NATIONAL QUALITY FORUM

Measure Applications Partnership

MAP Member Guidebook for the NQF Measure Selection Process

October 1, 2015

Contents

I. The National Quality Forum

Who is NQF?

The National Quality Forum (NQF), established in 1999, is a nonprofit, nonpartisan, membership-based organization that is recognized and funded in part by Congress and entrusted with an important public service responsibility: NQF brings together various public- and private-sector organizations to reach consensus on how to measure quality in healthcare to make it better, safer, and more affordable.

NQF was created by a coalition of public- and private-sector leaders in response to the recommendation of the *Advisory Commission on Consumer Protection and Quality in the Health Care Industry*. In its final report, published in 1998, the commission concluded that an organization like NQF was needed to promote and ensure patient protections and healthcare quality through measurement and public reporting.

Who is involved at NQF?

NQF has 430 organizational members who give generously of their time and expertise. In 2014, more than 883 individuals volunteered on more than 46 NQF-convened committees, working groups, and partnerships. The NQF Board of Directors governs the organization and is composed of key public- and private-sector leaders who represent major stakeholders in America's healthcare system. Consumers and those who purchase healthcare hold a simple majority of the at-large seats.

Member organizations of NQF have the opportunity to take part in a national dialogue about how to measure healthcare quality and publicly report the findings. Members participate in NQF through one of eight Member Councils:

- Consumer Council
- Health Plan Council
- Health Professionals Council
- Provider Organizations Council
- Public/Community Health Agency Council
- Purchasers Council
- Quality Measurement, Research, and Improvement Council
- Supplier and Industry Council

Each of these councils provides unique experiences and views on healthcare quality that are vital to building broad consensus on improving the quality of healthcare in America. Together, NQF members promote a common approach to measuring and reporting healthcare quality and fostering system-wide improvements in patient safety and healthcare quality. NQF's membership spans all those interested in healthcare. Consumers and others who purchase healthcare sit side-by-side with those who provide care and others in the healthcare industry. Expert volunteers and members are the backbone of NQF work.

What does NQF do?

In 2002, working with all major healthcare stakeholders, NQF endorsed its first voluntary, national consensus performance measures to answer the call for standardized measurement of healthcare services. Over the years, NQF has assembled a portfolio of more than 600 NQF-endorsed measures—most of which are in use by both private and public sectors—and an enormous body of knowledge about measure development, use, and performance improvement. NQF plays a key role in shaping our national health and healthcare improvement priorities, including the National Quality Strategy, through its convening of the National Quality Partners. NQF also provides public input to the federal government and the private sector on optimal, aligned measure use via its convening of the Measure Applications Partnership.

NQF reviews, endorses, and recommends use of standardized healthcare performance measures. Performance measures are essential tools used to evaluate how well healthcare services are being delivered. NQF's endorsed measures often are invisible at the clinical bedside, but quietly influence the care delivered to millions of patients every day. Performance measures can:

- make our healthcare system more information rich;
- point to actions that physicians, other clinicians, and organizations can take to make healthcare safe and equitable;
- enhance transparency around quality and cost of healthcare;
- ensure accountability of healthcare providers; and
- generate data that helps consumers make informed choices about their care.

Working with members and the public, NQF also helps define our national healthcare improvement 'to-do' list, and encourages action and collaboration to accomplish performance improvement goals.

Who benefits from this work?

Standardized healthcare performance measures help clinicians and other healthcare providers understand whether the care they provided their patients was optimal and appropriate, and if not, where to focus their efforts to improve the care they deliver. Measures are also used by all types of public and private payers for a variety of accountability purposes, including public reporting and pay-for-performance. Measures are an essential part of making quality and cost of healthcare more transparent to all, importantly for those who receive care or help make care decisions for loved ones. Use of standardized healthcare performance measures allows for comparison across clinicians, hospitals, health plans, and other providers.

Where do I find NQF-endorsed measures?

The Quality Positioning System (QPS) is a web-based tool that helps you find NQF-endorsed measures. Search by measure title or number, as well as by condition, care setting, or measure steward. Driven by feedback from users, QPS 2.0 now allows users to search for measures by their inclusion in federal reporting and payment programs; to provide feedback any time about the use and usefulness of measures; and to view measures that are no longer NQF-endorsed. QPS can also be used to learn from

other measure users about how they select and implement measures in their performance improvement programs. The QPS may be accessed online.

Where do I find more information about NQF?

The Field Guide to NQF Resources is a dynamic, online resource to help those involved with measurement and public reporting to access basic information and NQF resources related to performance measurement.

Glossary of Terms

A comprehensive glossary of terms used in NQF activities as well as performance measurement and quality improvement in general can be found on the NQF website. You may also find the NQF Phrasebook to be a useful quick reference to understanding measurement jargon.

II. Measure Applications Partnership (MAP) Overview

What is the role of MAP?

The Measure Applications Partnership (MAP) is a public-private partnership convened by NQF. MAP was created to provide input to the Department of Health and Human Services (HHS) on the selection of performance measures for public reporting and performance-based payment programs. NQF was selected by HHS to fulfill a statutory requirement to convene multistakeholder groups to:

- identify the best available performance measures for use in specific applications;
- provide input to HHS on measures for use in public reporting, performance-based payment, and other programs; and
- encourage alignment of public- and private-sector performance measurement efforts.

In convening MAP, NQF brings together stakeholder groups in a unique collaboration that balances the interests of consumers, businesses and purchasers, labor, health plans, clinicians and providers, communities and states, and suppliers.

What are the objectives of MAP?

In pursuit of the NQS, MAP informs the selection of performance measures to achieve the goal of improvement, transparency, and value for all. With that, the specified objectives of this partnership are to:

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

When MAP reviews performance measures, MAP prioritizes the selection of NQF-endorsed measures for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective. NQF-endorsed measures have undergone a rigorous multistakeholder evaluation to ensure that they address aspects of care that are important and feasible to measure, provide consistent and credible information, and can be used for quality improvement and decisionmaking.

III. NQF Measure Endorsement

According to the Institute of Medicine (IOM) definition, a performance measure is the "numeric quantification of healthcare quality." IOM defines quality as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." Thus, performance measures can quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the provision of high-quality care.

Performance measures are widely used throughout the healthcare arena for a variety of purposes. Not all measures are suitable for NQF's dual purpose of accountability (including public reporting) and performance improvement. NQF does not endorse measures intended only for internal quality improvement.

NQF's ABCs of Measurement brochure describes various aspects of performance measurement:

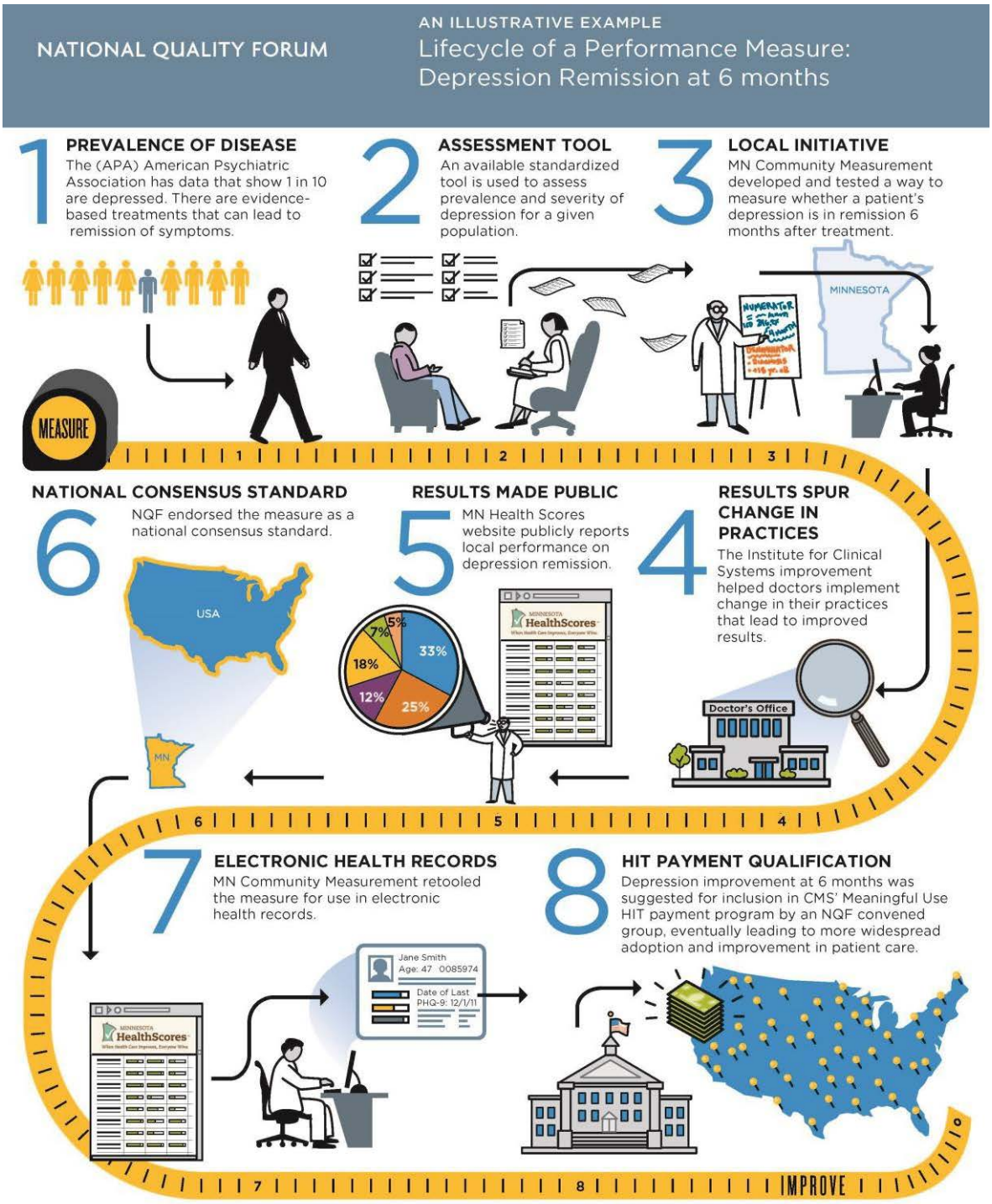
- The Difference a Good Measure Can Make
- Choosing What to Measure
- The Right Tools for the Job
- Patient-Centered Measures = Patient-Centered Results
- What NQF Endorsement Means
- How Endorsement Happens
- How Measures Can Work: Safety
- How Measures Will Serve Our Future
- What You Can Do

How does NQF endorse measures?

NQF uses a formal Consensus Development Process (CDP) to evaluate and endorse consensus standards, including performance measures, best practices, frameworks, and reporting guidelines. The CDP is designed to call for input and carefully consider the interests of stakeholder groups from across the healthcare industry. NQF's Consensus Development Process involves eight principal steps. Each contains several substeps and is associated with specific actions. Because NQF uses this formal process, it is recognized as a voluntary consensus standards-setting organization as defined by the National Technology Transfer and Advancement Act of1995 and Office of Management and Budget Circular A-119.

The CDP plays an integral role in helping the Measure Applications Partnership assess the suitability of measures for use in various programs. The results of evaluation for endorsement inform MAP's decisions about measures' implementation in federal programs. For example, if a measure has been reviewed for endorsement through the CDP but failed to gain endorsement, MAP might be cautious in recommending it be used in a high-stakes federal program. Conversely, if a measure is NQF-endorsed, MAP can advise its use in a program with high confidence in its scientific properties.

The infographic below illustrates the lifecycle of a performance measure from start to finish, including NQF's role in the process. MAP's role in measure selection is described in step 8. Endorsed measures are often recommended by MAP for use in federal quality measurement programs.


NATIONAL QUALITY FORUM
AN ILLUSTRATIVE EXAMPLE
Lifecycle of a Performance Measure: Depression Remission at 6 months
1 PREVALENCE OF DISEASE
The (APA) American Psychiatric Association has data that show 1 in 10 are depressed. There are evidence-based treatments that can lead to remission of symptoms.
2 ASSESSMENT TOOL
An available standardized tool is used to assess prevalence and severity of depression for a given population.
3 LOCAL INITIATIVE
MN Community Measurement developed and tested a way to measure whether a patient's depression is in remission 6 months after treatment.
MEASURE
MINNESOTA
NUMERATOR
1 2 3
NATIONAL CONSENSUS STANDARD
6
NQF endorsed the measure as a national consensus standard.
USA
MN
RESULTS MADE PUBLIC
5
MN Health Scores website publicly reports local performance on depression remission.
5%
7%
33%
18%
12%
25%
MINNESOTA HealthScores
RESULTS SPUR CHANGE IN PRACTICES
4
The Institute for Clinical Systems improvement helped doctors implement change in their practices that lead to improved results.
Doctor's Office
6 5 4
7 ELECTRONIC HEALTH RECORDS
MN Community Measurement retooled the measure for use in electronic health records.
Jane Smith
Age: 47 0085974
Date of Last PHQ-9: 12/1/11
MINNESOTA HealthScores
8 HIT PAYMENT QUALIFICATION
Depression improvement at 6 months was suggested for inclusion in CMS' Meaningful Use HIT payment program by an NQF convened group, eventually leading to more widespread adoption and improvement in patient care.
7 8 IMPROVE

IV. The Evolving Performance Measurement Landscape

MAP focuses its activities on the selection of high-quality measures that optimally address the National Quality Strategy's three aims, fill critical measurement gaps, and increase alignment.

The National Quality Strategy (NQS)

The Department of Health and Human Services' (HHS) release of the first National Quality Strategy (NQS) in 2011 marked a significant step forward in the effort to align an extremely fragmented healthcare system. The NQS aims and goals set forth a unified vision of the healthcare system that was understandable and applicable to all stakeholders at every level—local, state, and national.

The National Quality Strategy—heavily informed by the NQF-convened, private-public National Priorities Partnership—laid out a series of six priorities to focus the nation on the best ways to improve our health and healthcare rapidly. NQF has carefully aligned its work with these goals, utilizing them as a roadmap for much of its work.

The "triple aims" of the National Quality Strategy are used to guide and assess local, state, and national efforts to improve health and the quality of healthcare:

- **Better Care**: Improve the overall quality, by making healthcare more patient-centered, reliable, accessible, and safe.
- **Healthy People/Healthy Communities**: Improve the health of the U.S. population by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher-quality care.
- **Affordable Care**: Reduce the cost of quality healthcare for individuals, families, employers, and government.

To advance these aims, the National Quality Strategy focuses on six priorities:

- Making care safer by reducing harm caused in the delivery of care.
- Ensuring that each person and family is engaged as partners in their care.
- Promoting effective communication and coordination of care.
- Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
- Working with communities to promote wide use of best practices to enable healthy living.
- Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new healthcare delivery models.

THE PATH TO IMPROVEMENT BEGINS HERE

The National Strategy for Quality (NQS) Improvement in Health Care is a nationwide effort—involving providers, payers, purchasers, consumers, and measure developers—to align public and private interests to improve the quality of health and healthcare for all Americans. Development of the NQS was mandated by legislation and is guided by three aims that promise better, more affordable care, and better health for the nation.

Types of High-Priority Measures to Support NQS

For more than a decade the quality measurement enterprise— the many organizations focused on performance measurement to drive improvement in the quality and cost of healthcare provided in the United States—has rapidly grown to meet the needs of a diverse and demanding market place. As a result of greater experience with measurement, stakeholders have identified priorities for certain types of performance measures, described below. NQF's Standing Committees for measure endorsement are charged with reviewing measures to determine if they meet NQF's criteria to gain endorsement.

Outcome measures—Stakeholders are increasingly looking to outcome measures because the end results of care are what matter to everyone. Outcome measures assess rates of mortality, complications, and improvement in symptoms or functions. Outcome measures, including consumer experiences and patient- reported outcomes, seek to determine whether the desired results were achieved. Measuring performance on outcomes encourages a "systems approach" to providing and improving care.

Composite measures—Composite performance measures, which combine information on multiple individual performance measures into one single measure, are of increasing interest in healthcare performance measurement and public accountability applications. According to the Institute of Medicine, such measures can enhance the performance measurement enterprise and provide a potentially deeper view of the reliability of the care system.

Measures over an episode of care—To begin to define longitudinal performance metrics of individual-level outcomes, resource use, and key processes of care, NQF has endorsed a measurement framework for patient-focused episodes of care. This framework proposes a patient-centered approach to measurement that focuses on patient-level outcomes over time—soliciting feedback on patient and family experiences; assessing functional status and quality of life; ensuring treatment options are aligned with informed patient preferences; and using resources wisely.

Measures that address healthcare disparities—NQF has established a broader platform for addressing healthcare disparities and cultural competency by identifying a set of disparities-sensitive measures among the existing NQF portfolio of endorsed measures. These disparities-sensitive measures should be routinely stratified and reported by race/ethnicity and language. Additionally, the disparities-sensitive criteria were finalized and incorporated into a prospective approach for the assessment of disparities sensitivity for all new and maintenance measures submitted to NQF.

Measures that are harmonized—The current quality landscape contains a proliferation of measures, including some that could be considered duplicative or overlapping, while other measures evaluate the same concepts and/or patient populations somewhat differently. Such duplicative measures and/or those with similar but not identical specifications may increase data collection burden and create confusion or inaccuracy in interpreting performance results for those who implement and use performance measures. Recognizing that NQF can take on more of a facilitator role while accounting for the needs of measure developers, NQF has proposed a revised process to ensure that harmonization

and competing measures issues are adequately addressed and provide adequate time for measure developers to resolve questions.

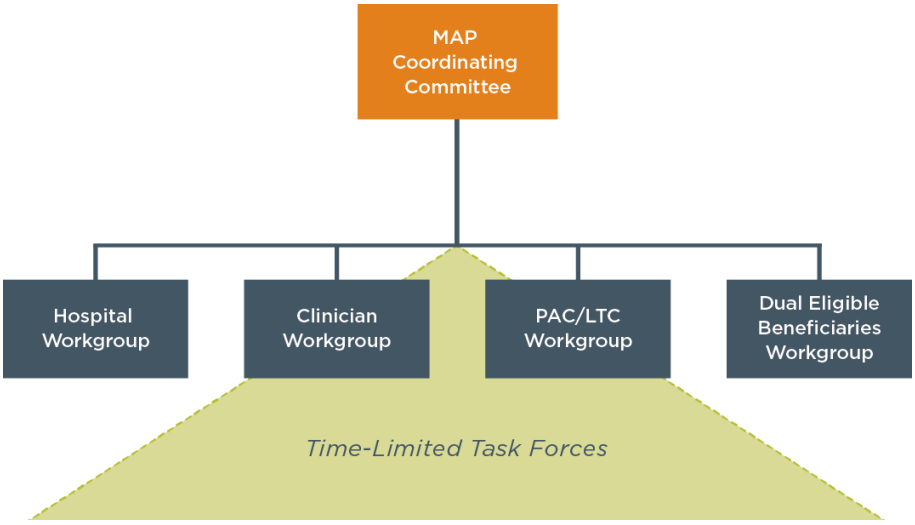
Measures for patients with multiple chronic conditions—Under the direction of the multistakeholder Multiple Chronic Conditions (MCCs) Committee, NQF has developed a person-centric measurement framework for individuals with MCCs. Specifically, this framework provides a definition for MCCs, identifies high-leverage domains for performance measurement, and offers guiding principles as a foundation for supporting the quality of care provided to individuals with MCCs.

eMeasures and Health Information Technology (HIT)—NQF is committed to improving healthcare quality through the use of health information technology (IT). Care can be safer, more affordable, and better coordinated when electronic health records (EHRs) and other clinical IT systems capture data needed to measure performance, and when that data are easily shared between IT systems. Our health IT initiatives— made up of several distinct yet related areas of focus— are designed to support an electronic environment based on these ideals; more importantly, these initiatives are designed to help clinicians improve patient care.

V. MAP Structure

How is MAP structured?

As depicted in the figure below, MAP comprises a governing body (the MAP Coordinating Committee), four workgroups, and task forces as needed to complete work on cross-cutting topics.



Coordinating Committee

The MAP Coordinating Committee serves as the governing body, which makes all final recommendations regarding the inclusion of measures in federal programs. MAP is currently operating under a three-year Strategic Plan to ensure the aims of the programs being considered are adequately represented and that the evaluation and selection of measures upholds the MAP objectives. The four workgroups and ad hoc task forces provide input to the MAP Coordinating Committee designed to offer in-depth analyses of the measures proposed for program use.

Hospital Workgroup

The Hospital Workgroup provides input to the Coordinating Committee on matters related to the selection and coordination of measures for hospitals, including inpatient acute, outpatient, cancer, and psychiatric hospitals. The Hospital Workgroup provides annual pre-rulemaking input on the following programs:

- Hospital Inpatient Quality Reporting
- Hospital Value-Based Purchasing
- Hospital Outpatient Quality Reporting
- Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs
- Prospective Payment System Exempt Cancer Hospital Quality Reporting
- Inpatient Psychiatric Facility Quality Reporting

- Hospital Readmission Reduction Program
- Hospital-Acquired Condition Reduction Program
- Ambulatory Surgical Center Quality Reporting
- End-Stage Renal Disease Quality Incentive Program

Clinician Workgroup

The Clinician Workgroup provides recommendations for coordinating clinician performance measurement across federal programs. This is achieved by ensuring the alignment of measures and data sources to reduce duplication and burden, identifying the characteristics of an ideal measure set to promote common goals across programs, and implementing standardized data elements. The Clinician Workgroup provides annual pre-rulemaking input on the following programs:

- Merit-Based Incentive Payment System (MIPS)
    - Physician Feedback/Value-Based Payment Modifier
    - Physician Quality Reporting System
    - Medicare and Medicaid EHR Incentive Program for Eligible Professionals
- Medicare Shared Savings Program
- Physician Compare

Post-Acute Care/Long-Term Care (PAC/LTC) Workgroup

The PAC/LTC Workgroup reviews measures for post-acute and long-term care programs. Its aim is to establish performance measurement alignment across PAC/LTC settings while emphasizing that alignment must be balanced with consideration for the heterogeneity of patient needs across settings. This is achieved by acknowledging the distinct types of care and levels of care across post-acute care and long-term care settings and identifying measures that can address these types and levels of care, while also taking into account the multiple provider types with varying payment structures (particularly differing requirements between Medicare and Medicaid). The workgroup also strives to standardize measure concepts across these settings, recognizing the need for measures to address the unique qualities of each setting. The PAC/LTC Workgroup provides annual pre-rulemaking input on the following programs:

- Home Health Quality Reporting
- Nursing Home Quality Initiative and Nursing Home Compare
- Inpatient Rehabilitation Facility Quality Reporting
- Long-Term Care Hospital Quality Reporting
- Hospice Quality Reporting

Dual Eligible Beneficiaries Workgroup

The MAP Dual Eligible Beneficiaries Workgroup makes recommendations to HHS on issues related to the quality of care for Medicare/Medicaid dual eligible beneficiaries. The workgroup is currently addressing measurement topics relevant to vulnerable individuals including quality of life, shared decisionmaking, and functional outcomes. Liaisons from the Dual Eligible Beneficiaries Workgroup join each of the setting-specific workgroups during the annual pre-rulemaking process to identify opportunities to improve measure alignment across programs for vulnerable populations, including dual eligible beneficiaries.

MAP Task Forces

To better identify measures to advance National Quality Strategy (NQS) priorities, MAP has convened a set of time-limited task forces drawn from current MAP membership. Each task force is chaired by a member of the MAP Coordinating Committee and comprises members of each of MAP's permanent groups.

Current Task Forces include the Medicaid Adult Task Force and the Medicaid Child Task Force to review measures in the Medicaid Adult Core Set and Medicaid/CHIP Children's Core Set, respectively. Completed task forces include the Health Insurance Exchange Task Force, the Measure Selection Criteria and Impact Task Force, and the Strategy Task Force. Three other completed task forces created families of aligned measures for the topics of Affordability, Person- and Family-Centered Care, and Population Health.

VI. MAP Membership

NQF continually strives to improve its measure selection process so as to remain responsive to its stakeholders' needs. Volunteer, multistakeholder committees are the central component to this process, and the success of NQF's MAP work is due in large part to the participation of its members.

Composition of MAP Coordinating Committee and Workgroups

Each MAP group represents a variety of stakeholders, including consumers, purchasers, providers, health professionals, health plans, suppliers and industry, community and public health, and healthcare quality experts. Because NQF attempts to represent a diversity of stakeholder perspectives on committees, a limited number of individuals from each of these stakeholder groups can be seated.

MAP includes organizational members, individual subject-matter experts, and nonvoting federal liaisons. Organizational members represent the views of their entire constituency. Individual subject-matter experts represent themselves. Only organizational members may send a substitute to a MAP meeting to represent their perspective, provided that the substitute is identified in advance. All MAP members are encouraged to engage colleagues and solicit input from their stakeholder networks throughout the process.

MAP Member Terms

MAP members are appointed for three-year terms, with approximately one-third of the members eligible for reappointment or turnover each year. There are no term limits for MAP at this time.

MAP Expectations and Time Commitment

Participation in MAP requires a significant time commitment. Over the course of the member's term, several in-person meetings, web meetings, and teleconferences will be scheduled. MAP participation includes many activities:

- Review meeting materials prior to each scheduled web or in-person meeting
- Participate in an annual web meeting to begin the pre-rulemaking cycle
- Attend scheduled in-person meetings of a workgroup or Coordinating Committee (1-2 annually, for 2 full days in Washington, DC)
- Participate in additional calls or web meetings as necessary
- Complete all surveys, pre-meeting assignments, and evaluations
- Consider serving on a MAP Task Force when invited

If a member has poor attendance or participation, the NQF staff will contact the member asking if he/she would like to forego their MAP membership. Organizations may replace their representatives on MAP as they choose in order to ensure consistent participation. The total length of the organization's term would not change. If individual subject matter experts are unable to fulfill their terms (for any reason), their seats would be removed during the annual nominations process and potentially given to other experts. An incoming expert would serve a full three-year term.

MAP Member Disclosure of Interest

Per the NQF Disclosure of Interest Policy for MAP, each nominee will be asked to complete a general disclosure of interest (DOI) form prior to being seated. The DOI form for each nominee is reviewed in the context of the programmatic areas in which MAP will be reviewing measures. Disclosures must be updated a minimum of annually.

MAP Nomination Requirements

MAP's membership is recalibrated annually. The MAP Coordinating Committee and workgroup members have staggered terms, with approximately one-third of the combined organizational and subject matter expert seats up for consideration each year. To strengthen the pool of nominees, NQF staff broadly publicizes nominations, MAP membership, and NQF membership when the annual nominations process is open. In addition, staff will contact MAP members whose terms are expiring to explore interest in reappointment, but reappointment is not guaranteed.

To be considered for appointment to MAP, one must submit the following information:

- A completed online nomination form, including:
  - A brief statement of interest
  - A brief description of nominee expertise highlighting experience relevant to the committee
  - A short biography (maximum 100 words), highlighting experience/knowledge relevant to the expertise described above and involvement in candidate measure development
  - Curriculum vitae or list of relevant experience (e.g., publications) *up to 20 pages*
- A completed electronic disclosure of interest form. This will be requested upon your submission of the nominations form for Committees actively seeking nominees
- Confirmation of availability to participate in currently scheduled calls and meeting dates

Materials should be submitted through the NQF website. Self-nominations are welcome. Third-party nominations must indicate that the organization or individual has been contacted and is willing to serve. NQF's principles of transparency require a public call for nominations and the opportunity for the public to comment on the members selected for the multistakeholder groups.

MAP Member Responsibilities

- Strong commitment to advancing the performance measurement and accountability purposes of MAP.
- Willingness to work collaboratively with other MAP members, respect differing views, and reach agreement on recommendations. Input should not be limited to specific interests, though sharing of interests is expected. Impact of decisions on all healthcare populations should be considered. Input should be analysis and solution-oriented— not reactionary.

- Ability to volunteer time and expertise as necessary to accomplish the work of MAP, including meeting preparation, attendance and active participation at meetings, completion of assignments, and service on task forces and ad hoc groups.
- Organizational MAP members will be responsible for identifying an individual to represent them.
- Commitment to attending meetings. Organizational representatives may request to send a substitute in exceptional circumstances and with advance notice; individual subject matter members will not be allowed to send substitutes to meetings.
- At the beginning of the pre-rulemaking cycle, NQF staff will contact each organizational member's leadership and ask the organization to designate potential substitutes for the pre-rulemaking cycle.
- Proxy voting, in which an organizational member votes on behalf of another organizational member, is not allowed under any circumstances. This is different from substitutes, in which the organization designates a different representative to represent its views at a particular meeting.
- If an organizational representative is repeatedly absent, the chair may ask the organization to designate a different representative.
- Demonstration of respect for the MAP decision-making process by not making public statements about issues under consideration until MAP has completed its deliberations.
- Acceptance of NQF's conflict of interest policy. Members will be required to publicly disclose their interests and any changes in their interests over time.

Role of the Co-Chairs

Two Coordinating Committee members are selected to serve as co-chairs. Each workgroup and task force is also led by two co-chairs. The co-chairs' responsibilities are to:

- facilitate MAP meetings and teleconferences;
- work with NQF staff to achieve the goals of the project;
- assist NQF staff in anticipating questions and identifying additional information that may be useful to the Workgroup and/or Coordinating Committee during deliberations;
- participate as full voting members of MAP; and
- For workgroup chairs, representing the perspective of the entire workgroup at Coordinating Committee meetings or teleconferences.

Guidelines for Participation in MAP Meetings

The following principles apply to all MAP meetings:

- **Disclosure of Interests** – Once a year, at the start of the pre-rulemaking process or other initiative, each MAP member is asked to disclose any potential conflicts of interest as identified on submitted Disclosure of Interest forms.

- **Open attendance** – Web and in-person meetings are open to the public. Participants can join the meeting in person at the NQF offices or remotely via web streaming and/or phone. Information about each meeting is available on the NQF website, including the meeting's agenda and materials.
- **Transparency** –All proceedings are recorded and transcribed. Recordings and/or summaries are posted on NQF's website.
- **Commenting** – NQF members and the public are provided opportunities to comment at designated times during the meeting.
- **Mutual respect** – As a multistakeholder group, MAP brings together varied perspectives, values, and priorities to the discussion. Respect for differences of opinion and collegial interactions with other MAP members and participants are critical. Members must avoid dominating a conversation and allow others to contribute their perspectives.
- **Efficiency in deliberations** – Meeting agendas are typically full. All MAP members are responsible for ensuring that the work of the meeting is completed during the time allotted. MAP members should be prepared for discussion, having reviewed the material before the meeting. Comments should be concise, focused, and relevant to the matter at hand. Members should remember to indicate agreement without repeating what has already been said.

SharePoint Site

- MAP members will receive the access link and password for the project SharePoint site.
- All project documents will be housed on SharePoint to provide ready access for all members.
- If you have difficulty accessing the SharePoint site, please contact the NQF project staff.

VII. MAP's Annual Pre-Rulemaking Review of Measures Under Consideration

Overview

During the pre-rulemaking review cycle, the federal government looks to MAP, a public-private partnership convened by NQF, to advise on the selection of measures for CMS quality initiative programs. Under statute, HHS is required to publish annually a list of measures under consideration for future federal rulemaking and to consider MAP's recommendations about the measures during the rulemaking process. The annual pre-rulemaking process affords MAP the opportunity to review the measures under consideration for federal rulemaking and provide upstream input to HHS in a global and strategic manner. Over the course of the review process, MAP promotes alignment across HHS programs and with private sector efforts, incorporates measure use and performance information into MAP decision-making, and provides specific recommendations about the best use of available measures and filling measure gaps.

Measures Under Consideration by HHS

Each year, HHS releases a list of measures being considered for use in a range of federal public-reporting, performance-based payment, and other programs. This list must be made available by December 1 annually. It is commonly abbreviated as the MUC list, short for "measures under consideration." The list of measures forms the basis of MAP's pre-rulemaking review.

Approach

MAP revised its approach to pre-rulemaking deliberations for 2015/2016. The approach to the analysis and selection of measures is a three-step process.

1. **Develop Program Measure Set Framework**. Using CMS critical program objectives and NQF measure selection criteria, NQF staff will develop a framework for each program measure set in order to organize each program's finalized measure set. These frameworks will be used to better understand the current measures in the program as well as how well any new measures might fit into the program by allowing workgroup members to quickly and visually identify gaps and other areas of needs.
2. **Evaluate measures under consideration for what they would add to the program measure sets**. MAP uses the Measure Selection Criteria and a defined decision algorithm to determine whether the measures under consideration will enhance the program measure sets. Staff perform a preliminary analysis based on the algorithm, and MAP workgroups discuss their recommendations for each measure under consideration during December in-person meetings.
3. **Identify and prioritize gaps for programs and settings.** MAP continues to identify gaps in measures within each program and provide measure ideas to spur development. MAP also considers the gaps across settings, prioritizing by importance and feasibility of addressing the gap when possible.

MAP's Standard Decision Categories

MAP reaches a decision about every measure under consideration. The decisions are standardized for consistency. Each decision is accompanied by one or more statements of rationale that explain why each decision was reached. The table below provides the decision categories and sample rationales used for each category.

MAP Decision Categories and Example Rationales

MAP Decision Category	Rationale (Examples)
Support	• Addresses a previously identified measure gap • Core measure not currently included in the program measure set • Promotes alignment across programs and settings
Conditional Support	• Not ready for implementation; should be submitted for and receive NQF endorsement • Not ready for implementation; measure needs further experience or testing before being used in the program.
Do Not Support	• Overlaps with a previously finalized measure • A different NQF-endorsed measure better addresses the needs of the program.
Encourage continued development	• Addresses a critical program objective, and the measure is in an earlier stage of development. • Promotes alignment, and the measure is in an earlier stage of development
Do not encourage further consideration	• Overlaps with finalized measure for the program, and the measure is in an earlier stage of development. • Does not address a critical objective for the program, and the measure is in an earlier stage of development.
Insufficient Information	• Measure numerator/denominator not provided

VIII. The MAP Measure Selection Process

MAP Measure Selection Criteria

The Measure Selection Criteria (MSC) are intended to assist MAP with identifying characteristics that are associated with ideal measure sets used for public reporting and payment programs. The MSC are not absolute rules; rather, they are meant to provide general guidance on measure selection decisions and to complement program-specific statutory and regulatory requirements. Central focus should be on the selection of high-quality measures that optimally address the National Quality Strategy's three aims, fill critical measurement gaps, and increase alignment. Although competing priorities often need to be weighed against one another, the MSC can be used as a reference when evaluating the relative strengths and weaknesses of a program measure set, and how the addition of an individual measure would contribute to the set. The MSC have evolved over time to reflect the input of a wide variety of stakeholders.

To determine whether a measure should be considered for a specified program, the MAP evaluates the measures under consideration against the MSC. MAP members are expected to familiarize themselves with the criteria and use them to indicate their support for a measure under consideration.

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

Subcriterion 1.1 Measures that are not NQF-endorsed should be submitted for endorsement if selected to meet a specific program need

Subcriterion 1.2 Measures that have had endorsement removed or have been submitted for endorsement and were not endorsed should be removed from programs

Subcriterion 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:

Subcriterion 2.1 Better care, demonstrated by patient- and family-centeredness, care coordination, safety, and effective treatment

Subcriterion 2.2 Healthy people/healthy communities, demonstrated by prevention and well-being

Subcriterion 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

Subcriterion 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)

Subcriterion 3.2 Measure sets for public reporting programs should be meaningful for consumers and purchasers

Subcriterion 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)

Subcriterion 3.4 Avoid selection of measures that are likely to create significant adverse consequences when used in a specific program

Subcriterion 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

Subcriterion 4.1 In general, preference should be given to measure types that address specific program needs

Subcriterion 4.2 Public reporting program measure sets should emphasize outcomes that matter to patients, including patient- and caregiver-reported outcomes

Subcriterion 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

Subcriterion 5.1 Measure set addresses patient/family/caregiver experience, including aspects of communication and care coordination

Subcriterion 5.2 Measure set addresses shared decision-making, such as for care and service planning and establishing advance directives

Subcriterion 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).

Subcriterion 6.1 Program measure set includes measures that directly assess healthcare disparities (e.g., interpreter services)

Subcriterion 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.

Subcriterion 7.1 Program measure set demonstrates efficiency (i.e., minimum number of measures and the least burdensome measures that achieve program goals)

Subcriterion 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)

Using MAP's Families of Measures to Promote Alignment Across Programs

As a primary tactic to achieve alignment of performance measurement, MAP has identified families of measures—sets of related available measures and measure gaps that span programs, care settings, levels of analysis, and populations for specific topic areas related to the National Quality Strategy (NQS) priorities and high-impact conditions. MAP uses the families of measures to guide its pre-rulemaking recommendations on the selection of measure sets for specific federal programs. MAP has developed 10 families of measures to address all of the NQS priorities as well as specific populations, including cardiovascular disease, diabetes, care coordination, patient safety, affordability, population health, person- and family-centered care, dual eligible beneficiaries, hospice and palliative care, and cancer care.

In doing so, MAP determined that:

- Measures need to be aligned with important concept areas, such as the aims of the National Quality Strategy, which will promote broad improvement across the health system.
- Families of measures provide a tool that stakeholders can use to identify the most relevant available measures for particular measurement needs, promote alignment by highlighting important measurement categories, and can be applied by other measurement initiatives.
- Although families include important current measures, the deliberations also found that there are not sufficient measures for assessing several priority areas, which highlights the need for further development of measures that matter in affordability, population health, and person- and family-centered care.

Families indicate the highest priorities for measurement and best available measures within a particular topic, as well as critical measure gaps that must be filled to enable a more complete assessment of quality. Setting- and level-of-analysis-specific core sets drawn from the families serve as an initial

starting place for evaluation of program measure sets, identifying measures that should be added to the program measure set or measures that should replace previously finalized measures in the program measure set. The following graphic depicts the process MAP used to develop its most recent families of measures.

Process for Developing a MAP Family of Measures

1) **Scan universe of measures:** NQF-endorsed portfolio of measures, measures used in federal programs (current and previous measures under consideration), and other public-private sector programs (e.g., Million Hearts, eValue8, IHA).
2) **Identify measures for high-leverage opportunities:** Staff identified potential measures for the families based on the task forces' discussions about high-leverage opportunities for the different measurement areas.
3) **Undergo initial staff review:** Staff used the MAP Measure Selection Criteria as a guide for selecting measures. Staff focused on measures that span the patient-focused episode of care and, when appropriate, used the Institute of Medicine's overarching criteria for choosing clinical priority areas (i.e., Impact, Improvability, Inclusiveness).
4) **Conduct initial task force review:** The task forces reviewed the staff measure suggestions through an online survey.
5) **Hold in-person task force meetings:** During in-person meetings, the task forces met to identify measures for inclusion in the family as well as measurement gaps, methodological challenges and data availability, and implementation issues. The task forces focused on whether the families addressed relevant care settings, populations, and levels of analysis; how to align or

harmonize measures where possible; providing appropriate types of measures (outcome, process, and structure); and encouraging parsimony.

Preliminary Analysis of Measures Under Consideration

To facilitate MAP's consent calendar voting process (described below), NQF staff conduct a preliminary analysis of each measure under consideration. The preliminary analysis is intended to provide MAP members with a succinct profile of each measure and to serve as a starting point for MAP discussions. Staff use an algorithm developed from the MAP Measure Selection Criteria to evaluate each measure in light of MAP's previous guidance. The preliminary analysis algorithm asks a series of questions about each measure under consideration:

1. **Does the MUC meet the Program Goals and Objectives?**

   Refer to *MAP MSC #3 "Program measure set is responsive to specific program goals and requirements"* and *CMS MUC Measure Selection Requirement (MSR) 2a "Measure is responsive to specific program goals and statutory requirements."*
   - Using the CMS 2015 Program Specific Measure Priorities and Needs document, determine how/whether the MUC addresses the program goals and objectives. Examples of the program summary with critical program objectives are included with the standard work templates.
   - How does the MUC address specific program objectives and measure requirements that are not already addressed by existing measures?
   - If the measure does not address a critical program objective, MUC to receive a **Do Not Support** for its preliminary analysis.

2. **Is this a high-value measure? High value measures –"measures that will drive the healthcare system to higher performance." Refer to *CMS MSR 2b "Measure addresses an important condition/topic with a performance gap and has a strong scientific evidence base to demonstrate that the measure when implemented can lead to desired outcomes and/or more affordable care."***

   MAP has identified the following measure types as high-value:
   - Outcome measures (e.g., mortality, adverse events, functional status, patient safety, complications, or intermediate outcomes, e.g., BP value, lab test value – not just the test is performed)
   - Patient –reported outcomes where the patient provides the data about their results of treatment, level of function and health status (NOT the clinician administering a tool/questionnaire for the patient to fill out – the measure must use the results of the information in the tool or questionnaire)
   - Measures addressing patient experience, care coordination, population health, quality of life or impact on equity. *MAP MSC # 5 and 6*
   - Appropriateness, overuse, efficiency and cost of care measures
   - Composite measures
   - Process measures close to outcomes with a strong evidence link.

3. **Does it fill a gap in the program measures set?**
   - Does it fill a gap in the MAP Families of measures?
   - Does it address a high priority domain identified by CMS that does not have adequate measures in the program set?

- If the measure does not fill a gap, MUC to receive a **Do Not Support** for its preliminary analysis.

4. Is the MUC fully specified?

CMS MSR 2e "Measure reporting is feasible and measures have been fully developed and tested. In essence, measures must be tested for reliability and validity."

- If the measure development status on the MUC list is "early development" or "field testing"; the MUC is not fully developed → Go to **"Measure Under Development" pathway**
- If the MUC is fully specified and tested, go to step 5.

5. Is the MUC tested for the appropriate setting and/or level of analysis for the program?

- If the measure is specified and tested for a different setting or level of analysis that is not appropriate for this program (e.g., a MUC for clinician programs that is specified/tested/endorsed at the health plan level only):
  - Hospital -→ **Do not support**
  - PAC/LTC: Could a hospital measures be used in the PAC/LTC setting or "tweaked" to use in the PAC/LTC setting? If yes, continue on to Step 4 but note that any support must be conditional on the measure being tested at the with PAC/LTCs before being used in a public reporting or payment program. If no, →**Do not support**
  - Clinician: Could the measure be used at the clinician level or "tweaked" to use at the clinician level? If yes, continue on to Step 4 but note that any support must be conditional on the measure being tested at the clinician level before being used in a public reporting or payment program. If no, →**Do not support**
    - Is the measure appropriate for clinician-level analysis?

6. Is the MUC currently in use? If not in use, go to Step 7.

- Determine if the MUC is currently in use in another federal program or in a private program. The MUC list generally indicates use in other programs.
- If in use, search out any information on measure performance.
  - Public reports
  - CMS or HHS reports (Impact report; National Quality Report, etc.)
  - Public reporting websites
  - Information from OPUS if measure has been submitted for endorsement.
  - Dry run data for some programs.
  - Search the web for info from the developers.
  - Search PubMed.
- If no performance data is identified, record "no data found".
- Look for any "red flags":
  - What is current performance? Is the measure performance close to 100%, i.e., is it topped out?
  - Is there a history of implementation challenges (e.g., data source issues)?

- Does the measure lead to misalignment (if information on specification is available)?
- Are there any known unintended consequences?
- Does the measure have a low selection rate amongst providers (for PQRS measures)?
  - PQRS utilization report.
- If no red flags, go to Step 7.

7. Does the MUC contribute to alignment and efficient use of measurement resources (burden and cost of measurement) *MAP MSC #2-7*:

- Is the measure used in other programs?
- Is this the best measure available (e.g. outcome measures are preferred over process measures)?
- Not duplicative of an existing measure BUT also consider whether the MUC is a better measure
  - If MUC is thought to be a better measure →**conditional support**; conditional on replacing the existing measure
- Captures the broadest population
- If the topic area already has outcome measures, is this process measure needed?
- Composite measures
- The burden of implementation should weigh the value of the measures for patients (e.g., implementing PROs may be burdensome but is extremely high value). Consider the cost-benefit balance.

- If the measure does not contribute to the efficient use of resources or support alignment across programs, MUC to receive a **Do Not Support** for its preliminary analysis. If yes, go to Step 8.

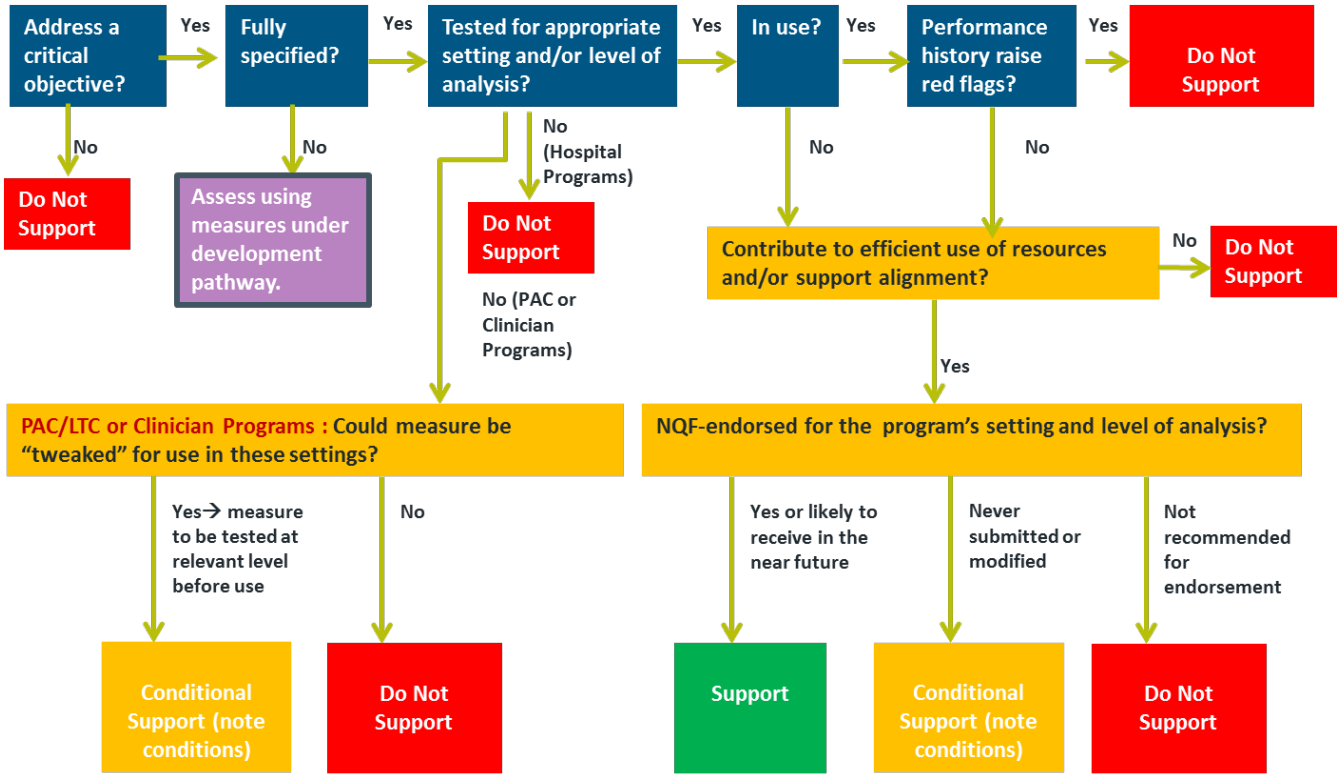
8. NQF endorsement status – *MAP MSC # 1 "NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective."*

- NQF-endorsed, or likely to receive NQF-endorsement in the near future at the level of analysis and for the setting in the program: MUC to receive a **Support** for its preliminary analysis
- Never submitted for NQF endorsement; OR
  failed initial endorsement submission but has since been modified to reflect NQF CDP Steering Committee feedback; OR a measure not specified at the clinician level that could be used at the clinician-level: → **Conditional Support** for its preliminary analysis. State condition that must be met and conditionally support MUC.
  i. Previous examples of conditions include, but are not limited to:
     1. Not ready for implementation; should be updated to reflect current guidelines.
     2. Not ready for implementation; data sources do not align with program's data sources.

3. Not ready for implementation; should be submitted for and receive NQF endorsement
4. The measure must be tested at the clinician level before being used in a public reporting or payment program.
5. Better measure to replace existing measure.

- Submitted for NQF endorsement, but not recommended by NQF CDP Steering Committee: MUC to receive a **Do Not Support** for its preliminary analysis.

The graphic below illustrates the MAP Preliminary Analysis Algorithm:



For measures that are earlier in development, MAP may not have the necessary information to answer all of the questions listed above. To encourage the development of innovative new measures, MAP will evaluate these measures using an abbreviated version of the algorithm. This is intended to provide CMS and measure developers with upstream information on the further development and potential applications for these measures. For measures still under development, the preliminary analysis algorithm asks:

1) Does the MUC meet CMS Program Goals and Objectives?
2) Is the MUC a high-value measure?
3) Does it fill a gap in the program measures set?
4) Is the MUC fully specified?
5) Does the MUC contribute to the efficient use of measurement resources (burden and cost of measurement)?

NQF Member and Public Comment Periods

One major priority of the improvement efforts was to ensure that there was broad input into the deliberations on measures. To encourage early input, NQF staff has formalized a process in which stakeholders can provide feedback on individual measures immediately after HHS provides the list of measures under consideration for the year. These public comments will be taken into account when MAP workgroups review the measures under consideration in December. Then, there will be another opportunity for public comment in which stakeholders can provide feedback on the individual workgroup decisions and broader measurement guidance for federal programs. These comments will be considered by the MAP Coordinating Committee when it approves the final decisions on measures and strategic input to the programs. Furthermore, during the workgroup and Coordinating Committee in-person meetings, the general public will have more frequent opportunities to comment. The public will now have an opportunity to comment on the *preliminary analysis* before each major discussion. In prior years, comments were generally made in the middle of the day and at the end of the day after decisions have already been made.

When a comment period opens, a notification is posted on the NQF website and will be available through the event calendar and on the specific project page. NQF also sends out an email notification to NQF members and members of the public who have signed up for these notifications. Both NQF members and interested members of the public can submit comments on the list of measures under consideration, individual workgroup decisions, and broader measurement guidance for federal programs. NQF members and nonmembers value the opportunity to weigh in on the deliberations, often offering constructive criticism, alternative viewpoints, or support for the Committee's recommendations. As part of NQF's commitment to transparency, all submitted comments will be posted on the NQF website, where anyone can review them.

Review of Measures Under Consideration During In-Person Meetings

MAP workgroups meet in person each December to evaluate measures under consideration and make recommendations about their potential use in federal programs. These recommendations are then reviewed by the MAP Coordinating Committee in January. In preparation for in-person meetings, MAP members received detailed materials, typically four to seven days before the meeting. Familiarizing oneself with the content prior to the meeting is critical.

Coordinating Committee Review

New to the 2015/2015 pre-rulemaking cycle, the MAP Coordinating Committee will be meeting prior to the in-person meetings of the MAP workgroups. This meeting in September will be focused on reviewing the preliminary analysis algorithm that will be used to evaluate measures under consideration by the workgroups. By reviewing the decision making framework used by the workgroups, the Coordinating Committee will provide strategic guidance on key issues, such as defining measure impact, the goals of alignment, and filling measure gaps. The Coordinating Committee will meet again after the winter in-person workgroup meetings to finalize MAP recommendations to HHS, and identify cross cutting themes across the workgroup deliberations.

IX. MAP Pre-Rulemaking Voting Procedure for Measures Under Consideration

Key Principles

The procedure described below is intended to allow MAP to move quickly through its decisionmaking process for straightforward and noncontroversial measures, reserving valuable discussion time for consensus-building on sensitive issues.

- MAP has established a consensus threshold of greater than 60 percent of participants.
  - Multiple stakeholder groups would need to agree to reach this threshold.
  - Abstentions do not count in the denominator.
- Every measure under consideration will be subject to a vote, either individually or as part of a slate of measures.
- Workgroups will be expected to reach a decision on every measure under consideration. There will no longer be a category of "split decisions" that would mean the Coordinating Committee decides on that measure. However, the Coordinating Committee may decide to continue discussion on a particularly important matter of program policy or strategy.
- Staff will provide an overview of the process for establishing consensus through voting at the start of each in-person meeting.
- After additional introductory presentations from staff and the chair to give context to each programmatic discussion, voting will begin.
- The in-person meeting Discussion Guide will organize content as follows:
  - Each workgroup's measures under consideration will be divided into a series of related groups for the purposes of discussion and voting. The groups are likely to be organized around programs (Hospital and PAC/LTC) or condition categories (Clinician).
  - Each measure under consideration will have been subject to a preliminary staff analysis based on a decision algorithm approved by the workgroups.
  - The discussion guide will note the result of the preliminary analysis (i.e., support, do not support, or conditional support) and provide rationale to support how that conclusion was reached.

Voting Procedure

- Step 1. Staff will review a Preliminary Analysis Consent Calendar
    - Staff will present the consent calendar reflecting the result of the preliminary analysis using MAP selection criteria and programmatic objectives
- Step 2. MUCs can be pulled from the Consent Calendar and become regular agenda items
    - The co-chairs will ask the Workgroup members to identify any MUCs they would like to pull off the consent calendar. Any Workgroup member can ask that one or more MUCs on the consent calendar be removed for individual discussion
    - Once all measures the Workgroup would like to discuss are removed from the consent calendar, the co-chair will ask if there is any objection to accepting the preliminary analysis and recommendation of the MUCs remaining on the consent calendar
    - If no objections are made for the remaining measures, the consent calendar and the associated recommendations will be accepted (no verbal vote will occur at this time)
- Step 3. Voting on Pulled Measures
    - Participant(s) who identified the need for discussion describe their perspective on the use of the measure and how it differs from the preliminary recommendation in the discussion guide.
    - Workgroup member(s) assigned as lead discussant(s) for the relevant group of measures will be asked to respond to the individual(s) who requested discussion. Lead discussant(s) should state their own point of view, whether or not it is in agreement with the preliminary recommendation or the divergent opinion.
    - Other workgroup members should participate in the discussion to make their opinions known. However, one should refrain from repeating points already presented by others in the interest of time.
    - After discussion of each MUC, the Workgroup will vote on the measure with three options:
        - Support
        - Support with conditions
        - Do not support

Tallying the votes:

- If a MUC receives > 60% for Support -- the recommendation is Support
- If a MUC receives > 60% for the SUM of Support and Conditional Support – the recommendation is Conditional Support
    - Staff will clarify and announce the conditions at the conclusion of the vote
- Otherwise the recommendation is “Do not support”
- Abstention should be discouraged and do not count in the denominator.

X. MAP Pre-Rulemaking Reports

When deliberating about specific measures, MAP identifies broader issues for each program, such as whether current metrics help the program achieve its goals, implementation challenges, and unintended consequences. By reviewing over 20 programs, MAP is also able to identify cross-cutting challenges and opportunities, such as opportunities for alignment across programs, areas for potential alignment between public and private programs, and progress in filling critical measurement gaps. This synthesis across programs is one of the ways in which MAP adds strategic value and captures the expertise of the multistakeholder group.

New Approach to MAP Deliverables

Prior to the 2014/2015 Pre-Rulemaking cycle, all MAP findings had been bundled into one final report, which included measure-by-measure analysis, strategic guidance for individual programs, and guidance on cross-cutting measurement challenges and opportunities. To address the challenge of producing such a large volume of information in a short time-frame, the final deliverables for the pre-rulemaking project will be separated into three distinct categories with different time frames. Separating the programmatic and individual measure analysis will make it easier for the report's readers to find the information most applicable to them. Staging their release also allows the reports to be more inclusive as it will provide longer commenting and review opportunities.

- *Stage 1: Recommendations on individual measures (February 1).* This deliverable, in spreadsheet format, would give feedback on each measure under consideration along with limited explanatory text. The spreadsheet will be standardized into a similar format as that produced in 2013/2014. This product would be released on February 1 to meet the statutory deadline.
- *Stage 2: Guidance for Hospital and PAC/LTC programs (February 15)*. This deliverable would include strategic guidance on the federal health programs focused on hospital and post-acute care/long-term care settings, as these programs generally have earlier timelines for proposed rules. This document will highlight the key strategic issues that programs for that setting should consider, such as whether current metrics address program goals, gaps in current program measures, ongoing measure implementation challenges, unintended consequences, strategies for improving alignment with other public and private programs, and filling critical gaps.
- *Stage 3: Guidance for clinician and special programs (March 15).* This deliverable would include strategic guidance on clinician programs and special programs, such as the Medicare Shared Savings Plan or the EHR incentive programs. The content and format would be similar to the stage 2 deliverable. In addition to the specific programmatic guidance, this document would cover cross-cutting issues that span federal health programs or cut across public and private programs, such as opportunities for alignment.