Report to Congress:

Annual Update: Identification of Quality Measurement Priorities and Associated Funding for the Consensus-Based Entity (currently the National Quality Forum) and Other Entities

United States Department of Health and Human Services

Centers for Medicare & Medicaid Services

(March 2020)

Executive Summary

The U.S. Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) are committed to leading the transition to a value-based health care system that is patient-focused, coordinated and cost effective. Value-based care improves the quality and effectiveness of care while lowering the cost of healthcare and making healthcare more affordable to consumers.

To drive that transition to value, CMS leads the design, development and refinement of quality measurement programs and initiatives. CMS measures health care quality in many areas including health outcomes, important clinical processes, patient safety, efficient use of resources, health care costs, care coordination, patient and consumer engagement, population and public health, and adherence to clinical guidelines. Systematic quality measurement provides valuable, transparent information to providers as well as to patients and consumers on the quality of care, and identifies what changes are needed to improve value. CMS' Meaningful Measures Initiative[i] unites strategic efforts to reduce the burden of quality measure reporting with a comprehensive approach to identify and adopt measures that are the most critical to providing high quality care and driving better patient outcomes at lower costs.

Specifically, CMS is actively working to encourage the use of parsimonious measure sets, develop more timely feedback reports on performance based on data, and to further prioritize more all-payer, patient-centric, population-based outcome measures. With the support of government contractors and federal stakeholders, CMS is prioritizing the development and use of electronic clinical quality measures, improved electronic infrastructure, harmonized measures across public and private quality reporting, and targeted efforts to address rural health concerns, health inequities, population health and patient reported outcomes.

In accordance with section 1890(e) of the Social Security Act (the Act), as added by section 50206(b) of the Bipartisan Budget Act of 2018 (BBA), this report provides the first annual update of the coordinated strategy and related funding for using the consensus-based entity (CBE) under contract with HHS—currently the National Quality Forum (NQF)—and other contractors that conduct activities pursuant to the quality and performance measurement provisions of sections 1890 and 1890A of the Act.

The information provided in this report reflects various task orders and activities that support the future direction of national quality measurement and includes an annual update regarding the obligated, expended and projected funding amounts for purposes of carrying out sections 1890 and 1890A of the Act. This Report to Congress addresses what has been accomplished with expended funds in the past calendar year, outlines the work that current and future funding supports and how it will advance CMS' quality goals, and provides an accounting of how funding correlates with the complexities of quality measurement methodologies and systems.

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[i] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment Instruments/QualityInitiativesGenInfo/MMF/General-info-Sub-Page.html

[ii] The initial report published in March 2019 was entitled, "Report to Congress: Identification of Quality Measurement Priorities – Strategic Plan, Initiatives, and Activities"

To briefly summarize, funding is used to support tasks in four broad categories of work (1) Duties of the Consensus-Based Entity (2) Dissemination of Quality Measures, (3) Program Assessment and Review, and (4) Program Oversight and Design. For example, in Category 1, with 2019 expended funds, NQF convened multi-stakeholder groups under the Measure Applications Partnership (MAP) to provide input to the Secretary on measures under consideration for use in Medicare value-based programs. Section III and Appendix B describe in more detail 2019 expended funds. NQF is a unique entity to lead quality initiatives, especially as they relate to quality measurement. NQF has a significant history of convening multi-stakeholder groups which represent voices from across the healthcare spectrum – from patients, to payers, to providers, and from hospitals, to ambulatory clinics and post-acute care. NQF is the leader of quality measure endorsement using both a Scientific Methods Panel and this multi-stakeholder consensus process. Because of these unique characteristics, NQF has a distinctive role in its work with CMS to advance the quality measurement agenda.

As a result of the work in 2019, CMS advanced understanding and efforts to increase measure alignment across programs and the health care system, reduce quality measure reporting burden, modernize public reporting of quality measure information and identify high priority measure gaps and best practices in quality measurement including unique concerns related to maternal morbidity and mortality, electronic health record data, rural communities, patient engagement, and care coordination. For example, the NQF Maternal Morbidity and Mortality Task Order will identify measures, as well as measures in development, that pertain to risk factors, prevalence, incidence, including those measures used by states to monitor and track maternal mortality and morbidity. Like other task orders, CMS will look broadly to better understand the pathways to different outcomes, opportunities for improvement and promising interventions to address maternal morbidity and potential distinct approaches to address maternal mortality. Throughout quality measurement and quality improvement work supported by NQF and other entities, CMS aims to eliminate disparities across facets of the healthcare system. In addition, the work described in this report will leverage the insights of clinical and quality measurement experts from academia, private sector, Federal and state governments, and patient advocates. For example, CMS will consider racial and ethnic disparities in maternal outcomes and will collaborate with a diverse group of stakeholders to inform the use of quality measures as a tool to reduce maternal morbidity and mortality.

Current and future funding for years 2020 and 2021 continue the work in the categories noted previously, since the nature of measures development is cyclical. NQF's work ensures that experts and stakeholders are active participants in CMS' continual efforts to improve healthcare quality and transition to value-based care. CMS is uniquely informed by these key health sector and national quality improvement leaders to develop frameworks, identify measure gap areas, and assess best practices that promote rewarding value and better patient outcomes while reducing burden on clinicians. The quality measurement work that NQF and other CMS contractors perform provides CMS with insight from diverse individuals, including providers, patients, and health plans, who have direct experience with the healthcare system. Their input provides CMS with the necessary context to integrate multiple public and private perspectives into actions, including the adoption of meaningful measures, that improve healthcare quality and patient safety, as well as inform decision making for patients, clinicians, and healthcare systems. Section IV discusses in detail the costs associated with specific quality measurement activities and deliverables to accomplish the quality goals as set out in this executive summary.

Quality measurement development and implementation is by nature multifaceted and challenging. By providing the details of the task orders, along with the cost estimates for the specific activities and deliverables, CMS hopes to bring transparency and clarity to this complex process that must involve the active participation and engagement of key private sector stakeholders to achieve the quality goals for the nation. Furthermore, cost estimates developed for 2020 and 2021, as specified in section IV, are informed, and refined by the experience and momentum gained in 2019 to reflect best value for taxpayer dollars.

I. Introduction

I.A. Background

CMS works in partnership with numerous entities, including clinicians, patients and families, state governments, health plan associations, specialty societies and quality measurement experts, to help ensure that all Americans have access to high quality, high value, equitable health care and outcomes. CMS has a unique role to implement innovative quality measurement activities focusing on national health care priorities and across the health care system. CMS supports quality measure development, selection and implementation across initiatives and programs to improve patient care and outcomes and to advance the momentum towards a value-based health care system. CMS currently contracts with the NQF, which is the consensus-based entity that CMS has selected under sections 1890 and 1890A of the Act to review and endorse quality measures and make recommendations to CMS on measures for use in its programs prior to rulemaking.

The first *Report to Congress: Identification of Quality Measurement Priorities – Strategic Plan, Initiatives, and Activities* (the 2019 Report to Congress) documented the CMS quality measurement processes and activities performed under sections 1890 and 1890A of the Act for the period of 2018 and prior. Last year's report also highlighted the Meaningful Measures Initiative as a key driver of strategic efforts to reduce the burden of quality measure reporting and as the framework for its comprehensive plan to identify the quality measurement needs for quality programs.

This report provides information regarding task orders, activities, and funding details including dollars obligated, expended, and projected to carry out the work required in sections 1890 and 1890A of the Act. It builds upon the 2019 Report to Congress and provides an annual update to reflect any key modifications to existing work and highlights new quality measurement activities since last year's report.

I.B. Report Organization Corresponding to Requirements of Sections 1890(e)(1)–(6) of the Act

Section 1890(e)(1) requires the Report to Congress to contain a comprehensive plan identifying the quality measurement needs for programs and initiatives overseen by the Secretary, as well as a strategy for how the Secretary plans to use the CBE and any other contractors to perform work associated with sections 1890 and 1890A of the Act, specifically with respect to Medicare and Medicaid programs. This section also provides that in years after the first plan is submitted to Congress, the Report to Congress can provide an update to the plan, rather than re-submit the

plan itself. CMS submitted the first Report to Congress containing the comprehensive plan on March 1, 2019. This is the second annual Report, organized as follows, submitted by the Secretary of HHS to meet the applicable statutory requirements, and provide transparent disclosure of CMS expenditures, obligations, and planned expenditures.

For a copy of the 2019 Report to Congress and a description of the requirements under section 1890(e) of the Act please go to, 2019 Report to Congress (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Downloads/CMS-RTC-Quality-Measurement-March-1-2019_508.pdf).

Section I: Introduction

The Introduction provides the background of continuing activities under sections 1890 and 1890A of the Act.

Section II: Comprehensive Plan

Section II of the first Report to Congress highlighted the Meaningful Measures Initiative as a key driver of strategic efforts to reduce the burden of quality measure reporting and as the framework for the comprehensive plan. CMS is not updating this section in this annual update.

For the following sections of this Report, the activities performed under sections 1890 and 1890A of the Act are divided into four broad categories:[ii]

- Duties of the CBE[iii]
- Dissemination of measures[iv]
- Program assessment and review[v]
- Program oversight and design[vi]

Section III: Funding, Obligations, and Expenditures for Activities Conducted Under Sections 1890 and 1890A of the Act

Section III describes the funding provided under section 1890(d) to carry out sections 1890 and 1890A of the Act, which include funding for NQF and other entities to conduct activities under contract with the Secretary. This section describes the amounts obligated and expended for such activities that are required by sections 1890 and 1890A of the Act.

Section IV: Estimated Expenditures and Anticipated Obligations for Activities Under Sections 1890 and 1890A of the Act

Section IV describes the anticipated obligations and expenditures for Fiscal Year (FY) 2020 through 2021 to support the advancement and refinement of the quality measurement activities required under sections 1890 and 1890A of the Act. Cost estimates developed for 2020 and 2021 were developed directly from the experiences and lessons learned from work in 2019 and reflect efforts to reduce overhead and focus on the specific activities and deliverables (as described in Section IV) that would drive us to accomplish the quality goals. For example, CMS observed that many Electronic Health Records (EHR)-based measures have not met the scientific rigor and

[ii] Functions associated with sections1890 and 1890A of the Act, as related to programs under title XVIII and title XIX of the Act.
[iii] Section 1890(b) of the Act.
[iv] Section 1890A(b) of the Act.
[v] Section 1890A(a)(6) of the Act.
[vi] Sections 1890 and 1890A of the Act.

testing requirements to achieve endorsement and maintenance. Therefore, we have planned work to research and create best practices as EHRs are a critical primary source of information essential to meet the Agency's interoperability goals. The estimates and tasks anticipated to be accomplished in 2020 and 2021 are subject to the availability of sufficient funds.

Section V: Glossary

This Report includes a glossary of acronyms and abbreviations.

Appendices

Appendix A includes links to the statutory language of sections 1890 and 1890A of the Act. Appendix B contains details of task orders and activities under sections 1890 and 1890A of the Act for actions awarded using FY 2019 funding under section 1890(d). For task orders and activities awarded in previous years, please see Appendix C in the 2019 Report to Congress.

II. Comprehensive Plan

Section 1890(e)(1) of the Act requires that this Report to Congress include a comprehensive plan that identifies the quality measurement needs of CMS programs and initiatives and provides a strategy for using the entity with a contract under section 1890(a) of the Act and any other entity the Secretary has contracted with, to perform work associated with section 1890A of the Act to help meet those needs, specifically with respect to Medicare and Medicaid.

CMS continues to be guided by the comprehensive plan detailed in the 2019 Report to Congress. In alignment with the comprehensive plan, CMS is continuing to drive towards patient-centered, value-based care through the development, selection, and implementation of quality measurement. Specifically, the CMS quality measurement needs identified include coordinating efforts for the future of health care quality measurement increasing development and use of electronic clinical quality measures, improving electronic infrastructure, harmonizing measures across public and private quality reporting, and targeted efforts to address rural health concerns, health inequities, population health and patient reported outcomes. CMS continues to foster and envision programs with more all-payer, patient-centric, population-based outcome measures aligned with the Meaningful Measure areas articulated in the 2019 Report to Congress.

III. Funding, Obligations, and Expenditures for Activities Conducted Under Sections 1890 and 1890A of the Act

In FY 2019, CMS advanced the critical knowledge base for the continued transition to a healthcare system built on value. With FY 2019 expended funds and the work of NQF and other entities per sections 1890 and 1890A of the Act, CMS builds on previous activities and continues its commitment and investment to support meaningful, scientifically sound quality measures which are essential to lower the cost and improve quality of healthcare. For example, accomplishments include updating core measure sets addressing the needs of rural healthcare providers, developing recommendations for a significant measure challenge related to low-case volume in sparsely populated rural areas; conducting multiple analyses of measure performance and evaluating the national impact of the use of quality measures across CMS programs; and promoting coordination efforts to transform public reporting websites to inform and empower individuals, providers and other stakeholders with transparent, meaningful healthcare quality information.

Table 1 identifies the authorized funding for sections 1890 and 1890A of the Act, the amount of funding provided under the authority, and funds obligated and expended under sections 1890 and 1890A of the Act.

Table 1: Funding authority (in millions), funds obligated, and funds expended by public law, 2019[vii]

	Authority	Sequester	Adjusted Authority	Obligations	Unobligated Authority	Expended Amount	Unexpended Balances
The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. L. 110-275, Sec.183) ***	$ 50.00	$ (0.51)	$ 49.49	$ 47.37	$ 2.12	$ 47.37	$ 0.00
The Patient Protection and Affordable Care Act of 2010 (ACA) (Pub. L. 111-148, Sec. 3014) ***	$ 100.00	$ (2.46)	$ 97.54	$ 97.46	$ 0.08	$ 95.70	$ 1.76
The Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. 113-93, Sec. 109)	$ 20.00	$ 0.00	$ 20.00	$ 20.00	$ 0.00	$ 20.00	$ 0.00
The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114-10, Sec. 207)	$ 75.00	$ (2.07)	$ 72.93	$ 72.61	$ 0.32	$ 56.07	$ 16.54
Bipartisan Budget Act of 2018 (Pub. L. 115-123, Sec. 50206)**	$ 15.00	$ 0.00	$ 15.00	$ 10.82	$ 4.18	$ 0.03	$ 10.79
Grand Total	**$ 260.00**	**$ (5.04)**	**$ 254.96**	**$ 248.26**	**$ 6.63**	**$ 219.17**	**$ 29.09**

Table 2 below identifies the total amounts of funding obligated, expended, and unexpended using funds appropriated to implement sections 1890 and 1890A of the Act in FY 2019. Activities under section 1890 of the Act were implemented by NQF (the CBE). Activities under section 1890A of the Act were carried out by NQF (convening multi-stakeholder groups to provide input on measures through the Measure Applications Partnership (MAP)), as well as other entities. To note, Table 2 excludes activities conducted by NQF that are not funded using

[vii] Numbers are accurate based on data at the time of submission of this report. Numbers have been rounded to the nearest 10,000.
Section 50206(a) of the Bipartisan Budget Act of 2018 provides $7.5 million for each of fiscal years 2018 and 2019.
The unobligated balances are no longer available.

the section 1890 or 1890A of the Act appropriation. Note that Appendix B provides a description of the activities, including the task orders, for which these funds were obligated or expended.

Table 2: Funding (in millions) obligated, expended, and unexpended under sections 1890 and 1890A of the Act, including administrative costs, 2019[viii]

Funding Section	Obligations	Expended Amount	Unexpended Balances
1890	$15.90	$1.23	$14.67
1890A	$7.17	$0.76	$6.41
Administrative	$2.60	$2.60	$0.00
Grand Total	**$ 25.67**	**$ 4.59**	**$ 21.08**

The section of this Report below provides information about the types of activities for which the funds provided under section 1890(d)(2) of the Act were used. The tasks under sections 1890 and 1890A of the Act are categorized by the four broad categories of work used throughout this Report: (1) Duties of the Consensus-Based Entity, (2) Dissemination of Quality Measures, (3) Program Assessment and Review, and (4) Program Oversight and Design.

(1) Funding, Obligations, and Expenditures Related to Duties of the Consensus-Based Entity

NQF is the CBE with which HHS has contracted to perform duties and tasks under sections 1890 and 1890A of the Act. Under the contract with HHS, NQF convenes multi-stakeholder committees to review new or endorsed quality measures for conceptual importance, scientific acceptability, use or usability, and feasibility. In addition, CMS has tasked NQF to identify measure priorities and measure gaps to support HHS efforts to improve quality of care and health outcomes. NQF is required to develop and submit an annual Report to Congress and the Secretary of HHS containing a description of the quality and efficiency measurement activities during the previous calendar year no later than March 1 of each year. In addition, as part of the effort in pre-rulemaking, NQF convenes the MAP which includes four multi-stakeholder workgroups that weigh in on the selection of quality performances to be used in quality reporting and value-based purchasing programs for hospital, post-acute care/long-term care, and clinician settings, with input from stakeholders, including but not limited to providers and patients from rural areas to provide rural perspectives.

Table 3 below describes the funding for FY 2019 for activities performed by the CBE under sections 1890 and 1890A. Those activities included: endorsement and maintenance of quality measures, a required annual report with prescribed activities, including identifying gaps in quality and efficiency measures, and priority setting by synthesizing evidence and convening stakeholders to make recommendations on priorities for health care performance measurement in different settings. These priority setting efforts included aligning quality measures used by public and private payers across a wide array of specialty areas to reduce provider burden; using quality measurement to support promising interventions to reduce maternal mortality and morbidity; continuing the review of social risk adjustment methodologies for outcome measures

[viii] Numbers have been rounded to the nearest 10,000.

submitted for endorsement or re-endorsement; and identifying quality measures that are highly relevant to health issues confronted by rural communities, but have requirements for minimum denominator size that pose challenges for rural providers to report. Other priority setting efforts included eliciting expert input on best practices for selecting patient-reported outcomes (PROs) and collecting PRO data; identifying data quality issues related to EHR data and promising approaches to addressing these issues for measure development purposes; reducing diagnostic error by leveraging quality measures related to data integration and documentation, diagnostic efficiency and accuracy, and care coordination; supporting person-centered planning by identifying priority measures and measure gaps for monitoring provider performance; and convening experts to review existing opioid and opioid use disorder measures and identify gap areas for future development. The duties of the CBE under section 1890A included: convening multi-stakeholder groups through the Measure Applications Partnership that provide input on measure selection for use in various quality programs including the rural health perspective. For further details of the purpose of each task order, please refer to Appendix B.

Table 3: Funding (in millions) for FY 2019 for activities performed by the CBE under sections 1890 and 1890A of the Act[ix]

Section and Fiscal Year	Obligations	Expended Amount	Unexpended Balances
Section 1890			
2019	$15.90	$1.26	$14.64
Section 1890A			
2019	$0.03	$0.02	$0.01
Grand Total	**$15.93**	**$1.28**	**$14.65**

(2) Funding, Obligations, and Expenditures Related to Dissemination of Quality Measures

The Measures Management System (MMS)

The MMS is an essential resource for the dissemination of quality measurement programs and initiatives across CMS and is also available for federal partners, stakeholders, and the public. As such, the MMS supports important efforts to standardize and promote best practices in quality measurement. One of the most important resources on the MMS is the Blueprint, which outlines the conceptual and operational phases and elements of quality measure development. By conveying standards that developers can use to gauge for the readiness of their measures to be endorsed, the Blueprint decreases the NQF Standing Committee's burden of reviewing low-quality measures. The MMS provides technical support for developers and education and outreach to stakeholders to increase engagement and knowledge of quality measurement, CMS quality reporting and value-based purchasing programs, the pre-rulemaking process, and the web-based CMS Measures Inventory Tool (CMIT).

CMS and its partners use the CMIT to search and retrieve measure details and to inform future measure development. It is a public repository of information about measures used in Medicare and Medicaid programs to inform stakeholders, manage the measure portfolio, promote measure

[ix] Numbers have been rounded to the nearest 10,000.

alignment, and guide measure development. CMS recently incorporated an environmental scan support tool into CMIT for all measure developers. The environmental scan aids measure developers, particularly in the maintenance phase of the measure life cycle, as a benchmark against which to compare manually conducted scans, and the measure concepts extracted from the abstract and article text may serve as a useful markup to increase the efficiency of abstract and article review. This provides evidentiary support for the opportunity for improvement.

The MMS education and outreach strategy to stakeholders includes the robust MMS website with learning materials, expansive links, and opportunities to actively engage in measure development, bimonthly informational webinars focused on quality measure development, and a monthly newsletter with over 80,000 subscribers. With respect to the pre-rulemaking process, the MMS supports CMS' gathering of measures for inclusion on the list of Measures Under Consideration that the Secretary considers for use under Medicare and for review by the public, and the MAP. Together, the activities under the MMS increase standardization, innovation, transparency, and stakeholder engagement in the measure development process across all measure-related activities at CMS.

Public Reporting Coordination

CMS is working to modernize public reporting while ensuring safety and quality improvement. CMS' current eight (8) Compare Sites and Data.Medicare.gov will be replaced with two useful websites that meet the needs of the various stakeholder groups making quality, price, and volume data accessible and interpretable enabling informed, personalized health care decision-making. CMS leveraged website and design technological advances and years of original Compare Site and Data.Medicare.gov user feedback to inform the development strategy. In March 2019, CMS awarded a contract to oversee the global transition effort namely the Alignment of Quality and Public Reporting Programs and Websites. Contractor responsibilities include project management, coordination, communication, and collaboration across internal CMS stakeholders and external data provider contractors that supply publicly reported quality measurement data.

Table 4 below describes the FY 2019 funding for activities related to the dissemination of quality measures, which included the Measures Management System (MMS), as well as coordination and alignment for the dissemination of quality measures via public reporting websites.

Table 4: Funding (in millions) provided in FY 2019 for activities under section 1890A of the Act related to dissemination of quality measures[x]

Fiscal Year	Obligations	Expended Amount	Unexpended Balances
2019	$ 4.64	$ 0.34	$ 4.30

(3) Funding, Obligations, and Expenditures Related to Program Assessment and Review

The Secretary must conduct an assessment, beginning not later than March 1, 2012, and at least once every three years thereafter, of the quality and efficiency impact of the use of endorsed

[x] Numbers have been rounded to the nearest 10,000.

measures described in section 1890(b)(7)(B) and make that assessment available to the public.[xi] To comply with this provision, CMS published reports in 2012, 2015, and 2018. For the 2018 Impact Assessment Report, CMS conducted multiple analyses of measure performance trends, disparities, patient impact, and costs avoided, as well as national surveys of hospital and nursing home quality leaders, to evaluate the national impact of the use of quality measures. In FY 2019, critical work was ongoing for the upcoming 2021 Impact Assessment Report. Key indicators (comprised of CMS quality measures) were selected to inform the 2021 Report with input from nationally-credential stakeholders comprising the Technical Expert Panel (TEP) and a Federal Assessment Steering Committee. These Key Indicators support the statutorily required assessment and evaluation of measure performance at the national level regarding the CMS health care quality priorities of patient safety, person and family engagement, care coordination, effective treatment, healthy living, and affordable care.

Table 5 below describes the funding that CMS used for the required assessment of the quality and efficiency impact of the use of endorsed measures, as described in the upcoming 2021 Impact Assessment Report.

Table 5: Funding (in millions) in FY 2019 related to activities under section 1890A of the Act for program assessment and review[xii]

Fiscal Year	Obligations	Expended Amount	Unexpended Balances
2019	$ 2.50	$ 0.40	$ 2.10

(4) Program Oversight and Design

To set up for success, initial year funding was provided to contractual entities to support the Secretary in project management and operations related to quality measurement. These quality measurement efforts included the development of a standard operating procedure (SOP) and project management schedules to support consistent and efficient execution. These contracts were completed and the last time a contract was awarded using Program Oversight and Design funds was in FY 2012. No contractual activities have been funded or implemented in FY 2019 under section 1890 or 1890A. Future expenditures in this area are not anticipated.

Table 6: Funding (in millions) for FY 2019 for activities under section 1890A of the Act related to program oversight and design[xiii]

Fiscal Year	Obligations	Expended Amount	Unexpended Balances
2019	$ 0.00	$ 0.00	$ 0.00

[xi] Section 1890A(a)(6) of the Act.

[xii] Numbers have been rounded to the nearest 10,000.

[xiii] Numbers have been rounded to the nearest 10,000.

IV. Estimated Expenditures and Anticipated Obligations for Activities Under Sections 1890 and 1890A of the Act

CMS continues to foster new ways to better serve our beneficiaries, improving the nation's health and quality of life. As the largest payer of healthcare services in the United States, CMS leads the way in driving improvements in quality through quality reporting programs that use payment incentives, quality improvement activities and increased transparency through public reporting of performance results. CMS continues to yield critical successes through its work managing quality measurement activities related to the CBE and other contractors responsible for dissemination of quality measures, and program assessment and review. The 1890/1890A task orders CMS anticipates in 2020 and 2021 will help to modernize the way the Agency approaches quality measurement and the way people receive information to make the best decisions for themselves and their families.

Through the efforts of the CBE and the committees convened by the CBE, CMS is uniquely informed by key health sector and national quality improvement leaders and is guided by the foundational work (outlined in sections 1890/1890A) to assess measures for endorsement, develop frameworks, identify measure gap areas, and recommend best practices that promote rewarding value and outcomes with an increased focus on patients and decreased burden on clinicians. This work supports and informs the measure development process outlined by the MMS and the prioritization happening through the Meaningful Measures initiative. It also helps to ensure the dissemination of quality measures via our public reporting sites. CMS' work to assess and review the programs through the triennial Impact Assessment report provides the feedback and analytical data needed for continual evaluation of the measurement work in this area and is a tool used by the CBE in their analyses. The expenditures and anticipated obligations for activities previously outlined in these four components create a cyclical process to ensure experts and stakeholders are active participants in guiding, evaluating, and benefitting from CMS' continual efforts to improve healthcare quality and transition to value-based care.

The quality measurement work related to the CBE and other contractors is integral to implementing quality reporting programs, value-based payment programs, and public reporting of measures, and in adopting meaningful measures to inform decision making for patients, clinicians, and healthcare systems. CMS seeks to make meaningful strides in all healthcare quality priority areas and is committed to making progress on value-based payments of which quality measurement is a critical component. While there is much more to be done, CMS has made considerable inroads. The Secretary estimates the following obligations and expenditures will be required in the succeeding two-year period (i.e., FY 2020 and FY 2021) to carry out quality measurement activities under the four categories of tasks previously described. Estimates are subject to the availability of sufficient funds.

Cost estimates for FY 2020 and FY 2021 were developed directly from the experiences and lessons learned from work in 2019 and reflect efforts to reduce overhead and focus on the specific activities and deliverables that would drive us to accomplish the quality goals. As an example, based on endorsement and maintenance of measure analysis completed in FY 2018, CMS identified a lower endorsement rate of electronic clinical quality measures (eCQMs) than other measures submitted. As a result, in FY 2019 CMS awarded the Electronic Health Records (EHRs) Data Quality task order to the CBE to do the following: identify risk factors that could impact data quality of EHRs, which in turn could reduce the reliability and validity of the

eCQMs calculated using EHR data; explore innovative approaches that assess EHR data quality for developing eCQMs, and address the data compatibility issue for EHR data coming from different platforms. As a further complement to that work in FY 2020, CMS is proposing a new task order, Leveraging eCQMs to Improve Care Communication and Coordination, to address the challenges of measuring provider performance in care coordination when the level of EHR adoption is uneven across care settings.

The task orders listed below are anticipated awards using FY 2020 and FY 2021 funding, building from lessons learned and experiences from FY 2019. As several of our activities have different periods of performance (e.g., more than 12 months), additional work may be performed in these years but will not be listed in this section because funds were obligated or expended prior to FY 2020. If contracts have been awarded and the cost is already negotiated for option years, this is indicated as 'negotiated' in the tables below. If a contract is new work anticipated to be awarded in 2020 or 2021, the cost is indicated as 'estimated' in the tables below.

(1) Duties of the Consensus-Based Entity

Endorsement and maintenance:

Period of Performance	Funding Amount	Fiscal Year
Option Year 3 09/27/20-09/26/21	**$9,956,081**	**2020 (Negotiated)**
Option Year 4 09/27/21-09/26/22	**$10,083,335**	**2021 (Negotiated)**

NQF-endorsed measures are considered the gold standard for healthcare measurement in the United States. Expert committees that are comprised of various stakeholders including patients, providers, and payers, evaluate measures for NQF endorsement. HHS, including CMS and other federal agencies, and many private sector entities use NQF-endorsed measures above all others because of the rigor and consensus process ensuring such measures meet standard, transparent criteria for evidence and testing. As CMS is the largest healthcare payer in this country, it is critical that our measures are valid and reliable so that we can properly evaluate the health of our beneficiaries, be accountable to our stakeholders and improve the quality of healthcare. It is also critical that the CBE endorsement and maintenance process help support CMS strategic initiatives and goals to deliver better value and results for patients across the healthcare system and across the entire continuum of care including nursing home, palliative and hospice care. The CBE process supports measures that address CMS priority efforts including systematic improvements in quality and patient safety in hospitals, nursing homes, hospices, home health facilities and other areas to promote a more coordinated, integrated healthcare system. This five-year task order will continue the statutorily required work for endorsing and maintaining quality and cost measures in a consensus-based process through 14 committees so that we can incorporate feedback and best in class measures in our quality and value-based purchasing programs.

The Measure Applications Partnership (MAP)

Period of Performance	Funding Amount	Fiscal Year
Option Year 2 03/27/20-03/26/21	**$1,393,823**	**2020 (Negotiated)**
Option Year 3 03/27/21-09/26/22	**$1,543,483**	**2021 (Negotiated)**

This is a five-year task order that supports that MAP, a multi-stakeholder partnership that guides HHS on the selection of performance measures for Medicare quality programs. This statutorily mandated activity is part of the Medicare pre-rulemaking process. The MAP convenes key stakeholders to evaluate and recommend quality and efficiency measures that are being considered for use in specific Medicare quality programs, including public reporting programs. CMS uses the published feedback and input in its federal rulemaking process when selecting measures for these programs. There are 3 workgroups that evaluate measures – a Hospital Workgroup, a Clinician Workgroup, and a Post-Acute Care/Long-term care workgroup and all these workgroups are informed by the Rural workgroup who reviews measures for rural relevancy. The MAP process and activities are fundamental to gaining expert insight and perspectives on the quality measurement and quality improvement approaches to promote better health outcomes for individuals and communities. The discussions and recommendations from technical experts and patient advocates through the various MAP workgroups provide CMS with critical input to address various priorities such as maternal health, nursing home quality and safety, hospice quality and safety, patient reported outcomes and affordability of care. The work of these groups provides transparency for CMS quality programs by having a vehicle across public and private sectors by which to discuss gaps and obtain early feedback on cross-cutting measurement issues.

The CBE's Annual Report to Congress and Secretary of HHS

Period of Performance	Funding Amount	Fiscal Year
Option Year 3 09/27/20-09/26/21	**$133,543**	**2020 (Negotiated)**
Option Year 4 09/27/21-09/26/22	**$133,836**	**2021 (Negotiated)**

The CBE (currently NQF) is statutorily required to submit a Report to Congress, not later than March 1st of each year, which highlights NQF's work and funding over the last year, emphasizing the broad use of endorsed measures and NQF's critical role building public/private sector consensus on healthcare improvement strategies. The report describes the implementation of quality and efficiency measurement initiatives, recommendations on an integrated national strategy and priorities for health care performance measurement and gaps, and performance of the CBE's duties required under its contract with the Secretary. Gaps identified are used to

prioritize future work to advance healthcare quality measurement and improvement. CMS supports this mandatory reporting via a five-year task order.

Task Orders of the Consensus-Based Entity

Other task orders are assigned through contracts to the CBE to help advance quality, quality measurement and promote value. These task orders leverage the unique strengths and expertise of the CBE and its wide network of multiple stakeholders to evaluate and make recommendations on specific initiatives which will meaningfully impact quality measurement and performance and promote measure alignment efforts across the public and private sectors.

- Core Quality Measures Collaborative (CQMC)

Period of Performance	Funding Amount	Fiscal Year
Option Year 2 09/14/20-09/13/21	**$264,013**	**2020 (Negotiated)**
Base Award Date TBD	**$275,000**	**2021 (Estimated)**

The CQMC is a collaboration between NQF, America's Health Insurance Plans (AHIP) and CMS to align quality measures across all payers, to reduce burden to providers and provide clear quality information to consumers. CMS supports this work via a three-year task order ending in FY 2021 and expects to award a follow-on task order beginning in FY 2021. The CQMC supports nationwide quality measure alignment between Medicare and private payers and in turn, advances the ongoing work to establish a health quality roadmap to align and improve reporting across programs and health systems, as referenced in the recent Executive Order on Improving Price and Quality Transparency in American Healthcare to Put Patients First[xiv]. To date, CQMC has developed eight (8) core measure sets to be used in high impact areas such as Orthopedic Surgery, Cancer, Cardiology and Primary Care. Future work includes:

- Development of updated core set prioritization criteria and an updated Implementation Guide for core set adoption by payers.
- Support for the development of new core measure sets in Behavioral Health and Neurology and additional future measure sets (the contract provides expansion of two sets per year). This includes organization, management, and oversight of web meetings for the workgroups for [these two core measure sets being developed.]
- Anticipated efforts to track adoption of the Core Measures in our Programs.

The work of the CQMC to develop core measure sets will address widely recognized and long-standing challenges of quality measure reporting and help to align quality measurement across all payers, reducing burden, simplifying reporting, and resulting in a consistent measurement process. This in turn can result in reporting on a broader number of patients, higher reliability of the measures, and improved and more accurate public reporting.

[xiv] The White House Executive Order, June 24, 2019: https://www.whitehouse.gov/presidential-actions/executive-order-improving-price-quality-transparency-american-healthcare-put-patients-first/

- Measurement Framework for Improving Opioid-related Behavioral Health and Quality Measurement for All-Payer Programs

Period of Performance	Funding Amount	Fiscal Year
Base Award Date TBD	**$1,000,000**	**2020 (Estimated)**
Option Year 1 Date TBD	**$650,000**	**2021 (Estimated)**

This work is a follow-on for the 2019-2020 Opioids and Opioid Use Disorder TEP Task Order (2019 Opioid TO), activated by Section 6093 of the 2018 SUPPORT Act and funded through 1890. The initial task order identified four domains of quality measurement related to the monitoring, screening, and treatment of opioid-use disorder, including pain management, treatment, harm reduction, and social determinants of health (SDOH). The task order planned for FY 2020 builds on the initial one by focusing on opioid users with co-occurring behavioral health conditions, who are polysubstance users and are at a higher risk for overdose and opioid-related mortality. This timely work will help address individuals and communities at higher risk by identifying and prioritizing measures and measure concepts that could inform care delivery and leveraging public health-public safety collaboration to combat the opioid epidemic, and enable the monitoring of unintended consequences among individuals with pain management needs due to sickle cell disease, cancer, or during recovery from surgeries as well. With guidance from a committee of experts and patients, this work will further CMS efforts to determine appropriate opioid use and behavioral health measures that align across all-payers, across health care settings, that are disparity-sensitive and low burden. There are many co-occurring projects around this area and CMS will be able to use this effort to increase efficiency in allocating resources for opioid-related measure development by targeting areas with the highest measurement needs. This twelve-month task order with the option of twelve additional months aims to ensure CMS' measures are high impact for addressing the evolving opioid epidemic and are high value because they can be easily adopted by other public or private payers.

- Leveraging Electronic Clinical Quality Measures (eCQM) to Improve Care Communication and Coordination

Period of Performance	Funding Amount	Fiscal Year
Base Award Date TBD	**$800,000**	**2020 (Estimated)**
Option Year 1 Date TBD	**$800,000**	**2021 (Estimated)**

Advancing electronic measurement is a key initiative of CMS to help connect healthcare information through interoperability, reduce provider burden of reporting, increase transparent performance, as well as enable more timely feedback and analysis. With the CBE's unique experience in the advancement of measurement science and knowledge base of cross-cutting

issues, it will use its network of multiple stakeholders to evaluate and make recommendations for a companion task order to the 2019 EHR Data Quality task order that ends 12/31/2020. This 2019 task order makes recommendations to improve data quality to raise endorsement rates and scientific acceptability for measures derived from electronic health records. However, as CMS is in the process of transitioning quality measures to be based on electronic data sources, more work needs to be done to leverage advanced analytics and "big data" modeling. This twelve-month task order with the option of twelve additional months will specifically address the challenge of measuring provider performance in care coordination when the level of EHR adoption is uneven across care settings. With this task order, CMS expects to identify best practices to improve care communication and coordination in an all-payer, cross-setting, fully electronic manner.

- Best Practices for Designing, Field-Testing, and Implementing PROMs

Period of Performance	Funding Amount	Fiscal Year
Base Award Date TBD	**$750,000**	**2020 (Estimated)**
Option Year 1 Date TBD	**$750,000**	**2021 (Estimated)**

Unleashing the voice of the patient through patient reported outcomes is another key strategy of CMS. However, there is a lack of detailed technical guidance that measure developers can use to develop high impact outcome measures based on patient reported data. Feedback from CMS staff who oversee measure development contracts has pointed to the need for expert input on how best to address the challenges of collecting data on patient-reported outcomes. For example, are web-based or mixed-mode surveys better than hardcopy questionnaires, and under what circumstances? Currently patient reported outcomes are difficult to use and burdensome, often requiring additional staff to call patients and transmit information to providers. This work will design a quality measurement approach from the point of view of the patient. CMS' quality programs strive to design measures that champion individual patient preferences, needs, and values ensuring that patient values guide all clinical decisions. Patient-Reported Outcomes (PROs) refer to the information collected directly from patients on patient questionnaires, tools, or survey instruments about health status, functioning, or symptoms. These survey instruments are called patient-reported outcome measures (PROMs). Taking it one step further, a performance measure or a patient-reported outcome performance measure (PRO-PM) can be developed based on the outcome information collected from the survey instrument or PROM. Although a few performance measures have been developed from PROMs, there is a critical gap in addressing implementation issues. This new work will address this gap by developing a step-by-step guide on how to turn a patient-reported outcome measure into a patient-reported outcome performance measure (PRO-PM). CMS needs this critical analysis to advance its work on these important measures, which are based on a patient's perspective and input, leading to differentiation of provider performance, and informing opportunities for quality improvement. This twelve-month task order with the option of twelve additional months builds upon the previous 2019-2020 Patient-Reported Outcomes Task Order (PRO Task Order), which focuses

on identifying best practices for selecting and interpreting PROs. This work will enable CMS to carry out its mission to empower patients and incorporate their input in measure development. It will inform CMS' efforts in all aspects of developing and implementing PRO-PMs. In particular, it will fill knowledge gaps in selecting high quality PROMs for developing high impact PRO-PMs, collecting outcomes data from patients with minimal burden, maximizing response rates to PROMs to increase representativeness, leveraging electronic health records for data collection, storage, and measure calculation, all of which will increase return on investment for CMS.

- Leveraging Quality Measurement to Improve Rural Health

Period of Performance	Funding Amount	Fiscal Year
Option Year 1 09/06/20-07/05/21	**$372,252**	**2020 (Negotiated)**
Option Year 2 07/06/21-09/05/22	**$387,870**	**2021 (Negotiated)**

Rural health continues to need support in terms of quality measurement, based on the Merit-based Incentive Payment System (MIPS) reporting which demonstrates lower scores for rural/individual providers. There are specific challenges to quality measurement data for rural/individual providers, especially as it relates to access to data, reporting infrastructure, and small denominators (lower case volumes) leading to statistical methodology challenges. This twelve-month task order with the option of twelve additional months continues to help operationalize support for rural quality measures reporting and performance, and bolster CMS' priority for strengthening the rural healthcare system, applying a rural lens to CMS' measure development work and measure selection for program use.

  - In FY 2021, the Rural Health Workgroup will review the rural relevant core set developed in 2018 to ensure that the measures remain feasible for rural providers to report with minimal effort, and to identify measures not in the core set for potential inclusion, evaluating whether they address high priority rural health issues and are feasible for rural providers to report. Consistent with the standard approach of the CQMC as well as quality measurement programs, a frequent, sometimes annual review of measure sets is necessary to ensure that new, emerging clinical findings, latest scientific evidence, and critical measure specification updates are addressed in each core set. In recent years, issues such as the opioid crisis, maternal mortality, chronic co-morbidities have afflicted the general population and are found to be even more acute among the rural population. To support the Administration's focus on improving the well-being of the rural populations, the core measure set needs to be reviewed and updated regularly to enhance its value and impact on improving rural health. In addition, the 2018 core measure set includes NQF-endorsed measures only. State and local health agencies also use quality measures that have not been submitted to NQF for endorsement review for quality improvement purposes. To expand the arsenal of measures for improving rural health, CMS will require the contractor to consider measures that have not obtained NQF endorsement. The major deliverables include a broad environmental scan of measures,

some of which that may not be endorsed, that can be considered for potential addition to the core set, and a final report on the Workgroup's recommendations.
  - In FY 2022, the Rural Health Workgroup will review telehealth measures and measure concepts identified in a 2017 NQF report to reflect CMS' expanding use and stakeholders' increased reliance on telehealth for rural health care delivery. The work will include an environmental scan of measures and measure concepts that can be considered for assessing telehealth provider quality, an identified gap area in current rural initiatives.

This work will continue to ensure that the measures developed or used by CMS reflect the efforts to put the needs of Rural America front and center. The final reports will inform CMS' measure development and pre-rulemaking by selecting measures that are feasible and minimally burdensome for rural health care providers.

- Social Risk Trial

Period of Performance	Funding Amount	Fiscal Year
Option Year 2 05/15/20-05/14/21	**$418,163**	**2020 (Negotiated)**
N/A	**N/A**	**2021 (N/A)**

This is the final year of the pilot project (designed as a 36-month effort) which looks at the appropriateness of social risk adjustment for new and endorsed outcome measures submitted for re-endorsement. This pilot is based off the efforts by the CBE to address unresolved issues from the first NQF SES trial (2015-2017) to advance the science of risk adjustment. Issues to be covered include preferred methodology, data sources, risk factors, methods to build conceptual rationale, and appropriate level of adjustment (system vs. individual vs. community/ neighborhood). This work will provide important information to CMS on the issue of taking into account social risk factors to accurately measure true performance and improve health equity across the healthcare system and ensuring a fair and consistent measurement process.

- Best Practices for Developing and Testing Risk Adjustment Models

Period of Performance	Funding Amount	Fiscal Year
Base Award Date TBD	**$2,000,000**	**2020 (Estimated)**
Option Year 1 Date TBD	**$2,000,000**	**2021 (Estimated)**

This work will build on the recommendations of the Assistant Secretary for Planning and Evaluation (ASPE) Report to Congress on Social Risk Factors and Medicare's Value-Based

Purchasing Programs[xv] and focus on developing a Standard Risk Adjustment Framework for Outcome and Resource Use Measures in Medicare Programs. Although the work ASPE does in this area helps define the recommendations and framework of social risk factors, this work with the CBE helps to operationalize those recommendations, specifically addressing collection of social risk data, evaluation of measures for appropriateness of social risk adjustment, and updating any measure recommendations for use in specific programs.

Beneficiaries with social risk factors suffer from worse outcomes for many quality measures, regardless of the providers they saw, and dual eligible status was the most significant predictor of poor outcomes. Providers serving a higher proportion of beneficiaries with social risk factors are more likely to be penalized by Medicare value-based purchasing programs than those serving a lower proportion of beneficiaries with social risk factors, even after beneficiary mix was accounted for. In response to early findings, it is critical for measure developers and endorsement organizations that we create a standard risk-adjustment framework that includes functional risk for all risk-adjusted outcome and resource use measures used in Medicare programs. This twelve-month task order with the option of twelve additional months will address the limitation of the current risk adjustment methodology of many measures, which do not include functional risk adjustment, despite the general consensus about the importance of medical risk adjustment. Developing a consistent risk-adjustment approach would enable CMS to set high, fair quality standards for all Medicare beneficiaries. It would facilitate accurate assessment of the role of social and medical risks, and comparison and monitoring of disparities across measures and patient populations. It would also enable comparison of provider performance across measures. Building off of work with ASPE, CMS sees benefits in ensuring that value-based purchasing programs include health equity measures and domains to help providers prioritize areas for particular focus that could reduce disparities, and to address health equity through service enhancement, patient engagement activities, and adoption of best practices to improve performance.

This task order will build on ASPE's recommendations by eliciting expert input on how best to develop, test, and analyze options for a standard risk adjustment model for all outcome and resource use measures in Medicare programs. This may require assessment of different combinations of clinical and/or social risk factors to examine their relative effects on measure performance in general, and among racial, ethnic, linguistic minority groups and the disabled in particular. Expert consensus, including a technical expert panel of statisticians from academia, independent research organizations, or affiliated with industry stakeholders, will be sought on the conceptual basis and statistical indicators that developers should consider to identify the optimal combination of risk factors for the standard risk adjustment framework. Expert input on health equity measures and domains that could be incorporated into the standard risk adjustment framework will also be sought. To complement ASPE recommendations and to strengthen the value of this effort to the government and taxpayers, this task order intends to go beyond general recommendations and focus on addressing a broad range of challenges in developing a standard risk adjustment model. The quality of a standard risk adjustment model depends on how well the data capture the concepts of clinical and social risks, and how vigorously the data are collected, edited, and compiled. Therefore, this task order would involve obtaining several national data on

[xv] Office of the Assistant Secretary for Planning and Evaluation (ASPE)'s Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs. (https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicares-value-based-purchasing-programs, accessed 2/3/2020).

healthcare cost, utilization, and health status for in-depth analyses and involve a sub-contract with a vendor with a strong track record in quantitative health services research. CMS intends to task the contractor to explore data compiled by commercial vendors, non-profit foundations, or other state or HHS agencies to maximize the pool of potential risk factors. Such nationwide data is crucial for testing different combinations of clinical and social risk factors and their impact on quality measures; however, accessing and transforming data is anticipated to be costly and require substantial resources. The results will be shared with the TEP for review and feedback on next steps for improving model precision and addressing methodological trade-offs. The final deliverable would provide a detailed discussion of a standard risk adjustment model appropriate for the outcome and resource use measures in Medicare programs.

- Attribution Models for Critical Illness and Injury

Period of Performance	Funding Amount	Fiscal Year
Base Award Date TBD	**$1,200,000**	**2020 (Estimated)**
N/A	**N/A**	**2021 (N/A)**

As CMS rapidly moves towards full value-based design, through its value-based purchasing programs and alternative payment models, that promotes a team-based care approach, this task order provides essential foundational work to best attribute care and payments in areas that have not previously been addressed. This task order related to attribution of care supports work, as authorized in section 1890, for the consensus-based entity to synthesize evidence and convene stakeholders to make recommendations with respect to activities conducted under the Medicare Act on an integrated strategy and prioritization of quality measures in all applicable settings, including in areas of high-cost chronic diseases and in efforts to improve the patient-centeredness of health care. CMS beneficiaries including Medicare recipients, are more likely than the general population to seek care from multiple providers and require effective and efficient care coordination. This task order will help CMS ensure that measures used in programs are able to attribute the care performance of multiple providers to a specific health outcome. This task order will not only benefit Medicare beneficiaries but also inform new care and payment models that will help Medicaid recipients and Health Insurance Exchange program enrollees. To identify all providers who took part in treatment during a specific care episode and to differentiate their individual performance and link it to the treatment outcome is a technically complex task that could move the science of outcome measures forward, and will strengthen CMS' on-going efforts to leverage outcome measures to improve the health and well-being of its beneficiaries. The approach taken for the attribution of care and payments can impact and improve the quality of care coordination which in turn, can enhance patient-centeredness and improve health outcomes. CMS currently uses attribution methodologies to determine which beneficiaries are included in the calculation of a health care provider's quality and cost performance; however, current attribution models are retrospective and attribute patients' outcomes to a single provider or group. Current attribution approaches are a substantial step forward, but in most cases, patients with co-morbidities often receive care from multiple providers across a wide variety of specialties. In an integrated healthcare system, clinicians from multiple specialties collaborate to provide care for patients with complex needs. Each member of

the health care team may have varying degrees of influence over specific health outcomes. For CMS, a major challenge in developing an attribution model that could incentivize team-based care is to determine the amount of reward that is commensurate with each team member's contribution to a specific health outcome of the patient. In this way, attribution models could make a significant difference in market stability and provider buy-in for CMS value-based programs and models.

This twelve-month task order builds on NQF's 2015-2016 Attribution: Principles and Approaches Task Order[xvi], the Health Care Payment Learning & Action Network (HCP-LAN)'s 2016 Report on Patient Attribution[xvii], and 2017-2018 Improving Attribution Models Task Order[xviii]. In particular, the NQF report from the 2015-2016 Task Order points out the kinds of model testing that should be conducted to strengthen payment programs. The HCP-LAN's 2016 report recommends a prioritization approach for attributing care quality to multiple providers. The NQF report from the 2017-2018 Task Order discusses the considerations for attributing provider performance for complex and vulnerable patients. Based on these recommendations, the new task order will elicit expert input on promising approaches to develop, test, and assess attribution models for measuring provider performance related to health outcomes for individuals with co-morbidities. Input will be elicited from experts in alternative payment models, value-based purchasing programs, and measure methodologies. The goal is to reward cost effective, team-based care, which is not possible under the current models. In addition, CMS sees this work as a key building block for future efforts to develop potential attributional approaches that encourage care coordination, that are population health-focused, and that can be used to gauge provider performance and strengthen accountability at the system level and across payers.

- Other High Priority Task Orders Under Consideration - For FY 2021, the overall quality measurement work for the CBE has not yet been fully determined because of the significant work currently underway across the government to fundamentally improve the quality measurement process. This includes consideration of the advances in technology, alignment efforts and prioritization in the area of measures development to best meet the needs of the population. There are not sufficient resources available to fully support this work so CMS must be sure that we are supporting the highest priority work requiring a consensus body. The following projects have currently risen to the top as high priority areas which would have substantial impact to improved quality performance and align with the strategic goals of CMS.

[xvi] National Quality Forum (December 2016) Attribution: Principles and Approaches. (http://www.qualityforum.org/ProjectDescription.aspx?projectID=80808, accessed 1/30/2020).
[xvii] Health Care Payment Learning & Action Network (June 30, 2016) Accelerating and Aligning Population-Based Payment Models: Patient Attribution. (https://hcp-lan.org/pa-whitepaper/, accessed 1/30/2020).
[xviii] National Quality Forum (August 2018) Improving Attribution Models. (http://www.qualityforum.org/ProjectDescription.aspx?projectID=80808, accessed 1/30/2020).

Period of Performance	Funding Amount	Fiscal Year
N/A	N/A	2020 (N/A)
Base Award Date TBD	$2,000,000	2021 (Estimated)

Patient safety continues to be an area of significant challenge to healthcare, despite many years' efforts since the publication of the Institute of Medicine reports[xix] "To Err is Human" and "Crossing the Quality Chasm". American healthcare still remains at the bottom of most industrialized nations for patient safety, and ongoing efforts are necessary to promote this most important aspect of care. Two patient safety issues related to devices and diagnostic care will be reviewed and recommendations made for improvement.

- Device-related Adverse Events (FY 2021)
  - This task order aims at identifying priorities and measure gaps related to adverse events (AEs) or near-misses resulting from medical devices. Complications from devices were among the conditions that incurred the highest inpatient expenditures. The U.S. Food and Drug Administration (FDA) has a passive reporting system for device-related AEs which is similar to reporting for adverse drug events. While CMS has supported efforts to identify measures related to medication-related AEs in the past, gaps remain in those related to medical devices. Through the work with the CBE, CMS can leverage expertise in quality measurement and convening of multi-stakeholder committees to inform the FDA efforts by identifying measure priorities and gaps related to reducing device-related AEs and to encourage providers to monitor and prevent device-related complications, injuries, or infections. This task order intends to address an important patient safety issue related to devices and also aims to enhance transparency, accountability, and inform providers on investment decisions related to medical devices.
- Diagnostic Accuracy (FY 2021)
  - This task order will build upon current efforts to identify priorities and measure gaps related to making the correct diagnosis first and avoiding errors of diagnosis which then lead to unnecessary testing but also patient concern. There are few measures which evaluate diagnostic accuracy and diagnostic mistakes, which is common not only to hospital settings, but to all settings of care.

The following task order is intended to be conducted by an independent entity to evaluate the CBE process of endorsement and maintenance.

- Evaluation of the Endorsement-Maintenance Process (FY 2021)
  - In an effort to simplify the endorsement and maintenance of quality measurement, this task order elicits recommendations to independently review and recommend appropriate performance metrics for evaluating resource use, timing, scheduling,

[xix] Institute of Medicine reports, *To Err is Human* (1999) (https://www.nap.edu/catalog/9728/to-err-is-human-building-a-safer-health-system) and *Crossing the Quality Chasm: A New Health System for the 21st Century (2001)* (https://www.nap.edu/catalog/10027/crossing-the-quality-chasm-a-new-health-system-for-the

communication, coordination, and other aspects of the Endorsement and Maintenance process to streamline these processes for quality and efficiency.

Total for duties of the Consensus-Based Entity

Funding Amount	Fiscal Year
$18,287,875	**2020**
$18,623,524	**2021**

(2) Dissemination of Quality Measures

The Measures Management System (MMS)

Period of Performance	Funding Amount	Fiscal Year
Option Year 2 09/30/20-09/29/21	**$4,060,072**	**2020 (Negotiated)**
Option Year 3 09/30/21-09/29/22	**$3,464,948**	**2021 (Negotiated)**

The technical support by the Measures Manager and its tools, resources, and education enable high caliber, meaningful quality measure development and alignment, which is critical for not only CMS and federally contracted work, but for all quality measure development work across the public and private sector to make data driven decisions. The MMS tools and education are used by the entire healthcare industry, supporting both statutory and non-statutory efforts. Specific activities include:

- Continued maintenance and improvements to the CMS Measures Inventory Tool (CMIT) to capture all past, current, and potential quality measures in CMS programs to further transparency and alignment across the public-private sector. Additionally, CMIT houses time and resource saving tools, the Environmental Scan Tool, and the De Novo Measure Scan, to aid measure developers in conceptualizing using machine learning. This tool will be expanded and enhanced to include industry measure submissions to support our statutorily mandated pre-rulemaking process.
- Enable the development of a web-based Blueprint, which outlines the process to develop high caliber and scientifically acceptable measures, to make the information more accessible and spread best practices to increase the quality and scientific acceptability of measures, especially from novice measure developers. This allows more specialty societies, patient advocacy groups, and other non-traditional measure developers to initiate measure development and engaging throughout the process.
- Education and outreach to patients, caregivers, clinicians, measure developers, and others to encourage and facilitate their involvement in the measure development process and

support patient-centered quality measurement through monthly communications to over 80,000 subscribers, bimonthly webinars, and the MMS website.

As CMS evolves its quality footprint, it is critical that the Measures Manager continues to engage, educate, and document best practices, and support measure developers to ensure consistent and high caliber measures to improve health outcomes for beneficiaries. In addition, and to complement the Measures Manager activities as well as overall value-based quality measurement work, CMS is currently developing a Quality Measure Index (using Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015, Section 102 funding) to objectively assess, in a data driven manner, the relative value of quality measures based on key measure characteristics. The tools developed by the Measures Manager in this five-year task order, like CMIT and the Blueprint, are instrumental in informing the design of the Index and populating it with measure information. The Quality Measure Index is intended to support and enhance the assessment and decision-making processes used by CMS for measure selection (like pre-rulemaking measures under consideration, which is managed by the Measures Manager), implementation, and continued use in CMS quality reporting programs. With the same goal and focus of improved health outcomes, the Measures Manager tools, resources, and technical assistance along with the Quality Measure Index work are intended to support improved measure development and alignment processes.

The Alignment of Quality and Public Reporting Programs and Websites

Period of Performance	Funding Amount	Fiscal Year
Option Year 1 03/22/20-03/21/21	**$1,143,408**	**2020 (Negotiated)**
Option Year 2 03/22/21-03/21/22	**$1,179,287**	**2021 (Negotiated)**

CMS has been a driving force behind public quality reporting on facility and clinician performance based on the premise that making this information available to the public will drive improvements to health care quality. A priority goal of the Agency is to empower patients to select and access the appropriate, high value care from high quality providers. Work under this five-year contract will support coordination efforts across the current state of the existing Compare websites, through the transition to human centered design public reporting and the future steady state of a standardized website, allowing users to access information through a single point of entry and simplified navigation to find the quality of care information they need. Significant work is needed to manage the existing Compare website environment, through the complex transition, including conducting and analyzing research, human centered design user and concept testing, development of industry best practice recommendations, and facilitation of meetings and trainings for internal and external stakeholders. Project management from this contract supports current state and future state operations to align project goals, objectives, timelines and perceptions across all stakeholders with provision of effective communication, coordination, reporting, and development and maintenance of a master project management plan across contracts/tasks. Although much work has been done to anticipate the needs of Medicare

beneficiaries, patients and stakeholders in accessing and using publicly reported data, CMS anticipates additional enhancements that require coordination as advocates, health care groups, health care providers, researchers and the larger clinical community preview new features and gather feedback. This task order is critical for ensuring beneficiaries and other users have access to the accurate and useful comparison information they rely on to make informed healthcare decisions.

Total for Dissemination of Quality Measures

Funding Amount	Fiscal Year
$5,203,480	**2020**
$4,644,235	**2021**

(3) Program Assessment and Review

Impact Assessment of CMS Quality and Efficiency Measures

Period of Performance	Funding Amount	Fiscal Year
Option Year 1 07/01/20-06/30/21	**$2,882,409**	**2020 (Negotiated)**
Option Year 2 07/01/21-06/30/22	**$2,309,217**	**2021 (Negotiated)**

This five-year task order will support statutorily mandated evaluation work through the use of expert services needed to conduct the Impact Assessment report. The statutory mandate requires CMS to publicly release a comprehensive document once every three years; therefore, the next Impact Assessment report will publish in 2021. The Impact Assessment is a comprehensive national evaluation encompassing 20 terabytes worth of data, more than 800 measures and 27 reporting programs that informs CMS on the value of quality measures in improving strategic healthcare priorities, patient outcomes, and reducing healthcare costs. Specific tasks to support the 2021 report include:

- Develop a standardized and transparent methodology to examine the impact of measures implemented in programs.
- Enhance the disparity analyses conducted for the Impact Assessment Report.
    - Include demographic information or available indicators of socioeconomic status, such as dual eligibility for both Medicare and Medicaid.
    - Use location data (i.e., rural versus urban) in combination with other variables, such as race/ethnicity and sex.

This work provides CMS with overall national performance rates, trends, and disparities. CMS will improve usability of the data with an interactive version of the National Quality

Dashboards[xx] to highlight results for measures or groups of measures used to gage performance in Meaningful Measure areas. This information enables CMS to assess beneficiaries across quality programs and settings and respond to healthcare trends.

Total for Program Assessment and Review

Funding Amount	Fiscal Year
$2,882,409	**2020**
$2,309,217	**2021**

(4) Program Oversight and Design

- Future expenditures are not anticipated in this area.

[xx] Introduced in the 2018 National Impact Assessment of CMS Quality Measures Report (2018 Impact Report).

	FY 2020	FY 2021
Consensus-Based Entity Activities		
Endorsement/Maintenance	$ 9,956,081	$ 10,083,335
Measures Application Partnership	$ 1,393,823	$ 1,543,483
Annual Report	$ 133,543	$ 133,836
Subtotal, Congressionally Mandated Activities	**$ 11,483,447**	**$ 11,760,654**
Task Orders of Consensus-Based Entity	$ 6,804,428	$ 6,862,870
Subtotal, Consensus-Based Entity Activities	**$ 6,804,428**	**$ 6,862,870**
Secretarial Activities		
Measures Management System	$ 4,060,072	$ 3,464,948
Alignment of Compare Websites	$ 1,143,408	$ 1,179,287
Subtotal, Dissemination of Quality Measures	**$ 5,203,480**	**$ 4,644,235**
Impact Assessment of CMS Quality & Efficiency Measures	$ 2,882,409	$ 2,309,217
Subtotal, Congressionally Mandated Program Assessment Activity	**$ 2,882,409**	**$ 2,309,217**
Total, Consensus-Based Activities	**$ 18,287,875**	**$ 18,623,524**
Total, Secretarial Activities	**$ 8,085,889**	**$ 6,953,452**
Total 1890 and 1890A Activities (all funding categories) *	**$ 26,373,764**	**$ 25,576,976**

Figure 1: Summary – Estimated Expenditures and Anticipated Obligations for Activities Under Section 1890 and 1890A. *Note: *H.R.1865 - Further Consolidated Appropriations Act, 2020 provided CMS with $4,830,000 in new funding in FY 2020*[xxi]*. In addition, CMS carried over previous 1890/1890A funding in the amount of $4,181,739 for a total of $9,011,739 available to be spent on 1890/1890A activities in FY20. As of 02/02/2020, CMS has been apportioned $5,250,739. The remaining $3,761,000 reapportionment is in progress and being approved by HHS. The total funding need in FY 2020 is $26,373,764. This leaves $17,362,025 in 1890/1890A projects vulnerable to lack of funding in the absence of additional appropriated extensions of 1890/1890A funding.*

The upcoming work in FYs 2020 and 2021 is critically important. CMS looks forward to opportunities to support efforts from both the public and private sectors to leverage quality measurement to improve health outcomes, reduce reporting burden, and enhance cost savings for the American people.

[xxi] H.R.1865 - Further Consolidated Appropriations Act, 2020: https://www.congress.gov/bill/116th-congress/house-bill/1865/text

V. Glossary

Acronym/ Abbreviation	Name or Term
ACA	Patient Protection and Affordable Care Act of 2010
ASPE	Office of the Assistant Secretary for Planning and Evaluation
ASPR	Office of the Assistant Secretary for Preparedness and Response
BBA	Bipartisan Budget Act of 2018
CBE	Consensus-Based Entity
CMIT	CMS Measures Inventory Tool
CMS	Centers for Medicare & Medicaid Services
CQMC	Core Quality Measures Collaborative
eCQM	Electronic Clinical Quality Measure
EHR	Electronic Health Record
FDA	U.S. Food and Drug Administration
FY	Fiscal Year
HHS	Department of Health and Human Services
IDIQ	Indefinite delivery, indefinite quantity
MACRA	Medicare Access and CHIP Reauthorization Act of 2015
MAP	Measure Applications Partnership
MIPS	Merit-based Incentive Payment System
MIPPA	Medicare Improvements for Patients and Providers Act of 2008
MMS	Measures Management System
NQF	National Quality Forum
PAMA	Protecting Access to Medicare Act of 2014
PRAC	Public Reporting, Alignment and Coordination
PRO	Patient-Reported Outcome
PROM	Patient-Reported Outcome Measure
PRO-PM	Patient-Reported Outcome Performance Measure
SES	Socioeconomic Status
SUPPORT Act	Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018
SOP	Standard Operating Procedures
TEP	Technical Expert Panel

Appendix A – Sections 1890 and 1890A of the Social Security Act – Links provided below for the 2019 RTC and the Social Security Act:

Report to Congress 2019

(https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Downloads/CMS-RTC-Quality-Measurement-March-1-2019_508.pdf)

Section 1890 of the Social Security Act

(https://www.ssa.gov/OP_Home/ssact/title18/1890.htm)

Section 1890A of the Social Security Act

(https://www.ssa.gov/OP_Home/ssact/title18/1890A.htm)

Appendix B – Description of the Activities and Work Performed under Sections 1890 and 1890A of the Act

Background

Appendix B lists activities and work performed by the CBE and other entities under the authority of sections 1890 and 1890A of the Act for FY 2019. The work is organized by year and by section 1890 and 1890A of the Act. The tasks are categorized by the four broad categories of work used throughout this Report: (1) Duties of the Consensus-Based Entity, (2) Dissemination of Quality Measures, (3) Program Assessment and Review, and (4) Program Oversight and Design. CMS notes that Appendix C of the 2019 Report to Congress includes all historical work awarded through FY 2018 using funds appropriated under Section 1890(d). Note that the NQF's Annual Report to Congress that details the CBE activities for the prior year described below can be found at the National Quality Forum page (http://www.qualityforum.org/Publications.aspx).

Details

2019

Section 1890:

(1) Duties of the Consensus-Based Entity

Sections 1890(b)(2) and 1890(b)(3)

- Endorsement and maintenance:

Period of Performance	Funding Amount	Fiscal Year
Option Year 2 09/27/19-09/26/20	**$9,679,359**	**2019**

  - Convened topic-specific multi-stakeholder committees with specialized expertise that reviewed new measures submitted for endorsement to ensure these measures are evidence-based, reliable, valid, verifiable, relevant to enhanced health outcomes, actionable at the caregiver level, feasible to collect and report, and responsive to variations in patient characteristics, such as health status, language capabilities, race or ethnicity, and income level; and is consistent across types of health care providers, including hospitals and physicians, thus advancing quality in healthcare for beneficiaries.
  - Utilized the established expert multi-stakeholder committees to ensure that measures endorsed by the CBE are updated (or retired if obsolete) as new evidence was developed and remains relevant.
  - CMS is the largest payer of healthcare. It is critically important to ensure the use of scientifically sound measures in CMS programs to move the needle on quality measurement and improvement for the good of the American people.
  - The process currently has two review cycles per year for each of the 14 topic-specific projects. Additional information about each of these projects and associated reports about the measures evaluated can be found at the links listed below:

- All-Cause Admissions and Readmissions Project
- Behavioral Health and Substance Use Project
- Cancer Project
- Cardiovascular Project
- Cost and Efficiency Project
- Geriatrics and Palliative Care Project
- Neurology Project
- Patient Experience and Function Project
- Patient Safety Project
- Perinatal and Women's Health Project
- Prevention and Population Health Project
- Primary Care and Chronic Illness Project
- Renal Project
- Surgery Project

  - The multi-stakeholder committees reviewed 36 new measures and 93 maintenance measures across 13 of the 14 project areas listed above.
  - The major deliverables were final project reports documenting the recommendations and final decisions by these committees.

Section 1890(b)(5)

- The CBE's Annual Report to Congress and Secretary of HHS

Period of Performance	Funding Amount	Fiscal Year
Option Year 2 09/27/19-09/26/20	**$123,821**	**2019**

  - Provided Congress and HHS Secretary with detailed information regarding the work completed in each task order awarded to the CBE. The 2019 report outlined the accomplishments and outcomes for the following task orders: Endorsement and Maintenance, Social Risk Trial, CQMC, Person-Centeredness Planning, Patient Reported Outcomes, EHR Data Quality, Diagnostic Error Maternal Mortality and Morbidity, Leveraging Quality Measurement to Improve Rural Health, and MAP.

Section 1890(b)(7)(A)

- Social Risk Trial

Period of Performance	Funding Amount	Fiscal Year
Option Year 1 05/15/19-05/14/20	**$401,660**	**2019**

  - Evaluated the use of social determinants in the risk-adjustment methodology for outcome measures as part of the measure endorsement/maintenance review process. In FY 2019, the Disparities Committee met during two web meetings and reviewed the risk-adjusted measures for the Spring and Fall

2019 endorsement cycle submissions, reviewed the risk models in use, and interpreted results. This work is critical because it will be used to inform the scientific standard for future endorsement and maintenance of measures.

- Core Quality Measures Collaborative (CQMC)

Period of Performance	Funding Amount	Fiscal Year
Option Year 1 09/14/19-09/13/20	**$275,884**	**2019**

  - Technical support updated the selection criteria for new core sets, prioritizing measures for implementation, developing an adoption guide for potential users, and providing technical support for measure calculation and implementation. The CQMC is a group which creates parsimonious groups of scientifically sound measures that efficiently promote a patient-centered assessment of quality that could be implemented across both commercial and government payers. In 2019, NQF convened the following CQMC workgroups: Accountable Care Organizations/Patient Centered Medical Homes/Primary Care, Cardiology, Gastroenterology, HIV & Hepatitis C, Medical Oncology, Obstetrics & Gynecology, Orthopedics and Pediatrics, which discussed the maintenance of the core sets. The HIV/Hepatitis C core set has been discussed and finalized by the workgroup and Steering Committee. Of the 12 HIV/Hepatitis C measures, 83% are currently used in CMS programs. The Gastroenterology workgroup finalized their maintenance discussion and voted on measures to update their core sets; their recommendations will be presented to the Steering Committee for finalization. The other workgroups continue to review and work on finalization of their core sets.

- Person-Centeredness Planning and Practices

Period of Performance	Funding Amount	Fiscal Year
Base Year 02/06/19-08/05/20	**$774,998**	**2019**

  - Defined the concept of person-centeredness, identified the competencies for performing person-centeredness planning, developed a measurement framework that evaluated the quality of person-centeredness care, identified gaps in the array of quality and efficiency measures that are available, identified priorities to advance or address these gaps for performance measurement; developed a research agenda, made recommendations for systems characteristics that support person-centered thinking, planning, and practice. The first interim report representing the Committee's efforts to date was made available for public comment in November 2019. In this report, the Committee addresses three key concerns related to designing practice

standards and competencies for person-centered planning. The final recommendation report is expected to be published in August 2020.

- Patient Report Outcomes - Best Practices on Selection and Data Collection

Period of Performance	Funding Amount	Fiscal Year
Base Year 06/10/19-06/09/20	**$502,288**	**2019**

  - Elicited expert input on how to identify patient reported outcomes (PROs) that are most valuable for care planning, interpreted PROs accurately, incorporated PRO data collection into clinician workflow, secured clinician buy-in for PRO data collection, measured and addressed respondent burden, increased and maintained a high response rate over time to ensure that the data collected are representative of the target population. Expert input will be applied to Use Cases in heart failure, joint replacement, and burn/trauma care to illustrate best practices. The initial discussions by the multi-stakeholder workgroup has prompted the conceptualization of additional patient reported outcomes – performance measures (PRO-PMs) with plans to develop these concepts to fully specified measures. The final recommendation report is expected to be published in June 2020, which will inform CMS' PRO measure development.

- Electronic Health Records Data Quality

Period of Performance	Funding Amount	Fiscal Year
Base Year 07/01/19-12/31/20	**$544,421**	**2019**

  - Awarded to identify risk factors that could impact data quality of EHRs, which in turn reduced the reliability and validity of the eCQMs calculated using EHR data; explored innovative approaches that assessed EHR data quality for developing eCQMs, addressed data compatibility issue for EHR data from different platforms, and validated EHR data, and examined the effectiveness of these approaches. With many eCQMs in development for several CMS programs, this work will ensure scientifically sound measures using quality EHR data. In 2019, the CBE convened a multi-stakeholder technical expert panel and started to conduct an environmental scan to seek existing literature discussing the extent of EHR data quality issues, current practices addressing these issues and their challenges, and key stakeholders' major findings on what relevant information is currently available. The multi-stakeholder technical expert panel had their first webinar meeting to discuss the scope of the work and lay the foundation for the research questions of the environmental scan. In the future, they will review the

environmental scan and make recommendations for the final report which is expected to be published in December 2020.

- Diagnostic Error

Period of Performance	Funding Amount	Fiscal Year
Base Year 07/15/19-10/14/20	**$524,854**	**2019**

  - In support of the Administrator's initiative to protect patients and improve their outcomes, awarded task order to refine the domain of Diagnostic Process and Outcomes of the Diagnostic Quality and Safety Measurement framework developed in 2017, and provide stakeholders with use cases to illustrate how to apply the measures in the domain to improve safety across care settings, systems, payers, and patient populations. A final report is expected to be published in October 2020.

- Maternal Mortality and Morbidity

Period of Performance	Funding Amount	Fiscal Year
Base Year 09/18/19-09/17/21	**$781,321**	**2019**

  - Maternal morbidity and mortality are key indicators of health and reflect the accessibility of maternal and other health care services. In support of CMS' initiative to improve this critical area, awarded task order to develop measurement frameworks that address maternal mortality and maternal morbidity by identifying risk factors for each outcome, and provide innovative approaches that could potentially improve outcomes and reduce disparities, especially among maternal patients from racial/ethnic minority groups and rural communities. Maternal mortality and maternal morbidity are addressed separately in this task order. This task order is a 24-month effort that will culminate with a final recommendation report to be published by mid-September 2021.

- Leveraging Quality Measurement to Improve Rural Health

Period of Performance	Funding Amount	Fiscal Year
Base Year 09/06/19-09/05/20	**$398,016**	**2019**

  - Awarded to identify quality measures that are high priority for improving rural health but are challenging for low-volume healthcare providers to report because these measures have minimum case requirements. These measures

were a priority for testing the innovative statistical approaches identified by the Rural Health Technical Expert Panel in 2019 and addressed the challenges of low case volume. The final recommendation report will be published in September 2020. Future contract years will focus on reviewing and updating the rural-relevant core measure sets developed by the MAP Rural Health Workgroup in 2018; and updating and expanding the telehealth framework developed in 2017 to enable comparison of quality delivered via telehealth versus in-person.

Section 1890A[xxii]:

(1) Duties of the Consensus-Based Entity

- The Measure Applications Partnership (MAP)

Period of Performance	Funding Amount	Fiscal Year
Option Year 1 03/27/19-03/26/20	**$1,357,149**	**2019**

- Convened the MAP, a multi-stakeholder partnership that provided recommendations to HHS on measure selection for federal quality reporting and value-based purchasing programs for hospitals, post-acute care/long-term care, and clinician settings. In April 2019, the MAP Rural Health Workgroup was convened to provide rural perspectives to the MAP Workgroups in measure selection for Medicare quality reporting and value-based purchasing programs. During the 2019 pre-rulemaking cycle, CMS received 50 submissions for the Measures Under Consideration (MUC) List, which was a reduction from the 67 submissions in 2018. By focusing on cross cutting priority areas associated with improved outcomes, CMS proposed 17 unique individual measures for review by the MAP. The 17 measures proposed in the 2019 MUC List included 9 outcomes measures, 6 process measures, 1 structural measure, and 1 composite measure, which reflected quality priorities including Making Care Safer by Reducing Harm Caused in the Delivery of Care, Strengthen Person and Family Engagement as Partners in Their Care, Promote Effective Communication and Coordination of Care, Promote Effective Prevention and Treatment of Chronic Disease and Make Care Affordable. The MAP supported 14 measures for use in CMS programs, and did not support 3 measures.

[xxii] The performance period for Option Year 1 of the MAP task order started on April 1, 2019 and is supported by FY 2019 funding. Option Year 1 will end on March 31, 2020.

(2) Dissemination of Quality Measures

Section 1890A(b)

- The Measures Management System (MMS)

Period of Performance	Funding Amount	Fiscal Year
Base Year mod + 09/30/18-09/29/19	**$228,974**	**2019**
Option Year 1 09/30/19-09/29/20	**$3,302,774**	
Total	**$3,531,748**	

  - Standardized systems for developing, implementing, and maintaining the quality measures used in various initiatives and programs both in the public and private sector. The MMS provides support and assistance to entities interested in measure development through education and resources through the MMS Blueprint, MMS website and monthly newsletters to over 80,000 subscribers. To further support the alignment and harmonization of quality measures across CMS and with private payers, the MMS also supports and maintains the CMS Measures Inventory Tool (CMIT), as well as other innovative tools, like the CMS Environmental Scan Tool, to ease the burden of environmental scans throughout the measure development by providing the most recent publications relevant to existing measures.

- The Alignment of Quality and Public Reporting Programs and Websites

Period of Performance	Funding Amount	Fiscal Year
Base Year 03/22/19-03/21/20	**$1,108,992**	**2019**

  - In support of the Administrator's initiative to liberate data in a consumable way for patients making healthcare decisions, awarded contract to align, document, and coordinate across eight original Compare Sites to support transition to a future state of public reporting.

(3) Program Assessment and Review

Section 1890A(a)(6)

- Impact Assessment of CMS Quality and Efficiency Measures

Period of Performance	Funding Amount	Fiscal Year
Base Year 07/01/19-06/30/20	**$2,498,558**	**2019**

- Assessed the quality and efficiency impact of the use of endorsed measures in CMS quality reporting programs and published a triennial report. The upcoming 2021 Impact Assessment Report will include a comprehensive analysis of quality measure performance trends, disparities, patient impact, and costs avoided, as well as the results of a national survey of quality improvement activities by leaders of Home Health Agencies related to the use of CMS quality measures. Work began in FY 2019 to evaluate more than 800 measures and 27 reporting programs to inform CMS on the value of quality measures in improving strategic healthcare priorities, patient outcomes, and reducing healthcare costs. Additionally, production was started on a national dashboard to contain more real-time data for quality improvement.

(4) Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act of 2018 (Section 6093)

Section 1890A(g)

- Technical Expert Panel for the Review of Opioid and Opioid Use Disorder Quality Measures

Period of Performance	Funding Amount	Fiscal Year
Base Year 02/07/19-02/06/20	**$542,555**	**2019**

- This Task Order fulfilled the mandate stipulated in the SUPPORT Act of 2018 section 6093 by convening a Technical Expert Panel (TEP) to review existing opioid and opioid use disorder measures for possible use in CMS programs and identify gap areas for future measure development. In September 2019, the CBE completed an environmental scan to assess the current state of opioid-related healthcare quality measures. This environmental scan report identified 207 performance measures and 71 measure concepts. The TEP will use the results of the scan as a foundation to develop guidance for inclusion of measures in various federal quality programs to best address the U.S. opioid epidemic. The TEP's final recommendations report will be published in February 2020.