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

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A Report Required by the Bipartisan Budget Act of 2018

United States Department of Health and Human Services

Centers for Medicare & Medicaid Services

(September 2022)

Executive Summary

The United States (U.S.) Department of Health and Human Services (HHS), which includes the Centers for Medicare & Medicaid Services (CMS), is committed to leading the transition to a value-based health care system that is patient-focused, coordinated, and cost effective. Ensuring the highest quality health care possible for all Americans, where payment is based on value and not volume of services, is a primary objective for CMS. Value-based care improves the quality and effectiveness of care while lowering the cost of healthcare and making healthcare more affordable to consumers.

For more than 20 years, CMS has been the leader in establishing and refining national quality standards and quality measurement programs that have led the efforts to improving health care for its beneficiaries across the U.S. CMS measures health care quality in many areas including health outcomes; 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 critical, transparent information to providers, as well as to beneficiaries, on the quality of care and identifies changes that are needed to improve health care value and patient outcomes.

As CMS moves forward and evolves the Meaningful Measures Initiative, the agency builds on the strengths of the initiative while working to create broader, agency-wide actions to modernize and expand quality work.

With the support of federal stakeholders and government contractors, CMS is prioritizing the development and use of digital measures, improved electronic infrastructure, harmonized measures across public (both within CMS and across federal agencies such as the Department of Veterans Affairs (VA) and Department of Defense (DOD)) and private payer quality reporting, and targeted efforts to address rural health concerns, health inequities, population health and patient-reported outcomes (PRO).

It has been another unprecedented year as CMS continues to lead the way to protect the health and safety of this nation's patients and providers in response to the Coronavirus (COVID-19) pandemic. Healthcare is at a point of transformation. As a result, CMS has adopted policies around expanded care and use of telehealth services, as well as other, flexibilities to ensure resources are at the disposal of healthcare providers across states, tribes, and localities.

Additionally, equity has become a key priority. As one resource to address health equity, CMS contracted with the consensus-based entity (CBE) to perform work related to addressing the health inequities identified during the ongoing COVID-19 pandemic. With a disparities lens, areas of measure framework development funded by CMS included the impact of telehealth on rural health care system readiness; maternal morbidity and mortality; functional and social risk adjustment; and collaboration with non-healthcare sectors to address polysubstance use among opioid users with behavioral health conditions. Additionally, endorsed measures were aligned and refined.

As required under 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 third annual update of the coordinated strategy and related funding for using the 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 fiscal 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.

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 2021 expended funds, the CBE 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 quality reporting programs. Section III and Appendix B describe in more detail 2021 expended funds. The current CBE 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. The CBE has a distinctive role in its work with CMS to advance the quality measurement agenda.

As a result of the work in 2021, CMS advanced understanding and efforts to increase measure alignment across programs and the health care system, reduced quality measure reporting burden, modernized public reporting of quality measure information and identified high priority measure gaps and best practices in quality measurement including unique concerns related to maternal morbidity and mortality[i], behavioral health, electronic health record (EHR) data, rural communities, patient engagement, and care coordination. Sections 1890 and 1890A funding have also supported the critical work during a public health emergency, examining care with use of telehealth services and other flexibilities, including completion of a foundational analysis in system readiness[ii] and telehealth that has paved the way for a modernized system of delivery and corresponding quality reporting. CMS believes these transformative actions will advance quality measurement that is actionable, informative, transparent, and less burdensome while improving healthcare outcomes and providing patients with meaningful information to best make informed healthcare choices. Throughout quality measurement and quality improvement work supported by the CBE and other entities, CMS aims to examine new risk adjustment techniques to support its efforts to reduce disparities in health. In addition, the work described in this report will leverage the insights of clinical and quality measurement experts from academia, private sector, Federal, tribal, and state governments, and patient advocates. For example, CMS continues to examine racial and ethnic health inequalities that continue to exacerbate poor health outcomes in

[i] The NQF Maternal Morbidity and Mortality task order is supported by FY 2019 funding. The performance period is from 9/18/2020 through 9/17/2021.

[ii] National Quality Forum (NQF) (June 2019). Healthcare System Readiness Final Report (http://www.qualityforum.org/Publications/2019/06/Healthcare_System_Readiness_Final_Report.aspx, accessed 7/14/2020).

rural communities and is collaborating with a diverse group of stakeholders to inform the use of quality measures as a tool to improve rural healthcare system readiness.

Current and future funding for years 2022 and 2023 continues the work in the categories noted previously, since the nature of measures development is cyclical. Through the CBE's efforts, 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 the CBE 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 and alignment of measures across public and private payers to 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 in order 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 intends 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 2022 and 2023, as specified in section IV, are informed and refined by the experience of previous years in order to reflect best value for taxpayer dollars.

I. Introduction

I.A. Background

CMS works in partnership with numerous entities, including patients and families; clinicians; hospitals and outpatient providers; post-acute care (PAC) and long-term care (LTC) facilities; 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 contracts with a CBE, currently NQF, pursuant to section 1890 of the Act to endorse 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 pursuant to sections 1890 and 1890A of the Act for the period of 2018 and prior. As a result of the work in 2020, CMS continued to advance

alignment of measures, identified quality measurement gaps in priority areas, and engaged stakeholders to root out healthcare inequities.

This year, CMS is strengthening its equity research, as COVID-19 has highlighted disparities in care with maternal health outcomes and disparities, overdose and mortality related to opioid use with behavioral health conditions, and telehealth and healthcare system readiness in rural areas. The CBE continued efforts with stakeholders to address identified gaps in measurement and make recommendations on these areas.

This Report to Congress 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, 2020, and 2021 Reports 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 Section 1890(e) of the Act

Section 1890(e)(1) requires this 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. CMS submitted the 2019 Report to Congress containing the comprehensive plan on March 1, 2019. This is the fourth annual Report to Congress, 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.

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 2019 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. The Meaningful Measures 2.0 Initiative remains to be the key driver of strategic efforts for the comprehensive plan.

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

- Duties of the CBE[iv]
- Dissemination of measures[v]

[iii] Functions associated with sections 1890 and 1890A of the Act, as related to programs under title XVIII and title XIX of the Act.

[iv] Section 1890(b) of the Act.

[v] Section 1890A(b) of the Act.

- Program assessment and review[vi]
- Program oversight and design[vii]

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, in part, 1890A of the Act, which include funding for the CBE 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) 2022 through 2023 to support the advancement and refinement of the quality measurement activities required under sections 1890 and 1890A of the Act. Cost estimates developed for 2022 and 2023 were developed directly from the experiences and lessons learned from work in 2021 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.

The estimates and tasks anticipated to be accomplished in 2022 and 2023 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 and the individual prior Reports to Congress. Appendix B contains details of task orders and activities under sections 1890 and 1890A of the Act for actions awarded using FY 2021 funding under section 1890(d). Appendix C includes information to address additional requirements in Section 1890(e)(2) of the Social Security Act, as added by the Consolidated Appropriations Act of 2021. The information in Appendix C reflects both FY 2020 and FY 2021 related activities.

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.

In 2017, CMS launched the Meaningful Measures Initiative to improve health outcomes for patients and beneficiaries by focusing on streamlining quality measurement and reducing burden

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

[vii] Sections 1890 and 1890A of the Act.

to measures entities. CMS used the Meaningful Measures framework to eliminate redundant, low-impact measures--along with prioritizing outcome measures, resulting in the removal 15% of the measures across the entire CMS portfolio.

Unfortunately, known challenges in quality measurement continue to exist, such as burden on measured entities, challenges associated with electronic health record (EHR) data for quality measurement, usefulness of measures for patients and caregivers, and the measurement of disparities in social determinants of health to inform equity improvement. Recognizing the continuation of these known challenges in quality measurement, CMS has committed to evolving the Meaningful Measures Initiative to build on the strengths of 1.0 while creating a broader, agency-wide initiative designed to modernize and expand the quality work across CMS. CMS will hold onto the original principles to streamline development and leverage individual measures to the fullest extent possible to drive outcome improvement, but more is needed to address these measurement challenges.

Throughout the first half of 2020, components across CMS worked together to draft initial healthcare priorities and actions to be implemented across the entire Agency, including a new, simplified quality measurement framework. In late 2020 and early 2021, CMS held multiple listening sessions with Medicare and Medicaid stakeholders to have in-depth discussions on the priorities and framework and gather stakeholder feedback resulting in five goals.

Based on these discussions and input, CMS finalized the Meaningful Measures 2.0 framework in 2021. Under the framework, CMS will strive to shape quality measures that drive value-based care.

CMS will use the following five interrelated goals to ensure the use of impactful quality measures to improve health outcomes and to support the delivery of value:

- Using only high-value quality measures that impact key quality domains.
- Aligning measures across value-based programs.
- Prioritizing outcome and patient-reported measures.
- Transforming measures to be fully digital and incorporating all-payer data.
- Developing and implementing measures that reflect social and economic determinants.

The goals outlined require work across the agency, and in some instances across the entire federal government, with support and input needed from private partners and stakeholders. CMS plans to continue gathering feedback on these goals internally and externally, as the plan is finalized. With the finalization of these interrelated goals, CMS hopes to:

- Align measures across CMS, federal programs, and private payers to reduce the number of unique measures, thereby reducing the burden to CMS and measured entities associated with those measures.
- Accelerate ongoing efforts to streamline and modernize programs, reducing burden, and promoting strategically important focus areas.
- Use data and information as essential aspects of a healthy, robust healthcare infrastructure to allow for payment and management of accountable, value-based care and development of learning health organizations.

- Empower patients through transparency of data and public reporting, so patients can make the best-informed decisions about their healthcare.
- Commit to a person-centered approach in quality measure and value-based incentives programs to ensure that quality and safety measures address healthcare equity.

It is through these goals and objectives that CMS will be able to use impactful quality measures to improve health outcomes and deliver value by empowering patients to make informed care decisions while reducing burden to measured entities, which starts with how the measures in CMS programs are developed, implemented, and evaluated.

As CMS continues to evolve the new comprehensive plan and ensure the goals and action resonate, not just across the Agency, but across the entire quality measurement enterprise, CMS will build on the strengths of this Meaningful Measures initiative. CMS will do this while creating a broader, agency-wide initiative designed to modernize and expand the quality work across CMS, impacting the entire industry and improving health outcomes for all patients.

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

In FY 2021, CMS advanced the critical knowledge base for the continued transition to a healthcare system built on value. With FY 2021 expended funds and the work of the CBE and other entities pursuant to sections 1890 and 1890A of the Act, CMS built 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 developing guide measurement to address gaps in maternal morbidity and mortality, opioids and behavioral health conditions, and rural telehealth and healthcare system readiness. These efforts closely align with key priorities of the Meaningful Measures 2.0 Framework, including behavioral health, equity, safety, seamless care coordination and wellness and prevention.

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, 2021*

	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	$ 96.35	$ 1.19	$ 95.5	$ 0.85
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	$ 72.40	$ 0.53	$ 71.20	$ 1.25
Bipartisan Budget Act of 2018 (Pub. L. 115-123, Sec. 50206)**	$ 15.00	$ 0.00	$ 15.00	$ 10.82	$ 4.18	$ 10.78	$ 0.04
Coronavirus Aid, Relief, and Economic Security Act (CARES Act) (Pub. L. 116-136, Sec. 3802)	$ 20.00	$ 0.00	$ 20.00	$ 24.82	$ (4.82)	$ 23.78	$ 1.04
Consolidated Appropriations Act of 2021 (CAA 2021) (Pub. L. 116-260, Sec. 102)	$ 26.00	$ 0.00	$ 26.00	$ 21.74	$ 4.26	$ 10.30	$ 11.44
Grand Total	**$ 306.00**	**$ (5.04)**	**$ 300.96**	**$ 293.50**	**$ 7.46**	**$ 278.93**	**$ 14.57**

* 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.
***Previously obligated balances have been de-obligated during FY2021. Some balances may be available for future obligations.

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 2021. Activities not performed by the Secretary[viii] under section 1890A of the Act were carried out by the CBE (convening multi-stakeholder groups to provide input on measures through the MAP), as well as other CMS funded contractors. Table 2 excludes activities conducted by the CBE that are not funded by the appropriations for sections 1890 and1890A of the Act. Appendix B provides additional details on the activities, including the task orders, for which these funds were obligated or expended.

Table 2: 2021 Funding (in millions) obligated, expended, and unexpended under sections 1890 and 1890A of the Act, including administrative costs*

Funding Section	Obligations	Expended Amount	Unexpended Balances
1890	$10.90	$0.82	$10.08
1890A	$10.81	$1.21	$9.60
Administrative	$0.03	$0.03	$0.00
Grand Total	**$ 21.74**	**$ 2.06**	**$ 19.68**

* Numbers have been rounded to the nearest 10,000.

The section of this Report below provides information about the types of activities for which the appropriated funds 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 current CBE with which HHS has contracted to perform duties and tasks under sections 1890 and 1890A of the Act. Under the contract with HHS, the CBE convenes multi-stakeholder groups to review new or endorsed quality measures for conceptual importance, scientific acceptability, use or usability, and feasibility. In addition, CMS has tasked the CBE to identify measure priorities and measure gaps to support HHS efforts to improve quality of care and health outcomes. The CBE 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 section 1890A pre-rulemaking process, the CBE convenes multi-stakeholder workgroups that provide input on the selection of quality measures under consideration for use in certain specified quality reporting and value-based purchasing (VBP) programs.

[viii] Section 1890(a), (b)(5)(B), and (e) describes activities performed by the Secretary. These activities are not included in Table 2.

Table 3 below describes the funding for FY 2021 for activities performed by the CBE under sections 1890 and 1890A of the Act. Those activities included: endorsement and maintenance of quality measures, publication of a required annual report with prescribed activities, including identifying gaps in quality and efficiency measures, and assisting CMS in 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 continued support for the CQMC to align quality measures used by public and private payers across a wide array of specialty areas; developing recommendations for geographical quality measurement attribution models applicable to mass casualty incidents, public health emergencies and high-acuity emergency care-sensitive conditions; and developing technical guidance for measure developers on selecting patient-reported outcome measures (PROMs) that may be used for digital patient-reported outcome performance measures (PRO-PMs). Other priority setting efforts included identifying all-payer measures and measure concepts that could address opioid-related overdose and mortality among polysubstance users with co-occurring behavioral health conditions; eliciting expert input to define and establish comprehensive terms to encompass the roles in measure development of patients, caregivers and Patient Advisors; recommended best practices for addressing challenges associated with leveraging EHR-sourced data to improve care communication and coordination. The duties of the CBE performed by NQF under section 1890A of the Act included convening multi-stakeholder groups through the MAP that provided input on measure selection for use in various quality programs. For further details of the purpose of each task order, please refer to Appendix B.

Table 3: Funding (in millions) for FY 2021 for activities performed by the CBE under sections 1890 and 1890A of the Act*

Section and Fiscal Year	Obligations	Expended Amount	Unexpended Balances
Section 1890			
2021	$10.90	$0.82	$10.08
Section 1890A			
2021	$2.98	$0.60	$2.38
Grand Total	**$13.88**	**$1.42**	**$12.46**

* Numbers have been rounded to the nearest 10,000.

(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, in addition to providing innovative tools to help address quality measurement challenges. 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 CBE 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 VBP 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 across CMS programs to inform stakeholders, manage the measure portfolio, promote measure alignment, and guide measure development. In addition, CMIT contains an environmental scan support tool for all measure developers to be used 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. Additionally, CMIT contains a new tool, the De Novo Measure Scan (DNMS), that is open to the public for use. The DNMS is a tool that helps users efficiently find up-to-date literature about novel measure concepts to support innovation in measure development and maintenance, re-specification, and other scenarios where current, accurate, and relevant evidentiary support specific to quality measurement is needed

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 100,000 subscribers. Webinars focus on key topics that promote the CMS quality priorities and goals. With respect to the pre-rulemaking process, the MMS supports CMS' gathering of measures for inclusion on the list of Measures Under Consideration (MUC) 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

In 2020, CMS modernized public reporting by replacing the original eight Compare Sites and Data.Medicare.gov with two new websites, Care Compare and Provider Data Catalog (PDC), that make safety standards and quality improvement measures accessible and interpretable to various stakeholder groups and the general public. In 2021, CMS continued efforts to maintain these websites and enhance features based on user feedback. Efforts included continued configuration of the Compare tools and PDC, defining processes and simplifying procedures for data refreshes and releases, implementation of multiple documentation repositories to facilitate improved coordination among the product and project teams. This contract oversees the global coordination and 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 2021 funding for activities under section 1890A of the Act related to the dissemination of quality measures, which included the MMS, as well as coordination, testing, and alignment for the dissemination of quality measures via the two new replacement websites.

Table 4: Funding (in millions) provided in FY 2021 for activities under section 1890A(b) of the Act related to dissemination of quality measures*

Fiscal Year	Obligations	Expended Amount	Unexpended Balances
2021	$ 4.64	$ 0.51	$ 4.13

*Numbers have been rounded to the nearest 10,000.

(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 measures described in section 1890(b)(7)(B) of the Act and make that assessment available to the public.[ix] To comply with this provision, CMS published Impact Assessment Reports in 2012, 2015, 2018, and 2021.

For the 2021 Impact Assessment Report, CMS conducted multiple analyses of measure performance trends, disparities, patient impact, and costs avoided, as well as national surveys of home health agency quality leaders, to evaluate the national impact of the use of quality measures. In FY 2021, we continued critical work for the upcoming 2024 Impact Assessment Report. The data period for the 2024 report spans from 2019 through 2022. The COVID-19 pandemic, which started in early 2020, will feature prominently in the 2024 report. In particular, the report will discuss how the pandemic has impacted measure use in various CMS programs, and how CMS quality measurement efforts have responded to the pandemic. We expect the topic of health equity to be front and center in the 2024 report. Because the COVID pandemic has aggravated existing disparities, the 2024 report will provide a deeper dive into the nature and extent of disparities experienced by various medically underserved communities. The report will illustrate successes in improving equity, and examine opportunities for narrowing the quality gaps.

As in previous reports, key indicators (comprised of CMS quality measures) were selected to inform the 2024 Impact Assessment report. These Key Indicators support the statutorily required assessment under section 1890A(a)(6) of the Act 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. CMS's efforts were supported not only by a Technical Expert Panel (TEP) comprised of nationally accredited private and public stakeholders, but also by an active Federal Assessment Steering Committee (FASC), including the Veterans Health Administration (VHA), the, Agency for Healthcare Research and Quality (AHRQ), Assistant Secretary for Planning and Evaluation (ASPE), Centers for Disease Control and Prevention (CDC), Defense Health Agency (DHA), Health Resources and Services Administration (HRSA), Indian Health Service (IHS), Office of the National Coordinator for Health Information Technology (ONC), and Substance Abuse and Mental Health Services Administration (SAMHSA).

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

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. 2024

Table 5: Funding (in millions) in FY 2021 related to activities under section 1890A of the Act for program assessment and review*

Fiscal Year	Obligations	Expended Amount	Unexpended Balances
2021	$ 3.19	$ 0.10	$ 3.09

* Numbers have been rounded to the nearest 10,000.

(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 in this area have been funded or implemented in FY 2021 under section 1890 or 1890A of the Act. Future expenditures in this area are not anticipated.

Table 6: Funding (in millions) for FY 2021 for activities under section 1890A of the Act related to program oversight and design*

Fiscal Year	Obligations	Expended Amount	Unexpended Balances
2021	$ 0.00	$ 0.00	$ 0.00

* 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

As the largest payer of healthcare services in the U.S., CMS continues to pursue improvements to the healthcare system through quality reporting programs that use payment incentives, quality improvement activities and increased transparency through public reporting of performance results.

The 1890/1890A task orders CMS anticipate in 2022 and 2023 will help to modernize the way CMS approaches quality measurement and the way people receive information to make the best decisions for themselves and their families, particularly in the current Public Health Emergency.

Through the efforts of the CBE and the multi-stakeholder groups convened by the CBE, CMS is uniquely informed by key health sector and national quality improvement leaders and is guided by the work (outlined in sections 1890 and 1890A of the Act) 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 high-value measures to inform decision making for patients, clinicians, and healthcare systems. CMS seeks to make significant 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's 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 2022 and FY 2023) to carry out quality measurement activities under the four categories of tasks previously described. Estimates for anticipated obligations are subject to the availability of sufficient funds.

Cost estimates for FY 2022 and FY 2023 were developed directly from the experiences and lessons learned from previous work and reflect efforts to reduce overhead and focus on the specific activities and deliverables that would drive us to accomplish the quality goals.

The task orders listed below are anticipated awards using FY 2022 and FY 2023 funding, building from lessons learned and experiences from previous years. 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 2022 and are described in prior Reports to Congress described in Appendix A. 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 FY 2022 or FY 2023, 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
Base Period 09/27/22-09/26/23	**$7,000,000**	**2022 (Estimated)**
Option Period 1 09/27/23-09/26/24	**$7,500,000**	**2023 (Estimated)**

Endorsed measures are considered the standard for healthcare measurement in the U.S. Expert multi-stakeholder groups that are comprised of various stakeholders including patients, providers, and payers evaluate measures for endorsement. HHS, including CMS

and other federal agencies, and many private sector entities use endorsed measures above all others because of the rigor and consensus-based process used to ensure such measures meet standardized, transparent criteria for evidence and testing. As CMS is the largest healthcare payer in this country, it is critical that its measures are valid and reliable so that CMS can properly evaluate the health of beneficiaries, be accountable to our stakeholders, and improve the quality of healthcare.

It is also critical that the CBE endorsement and maintenance process helps 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 homes, palliative, and hospice care. The CBE process supports measures that address CMS priorities 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 contract will continue the statutorily-mandated work under section 1890(b)(2)-(3) of the Act for endorsing and maintaining measures in a consensus-based process so that CMS can incorporate feedback and best-in-class measures in its quality and VBP programs.

The Measure Applications Partnership (MAP)

Period of Performance	Funding Amount	Fiscal Year
Base Period 09/27/22-09/26/23	**$3,800,000**	**2022 (Estimated)**
Option Period 1 09/27/23-09/26/24	**$4,000,000**	**2023 (Estimated)**

This is a five-year task order that supports the MAP, a multi-stakeholder partnership that guides HHS on the selection of performance measures for Medicare quality programs. This statutorily-mandated activity under section 1890A(a) of the Act is part of the Medicare pre-rulemaking process. Additionally, Section 102(c) of Division CC of the Consolidated Appropriations Act, 2021 amended section 1890(b) to add a new paragraph (4) that authorizes the CBE to provide input for measures that could be considered for removal.

The MAP convenes key stakeholders to evaluate quality and efficiency measures that are being considered for use in specific Medicare quality programs, including public reporting programs, and to review existing measures in various Medicare programs, as well as the review of measures for removal under the Measure Set Review process. CMS uses the published feedback and input in its federal rulemaking process when selecting and removing measures for these programs.

There are three workgroups that evaluate measures – a Hospital Workgroup, a Clinician Workgroup, and a Post-Acute Care/Long-Term Care Workgroup and all of these workgroups are informed by the Rural Health and Health Equity Advisory Groups, multi-

stakeholder groups that review measures for rural relevancy and impacts on health equity. 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 health equity, maternal health, nursing home quality and safety, hospice quality and safety, PRO-PMs, 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.

Other Task Orders of the Consensus-Based Entity

Other task orders are assigned through contracts to the CBE to help advance quality through 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
Base Period 09/14/22-09/13/23	**$768,157**	**2022 (Estimated)**
Option Period 1 09/14/23-09/13/24	**$600,000**	**2023 (Estimated)**

This task order implements the statutory provision of section 1890(b)(7) of the Act. The CQMC, a multi-stakeholder group of healthcare leaders that facilitate cross-payer measure alignment through the development of core sets of measures to assess the quality of healthcare in the U.S., is a public-private partnership between America's Health Insurance Plans (AHIP) and CMS and is currently convened by NQF in its role as the CBE. The CQMC supports nationwide quality measure alignment between Medicare and private payers and in turn, advances the ongoing work to align reporting across programs and health systems. This task order supports Agency efforts to reduce burden, creating parsimonious measure sets that reflect priorities related to equity and digital measurement.

To date, CQMC has developed 12 core measure sets to be used in high impact areas:

- ACO/PCMH/Primary Care
- Cardiology
- Gastroenterology

- HIV and Hepatitis C
- Medical Oncology
- Obstetrics and Gynecology
- Orthopedics
- Pediatrics
- Behavioral Health
- Neurology
- Digital Measures
- Cross-Cutting Measures

Additional work has been done to address equity, digital measures and cross cutting work in the aforementioned core sets. Future work will include support of implementation and the development of a long-term strategy, as well as additional core set work. 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.

- Building a Roadmap from Patient-Reported Outcome Measures to Patient-Reported Outcome-Performance Measures

Period of Performance	Funding Amount	Fiscal Year
Option Period 1 12/01/21-11/30/22	**$666,673**	**2022 (Negotiated)**
N/A	**N/A**	**2023**

This task order implements the statutory provision of section 1890(b)(7) of the Act. Incorporating the voice of the patient through patient-reported outcomes (PRO) is a priority of CMS. However, currently 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 PROs.

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 outcome measure (PROM)s and PROs refer to the information collected directly from patients on patient questionnaires, tools, or survey instruments about health status, functioning, or symptoms. Taking it one step further, performance measures can be developed for the healthcare entities providing the healthcare services.

Although a few performance measures have been developed from PROMs, this work will address this gap by developing a step-by-step guide on how to turn a PROM 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 work began in FY 2020 and continued in FY 2021. This task order will inform CMS' efforts in all aspects of developing and implementing PRO-PMs through the completion of a technical guide. 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 EHRs 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 Period 2 12/14/21-08/15/22	**$274,023**	**2022 (Negotiated)[x]**
N/A	**N/A**	**2023**

The need for quality measurement in rural healthcare persists. Rural providers continue to confront challenges in reporting quality measures, especially as it relates to access to data, reporting infrastructure, and small denominators (lower case volumes) leading to statistical methodology challenges. The CBE implemented the 15-month base period of this task order in FY 2020. With this work, the CBE maintains a focus on timely quality measurement issues to support CMS' priority for strengthening care provided in rural settings, applying a rural lens to CMS' measure development work and measure selection for program use.

  - In FY 2022, 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

[x] Option Period 2 will be supported by FY 2022, rather than FY 2021, funding because its performance period will not begin until 12/15/2021. Due to major staffing changes at NQF and the departure of all the key personnel for this project in early 2020, as well as the COVID-19 pandemic, NQF requested an extension for the performance period of the base period to get new staff up to speed for the project, and to enable the clinicians on the Rural Health Workgroup to focus on treating COVID-19 patients. CMS extended the performance period from 9/5/2020 to 9/29/2020. At the same time, CMS moved the telehealth work, originally slated for Option Period 2, to Option Period 1 to enable the agency to timely respond to COVID-19. Because of its scope, the telehealth work requires a longer performance period to complete. As a result, Option Period 1 had a 14.5-month performance period, from 9/29/2020 through 12/14/2021. Because FY 21 funding has to be spent before 10/1/2021, and Option Period 2 will not start until mid-December 2021, the work of Option Period 2 will be supported by FY22 funding rather than FY 21 funding.

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 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 morbidity, chronic co-morbidities have afflicted the general population and are found to be even more acute among the rural population. The major deliverables include an environmental scan of measures, some of which may not be CBE-endorsed, that can be considered for potential addition to the core set, and a final report of recommendations.

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 CBE's final reports will inform CMS' measure development and pre-rulemaking by selecting measures that are feasible and minimally burdensome for rural health care providers.

Total for Duties of the Consensus-Based Entity

Funding Amount	Fiscal Year
$14,008,85	**2022**
$13,300,00	**2023**

(2) Dissemination of Quality Measures Used by the Secretary under Section 1890A(b) of the Act

- The Measures Management System (MMS)

Period of Performance	Funding Amount	Fiscal Year
Option Period 3 mod 11/10/21-11/09/22 **Option Period 4 09/30/22-09/29/23** **Total**	**$6,980**** **$4,294,795** **$4,301,775**	**2022 (Negotiated)**
Option Period 4 mod 11/10/22-11/09/23 **Base Period 09/30/23-09/29/24** **Total**	**$6,000***** **$4,500,000** **$4,506,000**	**2023 (Estimated)**

*** $5,700 is an annual IT cost for the SSL Certificate for CMIT

The technical support by the Measures Manager and its tools, resources, and education enables 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 also includes measure submissions for the entire quality measure industry to support CMS' statutorily-mandated pre-rulemaking process under section 1890A(a) of the Act.
- 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 100,000 subscribers, and the MMS website.
- Continued support for measure developers, contracted by CMS and external to CMS, by providing a web-based Blueprint, allowing developers to find the information more easily. Additionally, for CMS-contracted measure developers and CMS staff the MMS provides a web-based library that houses many quality related deliverables submitted to CMS across contractors to promote the sharing of best practices, collaboration across contracts and programs, and the streamlining of work, such as environmental scans and business cases.

As CMS evolves its quality footprint, it is critical that the Measures Manager continues to engage and educate stakeholders, while also documenting best practices and supporting measure developers to ensure consistent and high caliber measures to improve health outcomes for beneficiaries. With the goal and focus of improved health outcomes, the Measures Manager tools, resources and technical assistance are intended to support improved measure development and alignment processes.

- The Quality Measure Index (QMI)

Period of Performance	Funding Amount	Fiscal Year
Option Period 2 mod 12/30/21-06/30/22	**$822,755**	**2022 (Negotiated)**
Option Period 3 07/01/22-06/30/23	**$228,372**	**2023**

CMS is developing the Quality Measure Index (QMI), a transparent and reliable scoring instrument based on standardized definitions of quantifiable measure characteristics, to systematically support the assessment and selection of individual quality measures that provide meaningful quality performance information. The QMI is capable of producing repeatable results yet adaptable to evolving priorities, and so it provides capabilities that are unique among current assessment tools used in decision-making for assessing measures in and for CMS quality reporting programs. The current measure characteristics that an overall QMI score is based on are standardized in variables including high priority, evidence-based, variation in performance, measure performance, feasibility, burden, shared accountability, reliability, risk adjustment and validity. The QMI also includes ways to stratify measures including Meaningful Measure classifications, measure type, digital measures and other aspects.

QMI is a tool intended to support and enhance the standardized 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. The development and testing of the QMI provides meaningful, quantifiable, and replicable quality performance information to assess in a data-driven manner, the score of a measure based on certain measure characteristics. The foundational work began with section 1848(s) of the Act to assess measures intended for use in the Quality Payment Program. This funding allows for expanded testing, analyses, and use of the QMI across healthcare settings and CMS quality reporting programs; supports further testing and validation activities for the QMI related to measures across different phases of the measure lifecycle; allows for further integration of the QMI variables across measure submission pathways to support standardization of data being obtained and reviewed by CMS leading to the development of post-submission evaluation processes; and supports the solicitation and analyses of public comment on the QMI methodology as well as refinement of the scoring methodology based on feedback.

The project is foundational in helping to establish a systematic assessment of quality measures and to improve standardization, transparency, and alignment of CMS measure submission requirements. This tool will serve as a complement to the tools developed by the Measures Manager, like CMIT and the Blueprint, and will enhance measure information that can be provided to stakeholders to support consistent measure decision making.

- <u>The Alignment of Quality and Public Reporting Programs and Websites</u>

Period of Performance	Funding Amount	Fiscal Year
Option Period 3 03/22/22-03/21/23	**$1,216,318**	**2022 (Negotiated)**
Option Period 4 03/22/23-03/21/24	**$1,254,527**	**2023 (Negotiated)**

For more than 20 years, Medicare's online compare tools have served as the cornerstone for publicizing quality care information for patients, caregivers, consumers, and the healthcare community. 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 CMS is to empower patients to select and access the appropriate, high value care from high quality providers.

Work under this five-year contract supported coordination efforts across the previous Compare websites, through the transition to human centered design public reporting and the current 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. The modernized compare sites launched in September 2020 to provide a single user-friendly interface, named Care Compare, that patients and caregivers can use to make informed decisions about healthcare based on cost, quality of care, volume of services, and other data as well as a more specific and technical provider data catalog for researchers and other stakeholders.

Efforts continue to maintain and manage the existing Compare website environment, including conducting and analyzing research, human centered design user and concept testing, and continuous improvement discussions with stakeholders to determine future enhancements. 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.

This task order is critical for ensuring that beneficiaries, caregivers and other users have access to the accurate and detailed information about all Medicare-certified providers, in order find and compare services and make informed healthcare decisions.

Total for Dissemination of Quality Measures

Funding Amount	Fiscal Year
$6,339,568	**2022**
$5,988,899	**2023**

(3) Program Assessment and Review

- Impact Assessment of CMS Quality and Efficiency Measures

Period of Performance	Funding Amount	Fiscal Year
Option Period 3 07/01/22-06/30/23	**$2,735,496**	**2022 (Negotiated)**
Option Period 4 07/01/23-06/30/24	**$2,652,344**	**2023 (Negotiated)**

This five-year task order will support our work under section 1890A(a)(6) of the Act, a statutorily mandated evaluation of the impact and efficiency of CMS quality measures at the system level through the use of expert contracting services needed to conduct the Impact Assessment Report. The statute requires CMS to publicly release a comprehensive document once every three years; therefore, work begins immediately following the publication of the previous Impact Assessment Report, to develop the content of the next Impact Assessment Report. The most recent Impact Assessment report was published in 2021.

For the next triennial report, to be published in 2024, CMS will conduct a comprehensive national evaluation to inform CMS on opportunities to use quality measurement as a lever to improve health equity for individuals served by Medicare, Medicaid, and the Marketplace Health Insurance Program. CMS' experience in measure use during the COVID-19 pandemic will be featured prominently. Of special interest is how CMS can heed lessons learned during the pandemic to use quality measures as levers to reduce disparities for vulnerable population groups. CMS will convene focus groups with leaders of community-based organizations (CBOs) that assist underserved communities. The purpose of these focus group discussions will help CMS better understand the disparities experienced by these CBO's constituents as they navigate the health care system.

The Technical Expert Panel of non-federal stakeholders and the Federal Assessment Steering Committee (FASC) who provided technical guidance on prior reports will be re-convened to shed light on promising pathways to leverage quality measurement to improve health equity. The 2024 report will examine how CMS responds to the lessons of the pandemic by using quality measures to strengthen patient and health care workforce safety, and to facilitate health care system readiness, and to continue the goals from before the pandemic to ensure patient-centered care affordability.

CMS will also continue to improve the usability of the data and real-time access to data for both CMS internal and external stakeholders with an interactive, electronic version of the National Quality Dashboard[xi] to highlight results for measures or groups of measures (defined as Key Indicators) used to gauge and track performance in Meaningful Measure areas. This information will enable CMS to apply data-driven results to the design and implementation of equity improvement efforts for underserved beneficiaries across quality programs and settings, and to be more targeted in our actions and initiatives, more

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

possible now than ever before, to address the heterogeneity of healthcare needs more effectively.

Total for Program Assessment and Review

Funding Amount	Fiscal Year
$2,735,496	**2022**
$2,652,344	**2023**

(4) Program Oversight and Design

- Future expenditures are not anticipated in this area.

Summary - Estimated Expenditures and Anticipated Obligations for Activities Under Sections 1890 and 1890A

	FY 2022	FY 2023
Consensus-Based Entity Activities		
Endorsement/Maintenance	$7,000,000	$7,500,000
Measures Application Partnership	$3,800,000	$4,000,000
Subtotal, Congressionally Mandated Activities	**$10,800,000**	**$11,500,000**
Task Orders of Consensus-Based Entity	$3,208,853	$1,800,000
Subtotal, Consensus-Based Entity Activities	**$3,208,853**	**$1,800,000**
Dissemination of Quality Measures		
Measures Management System	$4,301,775	$4,506,000
QMI	$822,755	$228,372
Alignment of Compare Websites	$1,216,318	$1,254,527
Subtotal, Dissemination of Quality Measures	**$6,340,848**	**$5,988,899**
Impact Assessment of CMS Quality & Efficiency Measures	$2,735,496	$2,652,344
Subtotal, Secretarial Activities	**$2,735,496**	**$2,652,344**
Total, Consensus-Based Activities	**$14,008,853**	**$13,300,000**
Total, Secretarial Activities	**$9,076,344**	**$8,641,243**
Total 1890 and 1890A Activities	**$23,085,197**	**$21,941,243**

The upcoming work in FYs 2022 and 2023 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.

V. Glossary

Acronym/ Abbreviation	Name or Term
ACA	Patient Protection and Affordable Care Act of 2010
AE	Adverse Event
AHIP	America's Health Insurance Plans
AHRQ	Agency for Healthcare Research and Quality
API	Application Programming Interface
APM	Alternative Payment Model
ASPE	Office of the Assistant Secretary for Planning and Evaluation
BBA	Bipartisan Budget Act of 2018
CARES Act	Coronavirus Aid, Relief, and Economic Security Act of 2020
CBE	Consensus-Based Entity
CMIT	CMS Measures Inventory Tool
CMS	Centers for Medicare & Medicaid Services
CQMC	Core Quality Measures Collaborative
DOD	Department of Defense
eCQM	Electronic Clinical Quality Measure
EHR	Electronic Health Record
FASC	Federal Assessment Steering Committee
FDA	U.S. Food and Drug Administration
FY	Fiscal Year
HH QRP	Home Health Quality Reporting Program
HHS	Department of Health and Human Services
HRSA	Health Resources and Services Administration
IDIQ	Indefinite delivery, indefinite quantity
IHS	Indian Health Service
IPT	Integrated Project Team
LTC	Long Term Care
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
MUC	Measures Under Consideration
MVPs	MIPS Value Pathways
NQF	National Quality Forum
ONC	Office of the National Coordinator for Health Information Technology
OUD	Opioid Use Disorder
OY	Option Year
PAC	Post-Acute Care
PAMA	Protecting Access to Medicare Act of 2014
PDC	Provider Data Catalog

PRAC	Public Reporting, Alignment and Coordination
PRO	Patient-Reported Outcome
PROM	Patient-Reported Outcome Measure
PRO-PM	Patient-Reported Outcome-Performance Measure
QMI	Quality Measure Index
SAMHSA	Substance Abuse and Mental Health Services Administration
SDOH	Social Determinants of Health
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
SSSO	Synthetic and Semi-Synthetic Opioids
TEP	Technical Expert Panel
VA	Department of Veterans Affairs
VBP	Value-Based Purchasing
VHA	Veteran Health Administration

Appendix A – Sections 1890 and 1890A of the Social Security Act – Links provided below for published Reports to Congress and the Social Security Act:

Report to Congress Links:

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

2020 Report – https://www.cms.gov/files/document/2020-report-congress-identification-quality-measurement-priorities-strategic-plan-initiatives-and.pdf

2021 Report – https://www.cms.gov/files/document/2021-report-congress-identification-quality-measurement-priorities-strategic-plan-initiatives.pdf

Sections 1890 and 1890A of the Social Security Act:

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

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 2021. The work is organized by sections 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) of the Act. Note that the CBE's Annual Report to Congress that details the CBE activities for the prior year described below can be found at: http://www.qualityforum.org/Publications.aspx.

Details

2021

Section 1890 of the Act:

(1) Duties of the Consensus-Based Entity

Sections 1890(b)(2) and 1890(b)(3) of the Act

- Endorsement and Maintenance of Measures:

Period of Performance	Funding Amount	Fiscal Year
Option Period 4 09/27/21-09/26/22	**$8,046,209**	**2021**

CMS is the largest payer of healthcare. It is critically important to ensure the use of scientifically sound measures in CMS programs as well as the programs of our partners including the VA and AHRQ to move the needle on quality measurement and improvement for the good of the American people. This work with the CBE is to establish, implement, and provide consensus-based processes for the endorsement and maintenance of healthcare performance measures for the industry.

- The CBE convened expert multi-stakeholder groups to ensure that measures endorsed by the CBE are updated (or retired if obsolete) as new evidence was developed and remains relevant.
- The CBE convened topic-specific multi-stakeholder groups 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.

- 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 groups reviewed approximately 23 new measures and 55 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 multi-stakeholder groups.

Section 1890(b)(5) of the Act

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

Period of Performance	Funding Amount	Fiscal Year
Option Period 4 09/27/21-09/26/22	**$133,836**	**2021**

With the variety of work the CBE, currently the NQF, performed in support of sections 1890 and 1890A of the Act, it is critical to write a robust annual report to showcase the activities and outcomes for each project underway and/or completed.

- The CBE provided Congress and HHS Secretary with detailed information regarding the work completed in each task order awarded to the CBE. The 2021 report summarized the accomplishments-to-date and outcomes for the following on-going task orders:
  - Endorsement and Maintenance,
  - MAP,
  - Leveraging Quality Measurement to Improve Rural Health,

        - the Measurement Framework for Improving Opioid-related Behavioral Health and Quality Measurement for All-Payer Programs;
        - Best Practices for Designing, Field-Testing, and Implementing PROMs;
        - Best Practices for Developing and Testing Risk Adjustment Models; and
        - Leveraging Electronic Health Record-sourced Measures to Improve Care Communication and Coordination;
    - The 2021 report also discussed several task orders completed during the calendar year, including:
        - Social Risk Trial,
        - CQMC,
        - Maternal Morbidity and Mortality, and
        - Attribution Models for Critical Illness and Injury.
    - The 2021 report aligns with previous financial and task order reporting requirements but also contains linkages to how the work has been used to further healthcare quality measurement.

Section 1890(b)(7)(A) of the Act

- Core Quality Measures Collaborative (CQMC)

Period of Performance	Funding Amount	Fiscal Year
Base Period 09/14/21-09/13/22	**$499,571**	**2021**

The CQMC, a multi-stakeholder group of healthcare leaders working to facilitate cross-payer measure alignment through the development of core sets of measures to assess the quality of healthcare in the U.S., is a public-private partnership between America's Health Insurance Plans (AHIP) and CMS and is currently convened by the CBE. The CQMC endeavors to efficiently promote a patient-centered assessment of quality that could be implemented across both commercial and government payers (e.g., CMS, VA).

- In 2021, the CQMC will have completed 3 years of work and a new one-year effort will be awarded to the CBE. The CBE reconvened the Implementation workgroup to develop any needed updates for the Implementation Guide. The goal of the Implementation Guide is to discuss the technical aspects of core set implementation for payment or quality reporting purposes, and to encourage buy-in among clinicians, provider facilities, and consumers.
- The CQMC updated selection criteria for measure addition and removal for multi-stakeholder feedback. These criteria shall be modified (if necessary) with the purpose of ensuring consistent decision-making, and facilitate the review of measures for addition to or removal from the current and future core sets.

- An analysis of gap areas is performed and in alignment with the speaker series, which gives the opportunity to specialty organizations, providers and payer organizations to outline their successes in core-set measures and implementation of core-sets. The CQMC will identify measure gaps for each core set and compile a list of measure gaps. For each gap area, the CQMC identifies measures under development (MUDs) or measure concepts (MCs) that might fill the gap as well as a framework for gap areas.
- Additionally, the CBE developed a Communications Plan to help gain industry use and awareness. The Communications Plan will be a tactical guide for how messaging will be performed for the CQMC amongst the industry. The Communications Plan shall include, but is not limited to:
  - the CBE's goals
  - target audiences
  - general messages, custom messages, modes of messaging
  - roll out management, issue management, specific dates and tasks
  - implementation monitoring, problem solving
  - evaluation to include metrics and to assess the efficacy of communications
- The CQMC put specific emphasis on measuring equity and any measures of equity that exist among the core sets. Deliverables include a scan of equity measures (which may include reaching out to registries, searching state and government sites and inventories, reviewing literature, utilizing developer tools, etc.) to include endorsed and non-endorsed measures based on the requirements of the measure selection criteria. The CQMC also reviewed existing measure sets to see which measures are 'disparities sensitive' and/or could be stratified.

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

Period of Performance	Funding Amount	Fiscal Year
Option Period 1 09/30/21-09/29/22	**$578,974**	**2021**

This work developed a measurement framework to address overdose and mortality resulting from polysubstance use (legal and/or illegal) involving synthetic and semi-synthetic opioids (SSSO) among individuals with co-occurring behavioral health conditions. This effort was built on the work by the 2019-2020 CBE Opioid and Opioid Use Disorder (OUD) TEP, authorized by section 6093 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (Pub. L. 115-271), which amended section 1890A of the Act.

- The CBE convened a multi-stakeholder group to develop a measurement framework to address overdose and mortality resulting from polysubstance use (legal and/or illegal) involving synthetic and semi-synthetic opioids (SSSO) among individuals with co-occurring behavioral health conditions.

- The CBE helped to 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 multi-stakeholder group of experts and patients, this work furthers 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. Option Period 1 aims to ensure CMS' measures are impactful for addressing the evolving opioid epidemic and are high value because they can be easily adopted by other public or private payers. In this vein, the CBE has continued to convene meetings with a multi-stakeholder group to continue/revisit the development of the measurement framework developed in the Base Period.

- Best Practices for Developing and Testing Risk Adjustment Models

Period of Performance	Funding Amount	Fiscal Year
Option Period 1 09/15/21-09/14/22	**$874,893**	**2021**

This work focused on both social and functional risk factors. During the Base Period, the CBE published a Technical Guidance on: (1) best practices for social risk adjustment; (2) best practices for functional risk adjustment; and (3) how best to assess the appropriateness of a standard risk adjustment framework. With 2021 funding, the CBE expanded stakeholder engagement activities to increase awareness of the Technical Guidance, and to explore potential addition of new topics for the document that could better address stakeholders' needs. These stakeholder engagement activities are as follows:

1) In-depth key informant interviews to gauge the reaction to the Technical Guidance of experienced measure developers or methodologists who are not members of the TEP
2) Focus group meeting with members of the CBE's Scientific Methods Panel with minority viewpoints that have not been captured by the Technical Guidance
3) Presentation of the Technical Guidance at various CMS-funded virtual or in-person meetings attended by different quality measure stakeholder groups, e.g. web meeting targeting CMS-funded measure developers, web meeting for CMS staff who lead measure development or program implementation work, and in-person meeting attended by federal staff involved in quality

measurement or quality improvement, representatives of state health agencies, quality improvement organizations, or independent research organizations, members of academia, patient or caregiver representatives, etc.

The CBE will synthesize input from these activities and present it to the TEP, who will provide consensus recommendations on topics to be added to the Technical Guidance, and how to address them. An updated Technical Guidance will be published in September 2022.

Link to report - http://www.qualityforum.org/Risk_Adjustment_Guidance.aspx

- Leveraging Electronic Health Record-sourced Measures to Improve Care Communication and Coordination

Period of Performance	Funding Amount	Fiscal Year
Option Period 1 09/25/21-09/24/22	**$781,502**	**2021**

This work is to identify best practices to leverage eCQMs to improve care communication and coordination of quality measurement in an all-payer, cross-setting, fully electronic manner.

- The CBE developed a final recommendations report based on the already convened multi-stakeholder committee's recommendations/ guidance/findings to identify best practices to leverage EHR-sources measures to improve care communication and coordination quality measurement in an all-payer, cross-setting, fully electronic manner. The report provided recommendations for:
  - how EHRs could better facilitate care communication and coordination,
  - how existing and future development of eCQMs can be leveraged to improve care communication and coordination, and
  - data collection for social determinants of health by EHRs as it relates to care communication and coordination (and other topics related to social determinants of health and care coordination).
- The final recommendations report also included possible eCQMs and EHR-sourced measures related to care communication and coordination measure concepts or specific areas of measurement within care communication and coordination. These measure concepts were either de novo or re-specified from already developed measures. Providing this information to measure developers, EHR vendors, providers and other quality measurement stakeholders supports the electronic evolution of measuring provider performance in care communication and coordination and drive quality improvement and health outcomes as a result.
- Additionally, the CBE developed a shortened version of the final report of recommendations to educate and engage a wider audience, targeting

policymakers and senior leaders in healthcare that may be new to quality measurement and are interested in learning more.

- Leveraging Quality Measurement to Improve Rural Health

Period of Performance	Funding Amount	Fiscal Year
Option Period 1 9/30/2020-12/13/2021	**$106,965**	**2021**

The key intent of this work is to identify best practices in leveraging quality measurement to improve rural health outcomes.

  - The CBE convened Rural Health stakeholders to identify high-priority rural-relevant measures with low case-volume for future testing of previously recommended statistical approaches recommended. The CBE led the Rural Telehealth and Healthcare System Readiness Committee in a review and update of the previously developed 2016-2017 Telehealth Framework, which links quality of care provided in rural areas with telehealth, healthcare system readiness, and health outcomes in disasters.

- Building a Roadmap from Patient Reported Outcome Measures to Patient Reported Outcome Performance Measures

Period of Performance	Funding Amount	Fiscal Year
Base Year 12/01/20-11/30/21	**$774,625**	**2021**

CMS' quality programs strive to design measures that champion individual patient preferences, needs, and values ensuring that patient values guide all clinical decisions. The purpose of this work is to provide measure developers with detailed guidance for developing quality measures that capture the patient perspective to inform the performance of health care entities. This work will design a quality measurement approach from the point of view of the patient.

Section 1890A[xii] of the Act:

(1) Duties of the Consensus-Based Entity

- The Measure Applications Partnership (MAP)

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

Period of Performance	Funding Amount	Fiscal Year
Option Period 3 03/27/21-09/26/22	**$1,543,483**	**2021**
Option Period 3 mod 06/28/21-09/26/22	**$1,440,728**	
TOTAL	**$2,984,211**	

This task order enables HHS to receive input from several multi-stakeholder groups convened as part of the pre-rulemaking process. The Consolidated Appropriations Act, 2021the law added a duty for authorized the consensus-based entity (CBE) to allow it to provide input to the Secretary on the removal of quality and efficiency measures as the selection of measures for various Medicare quality programs. As a result of this provision, CMS modified the task order to include this additional work.

Using this funding, the Measure Applications Partnership (MAP) provided input on the selection of quality and efficiency measures, as described in 1890(b)(7) of the Act, as part of the Federal pre-rulemaking process under Section 1890A of the Act, and the removal of quality and efficiency measures, as described in Section 1890(b)(4) of the Act.

The multi-stakeholder groups, with the support of the federal liaisons including CDC, HRSA, IHS, ONC, and AHRQ, provided input on the selection of quality and efficiency measures considered by the Secretary under the Measures Under Consideration list for use in Medicare payment and public reporting programs, along with review of the measure set to make recommendations on possible measures for removal.

- The CBE convened the MAP, a multi-stakeholder partnership that provided recommendations to HHS on measure selection for Medicare quality reporting and VBP programs for hospitals, PAC/LTC, and clinician settings. During the 2020-2021 cycle:
  - Clinician: The MAP reviewed a total of eleven measures under consideration for two clinician programs: MIPS and Medicare Shared Savings Program.
  - Hospitals: The MAP Hospital Workgroup reviewed a total of seven measures under consideration for seven hospital and setting-specific programs, with one measure considered for six programs and one measure considered for two:
    - End-Stage Renal Disease Quality Incentive Program (ESRD QIP)
    - Hospital Inpatient Quality Reporting (Hospital IQR) Program
    - Hospital Outpatient Quality Reporting (Hospital OQR) Program
    - Inpatient Psychiatric Facility Quality Reporting Program (IPFQR)
    - Ambulatory Surgical Center Quality Reporting (ASCQR)

- Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting (PCHQR)
- Medicare and Medicaid Promoting Interoperability Programs for Eligible Hospitals (EHs) or
- Critical Access Hospitals (CAHs)

▪ Post-Acute: The MAP reviewed three measures for Post-Acute Care/Long-Term Care programs, with one measure considered for three programs:
- Hospice Quality Reporting Program (HQRP)
- Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)
- Long-Term Care Hospital Quality Reporting Program (LTCH QRP)

▪ Skilled Nursing Facility Quality Reporting Program (SNF QRP)

o During the 2020-2021 pre-rulemaking cycle, CMS received approximately 42 submissions for the MUC List. By focusing on cross cutting priority areas associated with improved outcomes, CMS proposed 20 unique individual measures for review by the MAP. As CMS works to balance its measure portfolio, the measures proposed in the 2020 MUC List included outcomes measures, process measures, structural measures, and composite measures, which reflected the quality priorities outlined in the Meaningful Measures framework.

Total for Duties of the Consensus-Based Entity

Funding Amount	Fiscal Year
$13,899,196	**2021**

(2) Dissemination of Quality Measures Used by the Secretary
Section 1890A(b) of the Act

- The Measures Management System (MMS)

Period of Performance	Funding Amount	Fiscal Year
Option Period 2 mod 10/08/20-11/09/21	**$5,576*** **	**2021**
Option Period 3 09/30/21-09/29/22	**$3,464,948**	
Total	**$3,470,524**	

***SSL Cert Funds

As in prior years, the Measures Manager drove quality measurement by offering a standardized system of resources and tools for developing, implementing, and maintaining the quality measures used in various initiatives and programs both in the public and private sector. The MMS provided support and assistance to entities interested in measure development through education and resources through providing online resources, webinars, and monthly newsletters to over 100,000 subscribers.

The funds for Option Year 3 supported the:

- development and implementation of a web-based MMS Blueprint seamlessly integrated into the MMS website to increase accessibility to stakeholders, especially those new to quality measurement who may be overwhelmed with 100+ page documents.
- alignment and harmonization of quality measures across CMS through the redesign of CMIT to allow users to identify families of measures, measure standards, and variations of measures. This new organization will better showcase existing measure alignments, as well as identify possible opportunities for alignment within and across CMS programs.

The funding for Option Year 3 will support the maintenance and continued evolution of the various IT systems, resources, and support provided by the Measures Manager with a focus on stakeholder engagement.

- The Alignment of Quality and Public Reporting Programs and Websites

Period of Performance	Funding Amount	Fiscal Year
Option Period 3 03/22/22-03/21/23	**$1,216,318**	**2022**

This work served as part of the eMedicare initiative, which strives to modernize the way beneficiaries and patients get information about Medicare and create new ways to help them make the best health care decisions for themselves and their families. Specifically, this contract:

- Oversees the global coordination and transition effort for the Provider Data Catalog (PDC) and Care Compare;
- Supports efforts to improve the stakeholder experience for Provider Data Catalog (PDC) and Care Compare.
- Collaborated with subject matter experts and leaders on logistics and planning to enable an intuitive searchable user interface, meaningful and streamlined content and public reporting of quality measures.

- Provided project management for the integrated project team (IPT), including meeting coordination and facilitation; managing work products; and communication management;
- Coordinated alignment and prioritization of tasks and activities across the IPT;
- Supported documented operational processes and procedures for elements including system access, dataset file creation submission, centralized issue tracking, help support and triage, and content identification, display and management.

Total for Dissemination of Quality Measures

Funding Amount	Fiscal Year
$4,649,811	**2021**

(3) Program Assessment and Review

Section 1890A(a)(6) of the Act

- Impact Assessment of CMS Quality and Efficiency Measures

Period of Performance	Funding Amount	Fiscal Year
Option Period 2 07/01/21-06/30/22	**$2,308,102**	**2021**

This work obtains the expert services needed to conduct Impact Assessment work. The statutory mandate at section 1890A(a)(6) requires CMS to assess the quality and efficiency impact of the use of endorsed measures and make the assessment publicly available at least once every three years. The first comprehensive report was published in 2012 followed by subsequent comprehensive reports in 2015, 2018, and 2021. The next report, to be published in 2024, will focus on CMS' quality measurement efforts to improve health equity as the agency's response to the COVID-19 pandemic. This includes:

- A comprehensive national evaluation to inform CMS on opportunities to use quality measurement as a lever to improve health equity for CMS' beneficiaries, based on --
  - Focus groups with leaders of CBOs serving vulnerable communities on barriers to affordable care and high-quality care, especially those resulting from the pandemic.
  - Recommendations by the TEP and FASC on promising pathways to leverage quality measurement to improve health equity.
  - Expanded discussion on the topic of safety, which encompasses not just patient but also health care workforce safety
  - A new discussion on health care system readiness

        - Progress and opportunities to ensure patient-centered care and affordability.
    - Continuous development of an interactive, electronic version of the National Quality Dashboard[xiii] to enable CMS to apply data-driven results to inform efforts to improve health equity, and to address the heterogeneity of healthcare needs across medically underserved communities more effectively.

- The Quality Measure Index (QMI)

Period of Performance	Funding Amount	Fiscal Year
Option Period 1 mod 12/30/20-06/30/21	**$879,035**	**2021**

This funding supported work to adapt the QMI for broader use across CMS quality reporting programs, beyond clinician-level quality measure reporting. Additional literature review and environmental scan work to confirm applicability of QMI variables to additional settings including facility-based settings were performed. Coordination and collaboration with at least sixteen distinct CMS quality reporting programs to review each programs' measure information including updated performance data were conducted. The funding also supported application of the QMI to generate preliminary scoring of the programs' quality measures and continued testing and validation of the tool, and enabled development of a draft QMI methodology report.

Total for Program Assessment and Review

Funding Amount	Fiscal Year
$3,187,137	**2021**

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

Appendix C – Addressing Additional Requirements in Section 1890(e)(2) of the Social Security Act, as added by the Consolidated Appropriations Act of 2021

On September 19, 2019, the Government Accountability Office (GAO) published a report titled "Health Care Quality: CMS Could More Effectively Ensure Its Quality Measurement Activities Promote Its Objectives" (GAO-19-628), The report examined CMS's quality measurement activities funded by sections 1890 and 1890A of the Social Security Act (the "Act") and included recommendations on actions CMS could take to improve its quality measurement activities.

On December 27, 2020, the Consolidated Appropriations Act (CAA), 2021 was signed into law. [xiv] Among other things, section 102(b)(1)(G) of Division CC of the CAA, 2021, amended section 1890(e) of the Act requiring that the annual report to Congress

in 2021 and 2022, include: (1) a "comprehensive analysis detailing the ways in which [CMS] has addressed each of the recommendations" set forth in the GAO report; and (2) a "detailed description of any additional steps [CMS] expects to take to address the findings and recommendations set forth in such report [and] the anticipated timing for such steps." [xv]

Additionally, section 1890(e)(2)(B) of the Act, as added by section 102(b)(1)(G) of Division CC of the CAA, 2021, requires CMS, beginning in 2021, to provide in its annual report to Congress detailed information on four categories of quality measurement activities, the specific amounts obligated or expended on each activity, the specific quality measurement activities required and the future funding needed. The four categories of activities are:

a. Measure Selection Activities
b. Measure Development Activities
c. Public Reporting Activities
d. Education and Outreach Activities

This appendix to the annual Report to Congress provides information required by both of these new provisions in section 1890(e) of the Act, as added by the CAA, 2021, with respect to both FY 2020 and FY 2021.

[xiv] Pub. L. No. 116–230 (2020).

[xv] Section 1890(e)(2)(A)

Part I - Addressing GAO Recommendations

The Bipartisan Budget Act of 2018 required the GAO to "conduct a study on health care quality measurement efforts funded under sections 1890 and 1890A of the Social Security Act," including an examination of --

(1) "the extent to which the Secretary of Health and Human Services has set and prioritized objectives to be achieved for each of the quality measurement activities required under such sections 1890 and 1890A" of the Act;

(2) "efforts that the Secretary has undertaken to meet quality measurement objectives associated with such sections";

(3) the "total amount of funding provided to the Secretary for purposes of carrying out such sections, the amount of such funding that has been obligated or expended by the Secretary, . . . the amount of such funding that remains unobligated," and how the funds have been allocated; and

(4) the "extent to which the Secretary has developed a comprehensive and long-term plan to ensure that it can achieve quality measurement objectives related to carrying out such sections 1890 and 1890A in a timely manner and with efficient use of available resources. . . ."[xvi]

In September 2019, GAO submitted its report to the Congress and made three recommendations based on its findings. The recommendations were for CMS to:

(1) The Administrator of CMS should, to the extent feasible, maintain more complete information on both the total amount of funding allocated for quality measurement activities and the extent to which this funding supports each of its quality measurement strategic objectives. (Recommendation 1)

(2) The Administrator of CMS should develop and implement procedures to systematically assess the measures it is considering developing, using, or removing in terms of their impact on achieving CMS's strategic objectives and document its compliance with those procedures. (Recommendation 2)

(3) The Administrator of CMS should develop and use a set of performance indicators to evaluate the agency's progress towards achieving its quality measurement strategic objectives. (Recommendation 3) [xvii]

HHS concurred with all three recommendations.[xviii]

[xvi] The Bipartisan Budget Act of 2018, Pub. L. No. 115–123, § 50206(d), 132 Stat. 64, 183–184 (2018).

[xvii] GAO 19-628 Report to Congressional Committees on Health Care Quality, Appendix V, September 2019 available at https://www.gao.gov/assets/gao-19-628.pdf

[xviii] GAO 19-628 Report to Congressional Committees on Health Care Quality, Page 25, September 2019 available at https://www.gao.gov/assets/gao-19-628.pdf

As described above, section 1890(e)(2)(A) of the Social Security Act, as added by section 102(b)(1) of Division CC of the CAA, 2021 requires CMS to provide (1) "[a] comprehensive analysis detailing the ways in which CMS has addressed each of the recommendations" set forth in the aforementioned report and (2) "[a] detailed description of … any additional steps [CMS] expects to take to address the findings and recommendations set forth in such report [and] the anticipated timing for such steps."

Each recommendation is discussed and analyzed below.

Recommendation 1 – To the extent feasible, maintain more complete and detailed information on its funding for quality measurement activities

GAO found that CMS's core budget database, HIGLAS, does not capture all funding obligated for quality measurement activities and the extent to which funding supports CMS's quality measurement strategic objectives. GAO noted that CMS reported that some general-purpose appropriations recorded in HIGLAS are used for quality measurement purposes but are not labelled for such use in the database. GAO additionally found that HIGLAS does not track whether quality measurement funding is being used to further CMS's quality measurement strategic objectives. Lastly, GAO found that CMS's prior annual Reports to Congress on sections 1890 and 1890A funding lacked granular detail regarding the quality measurement activities CMS described in the report. GAO suggested that adding this may better inform the Congress of how CMS is spending quality measurement funds.

In response to GAO's findings and recommendation 1, CMS has maintained more complete and detailed information broken down at a granular level on funding for quality measurement activities including fiscal year budget spreadsheets to capture measure development costs by funding source and inclusive of measure type and stage of development information. Although HIGLAS has several limitations for tracking and customizing details of funding, CMS will continue to track quality measurement funding on a detailed level by program and initiative.

Recommendation 2 – Establish procedures to systematically assess measures under consideration based on CMS's quality measurement strategic objectives

GAO found that CMS takes different approaches in deciding which Medicare quality measures to use in its programs, which to remove, and which new measures to develop. GAO also found that CMS lacks procedures to ensure that these decisions are consistent with its quality measurement strategic objectives.

CMS has implemented several mechanisms for systematically assessing measures for possible development, use, and removal and to ensure these decisions promote CMS's quality measurement strategic objectives. Through substantive stakeholder outreach, CMS has advanced application of the new Quality Measure Index (QMI) tool, refinement to the Measures Management System (MMS) Blueprint, transparency through the CMS Measures Inventory Tool (CMIT), and broad use of the Meaningful Measures framework.

The Quality Measure Index (QMI) establishes standard definitions of quantifiable measure characteristics to systematically assess individual quality measures, which helps CMS ensure the consistent assessment of measures against the agency's quality measurement strategic objectives.

The QMI is a transparent and reliable scoring instrument that produces repeatable results yet is adaptable to evolving priorities. Since the measure information used by the QMI is standardized, the tool is unique among current assessment tools because measure assessment by the QMI is increasingly consistent and produces more objective results to be used in decision-making for assessing measures in and for CMS quality reporting programs. In addition, the scoring methodology and measure characteristics included in the QMI have flexibility to evolve if national health care priorities change. The current measure characteristics that an overall QMI score is based on are standardized in variables including high priority, evidence-based, measure performance, feasibility, provider burden, reliability, risk adjustment and validity.

The QMI also includes ways to stratify measures including Meaningful Measure classifications, measure type, digital measures, and other aspects. The QMI is used to help standardize assessment of quality measures and inform measure evaluation processes by supporting the selection of high value measures that meet agency priorities, align with the Meaningful Measures framework, and drive value-based care. CMS has completed testing of the QMI for clinician measures and has systematically applied the QMI to existing measures used in the Quality Payment Program. QMI scores will be used by CMS in considering measures for removal. In addition, for new measures considered for use, CMS incorporated the QMI tool into the pre-rulemaking process for 2021. For these new measures, the QMI scores will inform and facilitate decision-making by CMS for measure prioritization and selection to support agency quality measurement strategic objectives in quality programs. Finally, CMS completed a systematic review of existing measures currently implemented in all quality reporting programs using the QMI.

To help ensure the consistent review of measures against elements of CMS's quality measurement strategic objectives, CMS has also developed MERIT, the Measures Under Consideration Entry/Review Information Tool, which is a second-generation platform for submitting measures as part of the pre-rulemaking measure adoption process. MERIT incorporates components of the QMI, ensuring measure scoring information will be readily available from the start of the measure adoption process. MERIT was implemented during the MUC 2021 submission cycle, which began early in calendar year 2021. CMS will continue to refine MERIT to maintain alignment with other measure-related tools.

The guidelines and information outlined in the Measure Management System Blueprint helps CMS ensure the consistent assessment of measures against the agency's quality measurement strategic objectives, including the Meaningful Measures framework, by documenting and clarifying to stakeholders the core set of business processes and decision-making criteria for measure development, implementation, and maintenance. In September 2020, CMS updated the Blueprint to improve consistent usability of this critical resource, to align with NQF standards, and to streamline the information making it easier for measure developers to understand and follow standardized processes for measure development.

CMS has integrated its quality measurement strategic objectives, as documented in the Meaningful Measures framework, into its quality measure selection processes. CMS's decisions regarding measure selection are informed by the Meaningful Measure framework which highlights core areas to improve health care quality and health outcomes including person-centered care, equity, safety, affordability and efficiency, chronic conditions, wellness and prevention, seamless care coordination, and behavioral health. CMS reviews each measure used

in each program using the Meaningful Measures framework to determine whether to use measures in programs or to remove measures from programs.

To promote transparency and provide a systematic approach in the measure removal process, CMS finalized eight standardized measure removal factors through the rulemaking process for several programs. These factors support several agency quality measurement strategic objectives to use impactful quality measures to better address health care priorities and gaps, reduce quality measurement burden, and promote patient perspectives. CMS regularly evaluates the removal factors for appropriateness and will make all future updates through the rulemaking process. The current measure removal factors support maintaining only those high value measures in quality programs that meaningfully drive improvements in outcomes, increase person-centered measures, reduce harm and minimize administrative and cost burden. The eight removal factors are as follows:

- Factor 1. Measure performance among health care providers is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made (‘‘topped out’’ measures);
- Factor 2. A measure does not align with current clinical guidelines or practice;
- Factor 3. The availability of a more broadly applicable measure (across settings or populations), or the availability of a measure that is more proximal in time to desired patient outcomes for the particular topic;
- Factor 4. Performance or improvement on a measure does not result in better patient outcomes;
- Factor 5. The availability of a measure that is more strongly associated with desired patient outcomes for the particular topic;
- Factor 6. Collection or public reporting of a measure leads to negative unintended consequences other than patient harm;
- Factor 7. It is not feasible to implement the measure specifications; and
- Factor 8. The costs associated with a measure outweigh the benefit of its continued use in the program.

In addition, the broad transparency and access to CMS quality measure information that CMIT provides helps ensure the consistent assessment of measures against the agency’s quality measurement strategic objectives. CMIT is a compilation of measures used by CMS in various quality, reporting, and payment programs. CMIT lists each measure by program and includes measure specifications (including numerator, denominator, and exclusion criteria), Meaningful Measures domain, measure type, and NQF endorsement status. CMIT also contains Measures under Development or pipeline measures that are in the process of being developed for eventual consideration for a CMS program. These measures are populated using measure developer submissions to the Measure and Instrument Development & Support (MIDS) Resource Library and measures submitted for consideration in the pre-rulemaking process but have not yet been accepted into a program. CMIT advances quality measurement strategic objectives by empowering stakeholders and providing access to key measure information for the purposes of promoting transparency, measure coordination and harmonization, alignment of quality improvement efforts, and public participation. CMS updates the CMIT every February, July, and November to ensure stakeholders have the most up-to-date measure information possible.

Through various collaborations, CMS has made significant progress in achieving its Meaningful Measures quality measurement strategic objectives of reducing burden, promoting outcomes measures, and advancing the implementation of digital measures, patient reported outcomes, and alignment across the agency. CMS established an agency wide Meaningful Measures Affinity Group to ensure alignment in achieving CMS's quality measurement strategic objectives. The Affinity Group supports discussions, information exchange across CMS, sharing of best practices, and collaboration on how to best meet the CMS quality measurement strategic objectives.

CMS is working in collaboration across the agency, across Federal partners, and across all payers for quality measure alignment, prioritized development, use, and modification. CMS has partnered with the Department of Veterans Affairs (VA) and Department of Defense (DOD) to promote measure alignment, and introduced in 2021, through notice and comment rulemaking, the inclusion of VA hospitals on the Care Compare website. CMS remains committed to the partnership with America's Health Insurance Plans (AHIP) and NQF in developing core measure sets through the Core Quality Measures Collaboration (CQMC). To date, 10 specific measure sets have been agreed upon for standardized use by all payers.

Recommendation 3 – Develop and use performance indicators to evaluate progress in achieving its objectives

GAO found that CMS had not yet developed or implemented performance indicators to evaluate its overall progress toward achieving quality measurement strategic objectives for quality measurement. GAO noted that although CMS has discussed potential ways to evaluate the agency's progress in achieving the quality measurement strategic objectives laid out in the Meaningful Measures initiative, CMS had not yet determined how to gauge such progress, such as by establishing performance indicators.

CMS revamped the agency's Objectives and Key Results (OKRs) for 2021. These Key Results are expected to transform Medicare FFS Value-Based Incentive Programs to meet CMS quality measurement strategic objectives for quality measurement and to ensure CMS focuses on national health care priorities identified by the Meaningful Measures framework, simplifies quality measurement processes, reduces burden, and engages patients to help make the best care decisions.

CMS has also outlined the Quality Measurement Action Plan, which defines and tracks activities necessary to achieve quality measurement strategic objectives across all agency components.

Part II: Ensuring Detailed Information on Quality Measurement Activities

Section 102(b)(1)(B) of Division CC of the CAA, 2021 amended section 1890(e) of the Act by adding paragraph (2)(B), which requires CMS to provide detailed information on four categories of quality measurement activities, the specific amounts obligated or expended on each activity, and estimates of the obligations and expenditures anticipated to be needed to fulfill these quality measurement activities for the succeeding two-year period. This information is required to be included in the CMS annual Report to Congress. Accordingly, this appendix provides below detailed information on the following four categories of activities: Measure Selection, Measure Development, Public Reporting, and Education and Outreach.

Measure Selection

In this category, we have included the measure selection process that is undertaken through the statutory pre-rulemaking process, the endorsement and maintenance activities of the CBE, which are fundamental to the measure selection process, and the task orders of the CBE, which also provide us critical information that we can use, which feeds into the selection of measures.

There is an annual pre-rulemaking process that CMS follows, as defined in section 1890, to select measures for use in Medicare quality programs. CMS makes a number of decisions that influence measure selection throughout the process with the goals of filling critical gaps in quality measurement and focusing the high priority areas for quality measurement outlined in the Meaningful Measures Initiative that support improvements in health outcomes. Each year CMS asks measure developers to submit candidate quality measures to CMS for potential selection.

During measure selection process, is guided by Meaningful Measures framework to streamline quality measurement. This framework is intended to drive outcome improvement through public reporting and payment programs, transition CMS to digital measurement, promote person-centered quality measures, and advancing health equity and closing gaps in care.

CMS makes preliminary decisions on which of these measures it is considering for use in its quality programs, and it publishes this selection of measures in its annual Measures under Consideration list (MUC). The MUC list then undergoes public review by the Measure Applications Partnership, which is a multi-stakeholder group convened by the National Quality Forum. After this review, CMS considers the Measure Applications Partnership's feedback, and chooses which measures to propose to add to CMS quality programs through rulemaking.

In addition, endorsement and maintenance of quality measures is a key and important activity that contributes to the ability of CMS to select quality measures for use in CMS programs. Measures that have undergone the rigorous review by NQF and are ultimately endorsed indicate that these measures have met a gold standard of review. CMS prioritizes the use of endorsed measures in its programs when appropriate.

Finally, the task orders and projects discussed earlier in this report are included in this category of quality measurement because they provide critical information to us, including measure concepts that should be further developed, appropriateness of measures for certain programs, risk adjustment and measure gaps, all of which comprise part of the overall measure selection process.

In FY 2020, CMS obligated an estimated $16.6 million from funding available under sections 1890 and 1890A that is considered Measure Selection. In FY 2021, CMS continued this work with estimated obligations of $13.0 million.

In future years (FY 2022 and 2023), CMS will need an estimated $15 million and $13 million respectively to continue this level of Measure Selection work.

Measure Development

Appropriations for sections 1890 and 1890A funding source does not provide funding for quality measure development. As an example of measure development, under the Quality Payment Program, an annual report provides a break-down of quality measures being developed for

clinicians in this program. The most recent 2021 CMS Quality Measurement Development Plan Annual Report, which generally reflects FY 2020 measure development activities to support the Quality Payment Program, can be found here: https://www.cms.gov/Medicare/Quality-Payment-Program/Measure-Development/Measure-development. In the coming months, CMS will publish the 2022 Quality Measure Development Plan Annual Report reflecting similar activities undertaken in FY 2021. In addition to CMS-developed measures, private measure developers outside of CMS develop measures and submit them for consideration to CMS for inclusion in a particular quality program.

Public Reporting

In FY 2020, CMS modernized public reporting. CMS' original eight Compare Sites and Data.Medicare.gov were replaced with two new websites that meet the needs of the various stakeholder groups making quality, price, and volume data accessible and interpretable, and thereby enabling informed, personalized health care decision-making. The Contractor responsibilities in conjunction with the OC and other stakeholders provide support and/or facilitate documentation preparation, research, human centered design user and concept testing, analysis, industry best practice recommendations, and meetings and/or trainings for internal and external stakeholders for the advancement of public reporting into the next generation of tools and beyond. The Contractor supports CMS with current state and future state operations, communication, coordination, reporting, and development and maintenance of a master project management plan. The intent is to align project goals, objectives, timelines and perceptions across all stakeholders.

CMS also utilizes appropriations for sections 1890 and 1890A for public reporting of measure information through the Measure Management System (MMS). The MMS supports important efforts to standardize and promote best practices in quality measurement. Developed by the MMS, the web-based CMS Measures Inventory Tool (CMIT) provides the public access to those measures used in CMS programs.

The National Impact Assessment of CMS Quality Measures Report is published triennially and examines results that help to move CMS' goals to improve healthcare through the implementation of quality measures meaningful to both patients and providers. This report includes quality measures used in 26 CMS quality programs.

In FY 2020, CMS obligated an estimated $7.5 million from funding available under sections 1890 and 1890A to activities related to Public Reporting. In FY 2021, CMS continued this work and obligated $7.9 million for public reporting activities.

In future years (FY 2022 and 2023), CMS will need an estimated $4.7 million in each fiscal year to continue this level of Public Reporting work.

Education and Outreach

In FY 2020, CMS continued to increase CMS stakeholders' knowledge and engagement on quality measure and development topics through education and outreach by leveraging tools and outreach venues available through MMS. Given the role MMS plays at supporting

standardization of measure development, transparency of quality measures across CMS programs, and promotion of best practices, MMS is in the unique position to provide education to a diverse group of CMS stakeholders, agnostic to any one individual program or setting. Through various quality measurement technical assistance resources and tools, the MMS engages patients, caregivers, measure developers, clinicians and others. Contractor responsibilities include bimonthly informational webinars, advertising technical expert panels and other engagement opportunities for other CMS contractors and quality programs, distributing monthly newsletter, maintaining a robust website, and developing resources to further engage and educate stakeholders in the measure development process.

One of the most important resources is the CMS MMS 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 CBE Standing Committee's burden of reviewing low-quality measures. This past year, the team worked to simplify and streamline the Blueprint (Version 17.0 published in September 2021) to make it more accessible to specialty societies, patient advocacy groups, researchers, and other private sector entities looking to submit measures into CMS programs or engage with CMS in the measure development process.

The MMS provides education and outreach for patients, families, clinicians, caregivers, providers, hospitalists, measure developers, and others to engage with CMS in the measure development process and understand the impact quality measurement can have. The monthly MMS newsletter is distributed to over 100,000 subscribers across the quality measurement enterprise. The annual public webinars are attended by over 2,300 participants, with another 1,300 viewing the recording.

In FY 2020, CMS obligated $0.7 million from funding available under sections 1890 and 1890A to activities to be considered Education and Outreach. In FY 2021, CMS continued this work and obligated $0.8 million in education and outreach activities.

In the next two years, FY 2022 and FY 2023, CMS will need an estimated $2.3 million for each fiscal year to continue this level of Education and Outreach work.