home concept, inpatient rehabilitation hospitals and units, the pharmaceutical and medical technology industries, software vendors, individuals with quality measurement expertise, and measure developers.

Response. We agree that the membership of the Partnership should be both broad and balanced, reflecting the breadth and balance of the NQF council structure. We also agree that groups representing those at greatest risk of disparate health outcomes should be included. We confirm that all of the groups under the two-tiered structure will have multi-stakeholder composition.

Membership Selection Criteria

Commenters requested that explicit membership selection criteria be developed and subjected to public comment for groups in both tiers of the Partnership prior to calling for member nominations. Specific selection criteria that were recommended by commenters included: mission, membership, and capabilities of the organization; representation of a unique constituency; involvement in key measurement and reporting activities, forums, or initiatives; demonstrated organizational or individual expertise in quality measurement, public reporting, or performance-based payment; perspective on advancing national transparency efforts; ability to meet the member responsibilities; and contribution to diversity. Several commenters advised that the Partnership be kept to a manageable size.

Response. We agree that explicit membership selection criteria are necessary to inform a call for member nominations and should be publicly vetted; therefore, we are posting a proposed

set of selection criteria for member and public comment. We agree that the groups within both tiers of the Partnership must be kept to a manageable size, despite the need to broadly include affected stakeholders.

Member Responsibilities

Commenters stated that the roles and responsibilities of members in both tiers of the Partnership should be fully and clearly defined prior to calling for member nominations. Specific responsibilities that were recommended by commenters included commitment to the Partnership charge, ability to volunteer time and resources to the effort, and willingness to publicly disclose interests.

Response. We agree that member roles and responsibilities should be defined before calling for member nominations and should be publicly vetted; therefore, we are posting proposed member responsibilities for member and public comment.

Operational Issues

Operating Procedures

Commenters recommended that a strong set of operating procedures and rules of order be adopted for the Partnership and that the procedures be made available for public comment. Some of the specific operating procedures recommended by commenters include those discussed below under transparency/conflict of interest, NQF role, evaluation, and support for evidence-based decision making.

Response. We agree that the Partnership's operating procedures should be clearly defined and subject to public comment; therefore, we are posting proposed operating procedures for member and public comment.

Transparency/Conflict of Interest

Commenters stressed the need for transparency and open disclosure of interests by Partnership members. Commenters asked for open meetings, public posting of materials, written rationale for recommendations, and opportunity for public comment on recommendations.

Response. We agree that the activities of the Partnership must be fully transparent and free of conflict of interest; therefore, we are posting for member and public comment proposed operating procedures and member responsibilities containing elements meant to assure transparency and public disclosure of interests.

NQF Role

Commenters asked for clarification regarding the NQF role in convening the Partnership, given NQF's status as an HHS contractor, convener of the National Priorities Partnership (NPP), quality measure endorser, and member of several quality alliances. Specifically, what is the role of the NQF Board with the Partnership; how will the Partnership interface with the NPP; and what is the relationship between NQF's Consensus Development Process for measure endorsement and the Partnership? One commenter recommended that the Partnership's recommendations be independent of the NQF Board. Another commenter recommended that the Partnership's strategy be coordinated with the work of the NPP.

Response. Given its status as HHS contractor, convener of the NPP, measure endorser, and member of several quality alliances, NQF is uniquely situated to convene the Partnership and support its activities. The role of the NQF Board is to define the Partnership charge; establish structures and processes; appoint its members and leaders; and maintain fiduciary oversight of the resources allocated to Partnership activities. The Board will field issues of concern raised regarding the integrity of the Partnership's processes. The Board will not ratify or approve the recommendations of the Partnership, rather the Partnership will make recommendations directly to HHS/CMS. It is expected that the National Priorities and Goals defined by the NPP will inform the Partnership's strategy and activities. It is also expected that the Partnership will recommend the selection of NQF-endorsed measures. Where NQF-endorsed measures are not available, the Partnership will communicate with measure developers and NQF to promote the availability of endorsed measures needed for public reporting and payment programs. NQF will be a member of the Partnership, but, in its role as neutral convener, will be non-voting.

Support for Evidence-Based Decision Making

Commenters highlighted the need for explicit decision-making criteria for measure selection that align with the Secretary's national strategy. One commenter recommended that the Partnership have the flexibility to make conditional recommendations contingent on the resolution of challenges associated with the implementation of certain measures. Commenters advocated for an assessment of the strength of evidence, testing results, and potential adverse consequences for measures being considered for selection. Commenters also suggested specific criteria to ensure the importance, usability, and feasibility of measures selected.

Commenters agreed that both in-depth and quick turnaround analyses must be available to provide support for evidence-based decision making and to protect from politicized decisions. One commenter suggested that large data bases be leveraged to inform the selection of measures. Another commenter asked for clarification of the types of organizations that might provide analytical support and criteria for their selection.

Response. We agree that consistently applying clear criteria for the selection of measures and analytical support for evidence-based decision making are essential to the success of the Partnership. We anticipate that defining and adopting criteria for the selection of measures will be among the initial activities of the Partnership.

NQF will be engaging subcontractors to provide in-depth and quick turnaround analytic support. Engagement of subcontractors will be governed by NQF's procurement policies, which follow appropriate Federal contracting requirements to ensure that the process is open to all qualified entities and is free of conflicts of interest.

Evaluation

Commenters emphasized the importance of an independent evaluation process to determine what modifications of Partnership structures and processes over time might be necessary for continuous improvement. Commenters also requested that a formal complaint process be established. Commenters suggested specific criteria for evaluation, including success in appointing a diverse body of stakeholders, optimized resource utilization, minimal duplication with existing efforts, provision of recommendations that are accurate and representative of stakeholder interests, and ongoing progress in improving the health of the country.

Response. We agree that evaluation is important for promoting continuous improvement. The Partnership will provide an annual report on its progress to the NQF Board and that report will be posted for public comment. The Board will have the option of commissioning an independent external evaluation of the Partnership every three years.

A formal complaint process will be established. Issues of concern regarding a substantive recommendation of the Partnership will be resolved by the Partnership; issues of concern regarding the integrity of the Partnership's processes will be resolved by the NQF Board.