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

A Report Required by the Bipartisan Budget Act of 2018

United States Department of Health and Human Services

Centers for Medicare & Medicaid Services

(March 1, 2021)

Executive Summary

The United States (U.S.) Department of Health and Human Services (HHS), including 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 over 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, important clinical processes, patient safety, efficient use of resources, health care costs, care coordination, patient and consumer engagement, population and public health, and adherence to clinical guidelines. Systematic quality measurement provides critical, transparent information to providers as well as to beneficiaries on the quality of care, and identifies what changes are needed to improve health care value and patient outcomes. CMS' Meaningful Measures Initiative[i] unites strategic efforts to reduce the burden of quality measure reporting with a comprehensive approach to identify and adopt measures that are the most critical to providing high quality care and driving better patient outcomes at lower costs.

Specifically, CMS is actively working to encourage the use of parsimonious measure sets, to provide more timely and transparent feedback reports on performance-based data, and to further prioritize more all-payer, patient-centric, population-based outcome measures. 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 an unprecedented year as CMS and its healthcare partners across the country have led the way to protect the health and safety of this nation's patients and providers in response to the Novel Coronavirus (COVID-19) pandemic. CMS is working to rapidly re-evaluate its healthcare delivery system as clinicians and healthcare facilities have re-directed time and resources to focus on caring for patients. As a result, CMS has provided 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. In this vein, CMS is also continuing to engage with its healthcare partners to understand and assess the impact of this public health emergency and related response efforts on quality measurement and reporting and evolve accordingly.

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[i] Meaningful Measures Hub (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/MMF/General-info-Sub-Page)

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

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

The information provided in this report reflects various task orders and activities that support the future direction of national quality measurement and includes an annual update regarding the obligated, expended, and projected funding amounts for purposes of carrying out sections 1890 and 1890A of the Act. This Report to Congress addresses what has been accomplished with expended funds in the past 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 2020 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 2020 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 2020, 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[ii], 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[iii] and telehealthiv 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

[ii] 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.

[iii] 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).

[iv] NQF (August 2017). Creating a Framework to Support Measure Development in Telehealth (http://www.qualityforum.org/Publications/2017/08/Creating_a_Framework_to_Support_Measure_Development_for_Telehealth.aspx, accessed 7/14/2020).

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 disparities in maternal outcomes and is collaborating with a diverse group of stakeholders to inform the use of quality measures as a tool to reduce maternal morbidity and mortality.

Current and future funding for years 2021 and 2022 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 to accomplish the quality goals as set out in this executive summary.

Quality measurement development and implementation is by nature multifaceted and challenging. By providing the details of the task orders, along with the cost estimates for the specific activities and deliverables, CMS hopes to bring transparency and clarity to this complex process that must involve the active participation and engagement of key private sector stakeholders to achieve the quality goals for the nation. Furthermore, cost estimates developed for 2021 and 2022, as specified in section IV, are informed, and refined by the experience and momentum gained in 2020 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 the 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. The 2019 Report to Congress also highlighted the Meaningful Measures Initiative as a key driver of strategic efforts to reduce the burden of quality measure reporting and as the framework for its comprehensive plan to identify the quality measurement needs for quality programs.

This year in particular and in collaboration with the CBE, CMS is using its levers through its sections 1890 and 1890A work to strengthen a population health approach to quality measurement as COVID-19 becomes more prevalent across the country. For every community that witnesses daily increases in infection incidence, the pressure on that community's health care system and community resources in general has been unprecedented. Meanwhile, the scientific community's understanding of the risk factors for COVID-19 infection continues to evolve. Vulnerability to infection is not limited to individuals with a single risk factor but may be a function of interplay between different clinical and social risk factors.[v] A population health approach strengthens the ability of quality measures to facilitate the monitoring and tracking of a community's needs for screening and treatments during the pandemic or other national emergencies. Greater focus on a population health approach in quality measurement would guide CMS' efforts to improve the well-being of not only those on Medicare, Medicaid, or enrolled in qualified health plans through the Marketplaces, but every member of the community regardless of demographic characteristics and insurance type. This approach is reflected in the work that CMS is conducting via Meaningful Measures 2.0 as well as work in multiple task orders described in this Report to Congress including risk adjustment, attribution, and the Measurement Framework for Improving Opioid-related Behavioral Health and Quality Measurement for All-Payer Programs.

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 and 2020 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. This section also provides that in years after the first plan is submitted to Congress, the Report to Congress can provide an update to the plan, rather than re-submit the plan itself. CMS submitted the 2019 Report to Congress containing the comprehensive plan on March 1, 2019. This is the third annual Report to Congress, organized as follows, submitted by

[v] Selden, T.M., and T.A. Berdahl (September 2020). COVID-19 and Racial/Ethnic Disparities in Health Risk, Employment, and Household Composition. *Health Affairs*. https://doi.org/10.1377/hlthaff.2020.0089 (https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00897, accessed 7/22/2020).

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 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:[vi]

- Duties of the CBE[vii]
- Dissemination of measures[viii]
- Program assessment and review[ix]
- Program oversight and design[x]

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) 2021 through 2022 to support the advancement and refinement of the quality measurement activities required under sections 1890 and 1890A of the Act. Cost estimates developed for 2021 and 2022 were developed directly from the experiences and lessons learned from work in 2020 and reflect efforts to reduce overhead and focus on the specific activities and deliverables (as described in Section IV) that would drive us to accomplish the quality goals. For example, CMS has funded on-going work related to electronic clinical quality measures (eCQMs) in alignment with CMS' goals for interoperability and digital measurement. An initial task order examined how to improve the scientific rigor and testing requirements for eCQMs[xi] to achieve endorsement and maintenance. Building on this initial task order, CMS is continuing this foundational work with

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

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

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

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

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

[xi] The NQF Electronic Health Record Data Quality project (http://www.qualityforum.org/EHR_Data_Quality.aspx (accessed 7/19/2020).is supported by FY2019 funding. Its performance period is from 7/1/2019 through 12/31/2020.

a new task order to explore how to use measures that draw all or part of their data from EHRs to inform and enhance care coordination and improve health outcomes as this was identified as a key impediment to true interoperability and digital measurement.

The estimates and tasks anticipated to be accomplished in 2021 and 2022 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 2020 funding under section 1890(d). For task orders and activities awarded in previous years, please see Appendix C in the 2019 Report to Congress.

II. Comprehensive Plan

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

CMS continues to build on and be guided by the comprehensive plan detailed in the 2019 Report to Congress. In alignment with the comprehensive plan, CMS continues to drive towards patient-centered, value-based care through the development, selection, and implementation of quality measurement. CMS remains committed to providing transparent and comprehensive quality measurement information to patients to assist them with best medical decisions and continuing to align efforts across federal agencies and private payers and reducing burden to providers. Specifically, the CMS quality measurement needs identified include:

- providing rapid performance feedback to providers,
- accelerating the move to fully digital measures,
- unleashing the voice of the patient through use of patient-reported outcome measures,
- using measures that will advance innovative payment structures,
- increasing alignment of measures,
- promoting use of all payer data (where feasible), and
- focusing on major domain outcomes.

CMS fosters and envisions programs with more all-payer, patient-centric, population-based outcome measures aligned with the Meaningful Measure areas articulated in the 2019 Report to Congress. The CMS Meaningful Measures initiative introduced a framework for establishing highest priority measures and led to an evaluation of measures across many programs with a

20% reduction[xii] of measures used in Medicare quality programs to date. Throughout 2020, CMS shared a draft of key themes and the framework for Meaningful Measures 2.0 with a variety of stakeholders to solicit feedback. Meaningful Measures 2.0 is supported by and aligns with key themes from the draft CMS Quality Action Plan, a plan developed as an ongoing, multi-year strategy to advance the CMS vision for the future of quality healthcare.

In order to develop this plan, CMS collected feedback on the Quality Action Plan from stakeholders through discussions at the 2020 CMS Quality Conference, listening sessions with other agencies and key stakeholders, and routine presentations by programs. The CMS Quality Action Plan delineates objectives to guide actions supporting four interrelated goals[xiii]:

1. Use Meaningful Measures to Streamline Quality Measurement – Ensure high impact measures that promote best patient outcomes; focus on outcome measures over process measures; align across CMS, federal programs, and private payers where possible; and reduce the number and burden of measures.
2. Leverage Measures to Drive Outcome Improvement – accelerate ongoing efforts to streamline and modernize programs, reducing burden and promoting strategically important focus areas.
3. Improve Quality Measures Efficiency by a Transition to Digital Measures and Use of Advanced Data Analytics – use data and information as essential aspects of a healthy, robust health care infrastructure to allow for payment and management of accountable, value-based care.
4. Empower Patients to Make Best Healthcare Choices through Patient-Directed Quality Measures and Public Transparency – empower patients through transparency of data and public reporting, so that patients can make the best-informed decisions about their healthcare.

CMS plans to use all policy levers and program authorities to achieve these goals while promoting innovation in the delivery of services, implementing initiatives to reduce provider burden, and employing state-of-the-art technologies to assure program integrity. CMS can improve the quality of healthcare for all Americans by continuing to modernize the quality reporting and payment programs, including alignment across all CMS programs, as well as the advancement of Meaningful Measures 2.0 and the CMS Quality Action Plan.

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

In FY 2020, CMS advanced the critical knowledge base for the continued transition to a healthcare system built on value. With FY 2020 expended funds and the work of the CBE and other entities pursuant to sections 1890 and 1890A of the Act, CMS builds on previous activities

[xii] Data provided in the 2021 National Impact Assessment of the CMS Quality Measures Report, (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/National-Impact-Assessment-of-the-Centers-for-Medicare-and-Medicaid-Services-CMS-Quality-Measures-Reports) to be posted March 1, 2021.

[xiii] CMS anticipates finalization of the CMS Quality Action Plan in March 2021, however that is subject to change.

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 finalizing core measure sets through the support of the Core Quality Measures Collaborative (CQMC), addressing the needs of rural healthcare providers, and promoting coordination efforts to transform public reporting websites to inform and empower individuals, providers, and other stakeholders with transparent, meaningful healthcare quality information.

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

Table 1 Table 1: Funding authority (in millions), funds obligated, and funds expended by public law, 2020[xiv]

Act Name	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) [xv]	$ 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) [xvi]	$ 100.00	$ (2.46)	$ 97.54	$ 97.54	$ 0.00	$ 93.08	$ 4.46
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	$ 72.93	$ 0.00	$ 70.10	$ 2.09
Bipartisan Budget Act of 2018 (Pub. L. 115-123, Sec. 50206)[xvii]	$ 15.00	$ 0.00	$ 15.00	$ 15.00	$ 0.00	$ 5.68	$ 5.64

[xiv] Numbers are accurate based on data at the time of submission of this report. Numbers have been rounded to the nearest 10,000.

[xv] Previously obligated balances have been deobligated during FY2020. Some balances may be available for future obligations.

[xvi] Previously obligated balances have been deobligated during FY2020. Some balances may be available for future obligations.

[xvii] Section 50206(a) of the Bipartisan Budget Act of 2018 provides 7.5 million for each of fiscal years 2018 and 2019.

Act Name	Authority	Sequester	Adjusted Authority	Obligations	Unobligated Authority	Expended Amount	Unexpended Balances
Coronavirus Aid, Relief, and Economic Security Act (CARES Act) (Pub. L. 116-136, Sec. 3802)	$ 20.00	$ 0.00	$ 20.00	$ 17.25	$ 2.75	$ 1.85	$ 15.40
Grand Total	**$ 280.00**	**$ (5.04)**	**$ 274.96**	**$ 270.09**	**$ 4.87**	**$ 242.50**	**$ 27.59**

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 2020. Activities not performed by the Secretary[xviii] under section 1890 of the Act were implemented by the CBE. Activities not performed by the Secretary 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 entities. To note, Table 2 excludes activities conducted by the CBE that are not funded using the section 1890 or 1890A of the Act appropriation. Note that Appendix B provides a description of the activities, including the task orders, for which these funds were obligated or expended.

Table 2: 2020 Funding (in millions) obligated, expended, and unexpended under sections 1890 and 1890A of the Act, including administrative costs[xix]

Funding Section	Obligations	Expended Amount	Unexpended Balances
1890	$15.34	$0.26	$15.08
1890A	$9.48	$2.57	$6.91
Administrative	$0.04	$0.04	$0.00
Grand Total	**$ 24.86**	**$ 2.87**	**$ 21.99**

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

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

NQF is the 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

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

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

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 pre-rulemaking, the CBE convenes the MAP which includes four multi-stakeholder workgroups that weigh in on the selection of quality performances to be used in quality reporting and value-based purchasing (VBP) programs for hospital, PAC/LTC, and clinician settings, with input from stakeholders, including but not limited to providers and patients from rural areas to provide rural perspectives.

Table 3 below describes the funding for FY 2020 for activities performed by the CBE under section 1890 of the Act. Those activities included: endorsement and maintenance of quality measures, a required annual report with prescribed activities, including identifying gaps in quality and efficiency measures, and priority setting by synthesizing evidence and convening stakeholders to make recommendations on priorities for health care performance measurement in different settings. These priority setting efforts included supporting the CQMC to align quality measures used by public and private payers across a wide array of specialty areas, including the newly-added areas of neurology and behavioral health, to reduce provider burden; reviewing and developing final recommendations on the appropriateness of social risk adjustment for outcome measures submitted for endorsement or re-endorsement; and identifying quality measures that could facilitate assessment of the effects of telehealth on health system readiness and health outcomes in national emergencies in rural communities. Other priority setting efforts included identifying all-payer measures and measure concepts that could address opioids-related overdose and mortality among polysubstance users with co-occurring behavioral health conditions; eliciting expert input on best practices for using patient-reported outcome measures (PROMs) to develop digital patient-reported outcome performance measures (PRO-PMs); developing technical guidance for building risk adjustment models; leveraging EHR-sourced measures to improve care coordination; and examining promising population/geographic-based attribution approaches for measuring critical illness and injury care delivery. The duties of the CBE performed by NQF under section 1890A of the Act included: convening multi-stakeholder groups through the MAP that provide input on measure selection for use in various quality programs including the rural health perspective. For further details of the purpose of each task order, please refer to Appendix B.

Table 3: Table 3: Funding (in millions) for FY 2020 for activities performed by the CBE under sections 1890 and 1890A of the Act[xx]

Section and Fiscal Year	Obligations	Expended Amount	Unexpended Balances
Section 1890 2020	$15.34	$0.26	$15.08
Section 1890A 2020	$1.39	$0.70	$0.69
Grand Total	**$16.73**	**$0.96**	**$15.77**

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

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

The Measures Management System (MMS)

The MMS is an essential resource for the dissemination of quality measurement programs and initiatives across CMS and is also available for federal partners, stakeholders, and the public. As such, the MMS supports important efforts to standardize and promote best practices in quality measurement. One of the most important resources on the MMS is the Blueprint, which outlines the conceptual and operational phases and elements of quality measure development. By conveying standards that developers can use to gauge for the readiness of their measures to be endorsed, the Blueprint decreases the CBE Standing Committee's burden of reviewing low-quality measures. This past year, the team worked to simplify and streamline the Blueprint 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 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.

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 94,000 subscribers. Webinars focus on key topics that promote the CMS quality priorities and goals such as "Understanding Clinical Quality Measures: How CMS is modernizing its approach to digital measurement" and "Respecifying Measures to Electronic Clinical Quality Measures (eCQMs)". 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 while ensuring safety and quality improvement. 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 enabling informed, personalized health care decision-making.[xxi]

[xxi] Press Release –(https://www.cms.gov/newsroom/press-releases/cms-care-compare-empowers-patients-when-making-important-health-care-decisions). Care Compare on Medicare.gov - https://www.medicare.gov/care-compare/. Provider Data Catalog on data.CMS.gov - https://data.cms.gov/provider-data/

Integrating human centered design, CMS leveraged website and design technological advances and years of original Compare Site and Data.Medicare.gov user feedback to inform the development strategy. 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 2020 funding for activities under section 1890A of the Act related to the dissemination of quality measures, which included the Measures Management System (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 2020 for activities under section 1890A(b) of the Act related to dissemination of quality measures[xxii]

Fiscal Year	Obligations	Expended Amount	Unexpended Balances
2020	$ 5.21	$ 0.89	$ 4.32

(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.[xxiii] To comply with this provision, CMS published Impact Assessment Reports in 2012, 2015, and 2018. For the 2018 Impact Assessment Report, CMS conducted multiple analyses of measure performance trends, disparities, patient impact, and costs avoided, as well as national surveys of hospital and nursing home quality leaders, to evaluate the national impact of the use of quality measures. In FY 2020, we continued critical work for the upcoming 2021 Impact Assessment Report. Key indicators (comprised of CMS quality measures) were selected to inform the 2021 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' 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).

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

[xxiii] 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, as described in the upcoming 2021 Impact Assessment Report.

Table 5: Funding (in millions) in FY 2020 related to activities under section 1890A of the Act for program assessment and review[xxiv]

Fiscal Year	Obligations	Expended Amount	Unexpended Balances
2020	$ 2.88	$ 0.98	$ 1.90

(4) Program Oversight and Design

To set up for success, initial year funding was provided to contractual entities to support the Secretary in project management and operations related to quality measurement. These quality measurement efforts included the development of a standard operating procedure (SOP) and project management schedules to support consistent and efficient execution. These contracts were completed and the last time a contract was awarded using Program Oversight and Design funds was in FY 2012. No contractual activities have been funded or implemented in FY 2020 under section 1890 or 1890A of the Act. Future expenditures in this area are not anticipated.

Table 6: Funding (in millions) for FY 2020 for activities under section 1890A of the Act related to program oversight and design[xxv]

Fiscal Year	Obligations	Expended Amount	Unexpended Balances
2020	$ 0.00	$ 0.00	$ 0.00

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

CMS continues to foster new ways to better serve our beneficiaries, improving the nation's health and quality of life. As the largest payer of healthcare services in the U.S., CMS leads the way in driving improvements in quality through quality reporting programs that use payment incentives, quality improvement activities and increased transparency through public reporting of performance results. CMS continues to yield critical successes through its work managing quality measurement activities related to the CBE and other contractors responsible for dissemination of quality measures, and program assessment and review. Many of our on-going and new task orders have implications for VA and DOD stakeholders, and we are planning to include their agency staff as federal liaisons or nominate researchers funded by them as committee members to facilitate alignment and burden reduction. These task orders include Opioids and Behavioral Health, Rural Health (esp. the Telehealth work in Option Year (OY) 1), EHR-sourced measures and care coordination, Attribution (e.g., traumatic brain injury and other

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

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

high-acuity injury), the upcoming task order on High Reliability Organizations, device-related adverse events (e.g., pacemakers, hip replacement), and system readiness.

The 1890/1890A task orders CMS anticipate in 2021 and 2022 will help to modernize the way the Agency approaches quality measurement and the way people receive information to make the best decisions for themselves and their families, particularly in light of the unprecedented Novel Coronavirus (COVID-19) outbreak.

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 is much more to be done, CMS has made considerable inroads. The Secretary estimates the following obligations and expenditures will be required in the succeeding two-year period (i.e., FY 2021 and FY 2022) 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 2021 and FY 2022 were developed directly from the experiences and lessons learned from work in FY 2020 and reflect efforts to reduce overhead and focus on the specific activities and deliverables that would drive us to accomplish the quality goals. As an example, critical foundational work from the 2017 Telehealth and the 2019 Healthcare System Readiness projects were performed using this funding source to identify measures or measure concepts that could facilitate the monitoring and assessment of telehealth on improving readiness and reducing mortality in national emergencies, like COVID-19, other pandemics, mass violence, natural disasters, etc. in rural areas. In response to the Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020, follow-on work is supported by CMS that focuses on the expansion of telehealth services for health care providers across the nation, especially in rural areas.

The task orders listed below are anticipated awards using FY 2021 and FY 2022 funding, building from lessons learned and experiences from FY 2020. 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 2021 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 2021 or FY 2022, the cost is indicated as 'estimated' in the tables below.

(1) Duties of the Consensus-Based Entity

Endorsement and Maintenance:

Table 7: Endorsement and Maintenance Funding

Period of Performance	Funding Amount	Fiscal Year
Option Period 4 09/27/21-09/26/22	**$10,083,335**	**2021 (Negotiated)**
Base Period Date TBD	**$10,500,000**	**2022 (Estimated)**

NQF-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 task order 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 through 14 multi-stakeholder groups, so that CMS can incorporate feedback and best-in-class measures in its quality and VBP programs.

The Measure Applications Partnership (MAP)

Table 8: MAP Funding

Period of Performance	Funding Amount	Fiscal Year
Option Period 3 03/27/21-09/26/22	**$1,543,483**	**2021 (Negotiated)**
Base Period Date TBD	**$1,700,000**	**2022 (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. The MAP convenes key stakeholders to evaluate and recommend quality and efficiency measures that are being considered for use in specific Medicare quality programs, including public reporting programs. CMS uses the published feedback and input in its federal rulemaking process when selecting measures for these programs. There are three workgroups that evaluate measures – a Hospital Workgroup, a Clinician Workgroup, and a Post-Acute Care/Long-Term Care Workgroup and all these workgroups are informed by the Rural Health Workgroup, a multi-stakeholder group, who reviews measures for rural relevancy. The MAP process and activities are fundamental to gaining expert insight and perspectives on the quality measurement and quality improvement approaches to promote better health outcomes for individuals and communities. The discussions and recommendations from technical experts and patient advocates, through the various MAP workgroups, provide CMS with critical input to address various priorities such as maternal health, nursing home quality and safety, hospice quality and safety, 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.

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

Table 9: The CBE's Annual Report to Congress and Secretary of HHS Funding

Period of Performance	Funding Amount	Fiscal Year
Option Period 4 09/27/21-09/26/22	**$133,836**	**2021 (Negotiated)**
Base period Date TBD	**$140,000**	**2022 (Estimated)**

The CBE (currently NQF) is statutorily required under section 1890(b)(5) of the Act to submit a Report to Congress, not later than March 1st of each year, which highlights the CBE's work and funding over the last year, emphasizing the broad use of endorsed measures and the CBE's critical role building public/private sector consensus on healthcare improvement strategies. The CBE's report must: describe and make recommendations on the implementation of quality and efficiency measurement

initiatives; describe performance of the CBE's duties required under its contract with the Secretary; describe gaps in endorsed quality and efficiency measures including measures that are within the priority areas under the Secretary's national strategy; describe areas in which evidence is insufficient to support endorsement of quality and efficiency measures in priority areas under the Secretary's national strategy; and describe the CBE's obligations to convene multi-stakeholder groups. The CBE's report must also provide an itemization of financial information for the fiscal year ending September 30 of the preceding year as well as any updates or modifications of internal policies and procedures of the CBE as they relate to the CBE's duties under its contract with the Secretary.

The gaps identified by the CBE are used to prioritize future work to advance healthcare quality measurement and improvement. CMS supports this mandatory reporting via a five-year task order. In the 2020 Annual Report to Congress, the CBE discussed CMS-funded activities during the calendar year, and how project activities were adjusted to facilitate effective response to the COVID-19 pandemic.

Other Task Orders of the Consensus-Based Entity

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

- Core Quality Measures Collaborative (CQMC)

Table 10: CQMC Funding

Period of Performance	Funding Amount	Fiscal Year
Base Award Date TBD	**$500,000**	**2021 (Estimated)**
Option Period 1 Date TBD	**$500,000**	**2022 (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 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 NQF in its role as the CBE. CMS supports specific activities under this work via a three-year task order ending in FY 2021 and expects to award a follow-on task order beginning in FY 2021 to continue this important work. The CQMC supports nationwide quality measure alignment between Medicare and private payers and in turn, advances the ongoing work to establish a health quality roadmap to align and improve reporting across programs and health systems, as referenced in the recent Executive Order on Improving Price and

Quality Transparency in American Healthcare to Put Patients First[xxvi]. This task order will support all three principles of the Roadmap:

1. New governance oversight that has substantial input from public stakeholders
2. Modernize approach to data collection, including new data structures that allow for seamless transmission of measures (leveraging interoperability)
3. Reform of quality measures including number, development and use in federal quality programs

To date, CQMC has developed 10 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

Future work includes:

- Development of updated core set prioritization criteria is performed on a yearly basis and maintenance of a finalized Implementation Guide and messaging for core set adoption by payers is also updated yearly.
- In 2021, cross-cutting work that focuses on improving the measures in the 10 core sets to fill gaps identified in these sets. For example, the core sets will incorporate more Digital Measures and patient-reported outcome measures.
- In 2022, it is expected that new core measure sets in clinical areas will be developed.

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.

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

[xxvi] The White House Executive Order, June 24, 2019 (https://www.federalregister.gov/documents/2019/06/27/2019-13945/improving-price-and-quality-transparency-in-american-healthcare-to-put-patients-first)

Table 11: Measurement Framework for Improving Opioid-related Behavior Health and Quality Measurement for All-Payer Programs Funding

Period of Performance	Funding Amount	Fiscal Year
Option Period 1 09/30/21-09/29/22	**$578,974**	**2021 (Negotiated)**
N/A	**N/A**	**2022 (N/A)**

This task order implements the statutory provision of section 1890(b)(7) of the Act. This work is a follow-on for the 2019-2020 Opioids and Opioid Use Disorder (OUD) TEP Task Order (2019 Opioid Task Order)[xxvii]. The 2019 Opioid Task Order identified four domains of quality measurement related to the monitoring, screening, and treatment of opioid-use disorders, including pain management, treatment, harm reduction, and social determinants of health (SDOH).

The follow-on task order, awarded in FY 2020 and continuing in 2021, builds on the initial task order by focusing on opioid users with co-occurring behavioral health conditions who are polysubstance users and are at a higher risk for overdose and opioid-related mortality. This timely work will help address individuals and communities at higher risk by identifying and prioritizing measures and measure concepts that could inform care delivery and leveraging public health-public safety collaboration to combat the opioid epidemic and enable the monitoring of unintended consequences among individuals with pain management needs due to sickle cell disease, cancer, or during recovery from surgeries. With guidance from a multi-stakeholder group of experts and patients, this work will further CMS's efforts to determine appropriate opioid use and behavioral health measures that align across all-payers, across multiple health care settings, that are disparity-sensitive and low burden. There are many co-occurring projects around this area, and CMS will be able to use this effort to increase efficiency in allocating resources for opioid-related measure development by targeting areas with the highest measurement needs.

This 12-month task order will culminate with the publication of a final recommendation report in September 2021. A 12-month option year will follow immediately, and an updated version of the final report will be published in September 2022. This task order aims to ensure CMS's measures are high impact for addressing the evolving opioid epidemic and are high value, because they can be easily adopted by other public or private payers.

- Leveraging Electronic Health Record (EHR) Sourced Measures to Improve Care Communication and Coordination

[xxvii] This work was required by section 6093 of the 2018 Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act and funded through section 1890(d)(2) of the Act.

Table 12: Leveraging EHR Sourced Measures to Improve Care Communication and Coordination Funding

Period of Performance	Funding Amount	Fiscal Year
Option Period 1 09/25/21-09/24/22	**$781,502**	**2021 (Negotiated)**
N/A	**N/A**	**2022 (N/A)**

This task order implements the statutory provision of section 1890(b)(7) of the Act. Electronic Health Records hold promises of enhancing care coordination[xxviii] [xxix], potentially improving quality of care[xxx]. Advancing electronic measurement is a key initiative of CMS to help connect healthcare information through interoperability, reduce provider burden of reporting, increase transparency in measuring provider performance, as well as enable more timely feedback and analysis. This work is a companion task order to the 2019 EHR Data Quality task order (2019 EHR task order) that ended December 31, 2020. The 2019 EHR task order made recommendations to improve data quality to raise endorsement rates and scientific acceptability for measures derived from EHRs. As CMS is in the process of transitioning quality measures to be based on digital data sources, more work needs to be done to leverage advanced analytics and "big data" modeling. This 12-month task order with the option of 12 additional months, which began on 9/25/2020 specifically addresses the challenge of measuring provider performance in care coordination when the level of EHR adoption is uneven across care settings. With this task order, CMS expects to identify best practices to leverage EHR sourced measures to improve care communication and coordination quality measurement in an all-payer, cross-setting, fully electronic manner. CMS believes that this work is critical to transitioning quality measurement to an all-digital environment and this task order provides a forum to bring together critical stakeholders including payers, providers, vendors, and measure developers.

- Best Practices for Designing, Field-Testing, and Implementing PROMs[xxxi]

[xxviii] The National Coordinator for Health Information Technology (ONC) (September 15, 2017) Improve Care Coordination (https://www.healthit.gov/topic/health-it-basics/improve-care-coordination, accessed 7/24/2020).

[xxix] Office of the Inspector General (May 2019). Using Health IT for Care Coordination: Insights from Six Accountable Care Organizations. U.S. Department of Health and Human Services (https://oig.hhs.gov/oei/reports/oei-01-16-00180.pdf, accessed 7/24/2020).

[xxx] Stanhorpe, V., and E.B. Matthews (2019) Delivering Patient-Centered Care with an Electronic Health Record. *BMC Health Informatics and Decision Making* (https://bmcmedinformdecismak.biomedcentral.com/articles/10.1186/s12911-019-0897-6, accessed 7/24/2020).

[xxxi] Because of its scope, this work requires a longer performance period to complete the Base Period. Because FY 2021 funding has to be spent before 10/1/2021, and Option Period 1 will not start until December 2021, the work of Option Period 1 will be supported by FY 2022 funding.

Table 13: Best Practices for Designing, Field Testing, and Implementing PROMs Funding

Period of Performance	Funding Amount	Fiscal Year
N/A	**N/A**	**2021 (N/A)**
Option Period 112/01/21-11/30/22	**$666,673**	**2022 (Negotiated)**

This task order implements the statutory provision of section 1890(b)(7) of the Act. Unleashing the voice of the patient through patient-reported outcomes (PRO) is another key strategy of CMS. However, there is a lack of detailed technical guidance that measure developers can use to develop high impact outcome measures based on patient-reported data. Feedback from CMS staff who oversee measure development contracts has pointed to the need for expert input on how best to address the challenges of collecting data on PROs. For example, whether web-based or mixed-mode surveys are better than hardcopy questionnaires, and under what circumstances. Currently, PROs are difficult to use and burdensome, often requiring additional staff to call patients and transmit information to providers. This work will design a quality measurement approach from the point of view of the patient. CMS' quality programs strive to design measures that champion individual patient preferences, needs, and values ensuring that patient values guide all clinical decisions. PROs refer to the information collected directly from patients on patient questionnaires, tools, or survey instruments about health status, functioning, or symptoms. These survey instruments are called patient-reported outcome measures (PROMs). Taking it one step further, a performance measure or a patient-reported outcome performance measure (PRO-PM) can be developed based on the outcome information collected from the survey instrument or PROM. Although a few performance measures have been developed from PROMs, there is a critical gap in addressing implementation issues. This new work will address this gap by developing a step-by-step guide on how to turn a PROM into a 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 12-month task order with the option of 12 additional months builds upon the previous 2019-2020 Patient-Reported Outcomes Task Order (PRO Task Order), which focuses on identifying best practices for selecting and interpreting PROs. This work awarded in FY 2020 with an option year in FY 2021 will enable CMS to carry out its mission to empower patients and incorporate their input in measure development. It will inform CMS' efforts in all aspects of developing and implementing PRO-PMs. In particular, it will fill knowledge gaps in selecting high quality PROMs for developing high impact PRO-PMs, collecting outcomes data from patients with minimal burden, maximizing response rates to PROMs to increase representativeness, leveraging 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

Table 14: Leveraging Quality Measurement to Improve Rural Health Funding

Period of Performance	Funding Amount	Fiscal Year
N/A	**N/A**	**2021 (N/A)**
Option Period 2 12/14/21-08/15/22	**$274,023**	**2022 (Negotiated)[xxxii]**

This task order implements the statutory provision of section 1890(b)(7) of the Act. Rural health continues to need support in terms of quality measurement. Rural providers having been confronting 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 12-month base period of this task order in FY 2020. During the two option years, the CBE continues to focus on timely quality measurement issues to support CMS' priority for strengthening the rural healthcare system, applying a rural lens to CMS' measure development work and measure selection for program use.

- In FY 2021, the CBE will convene a multi-stakeholder group in telehealth as well as healthcare system readiness in rural setting. This work will support CMS' efforts to respond to the rapid increase of telehealth adoption across the healthcare industry and the need to better assess the impact of telehealth on strengthening healthcare system readiness and improving health outcomes in rural areas during the COVID-19 pandemic as well as future national emergencies. This work builds on foundational efforts from the 2017 Telehealth project[xxxiii] and the 2019 Healthcare System Readiness project[xxxiv] to identify measures or measure concepts that could facilitate the monitoring and assessment of telehealth on improving readiness and reducing mortality in national emergencies, like COVID-19, other pandemics, mass violence, natural disasters, etc. in rural areas. The final deliverable of this work will be a report documenting multi-stakeholder recommendations on priority measures and gap areas.
- 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 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

[xxxii] 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 respond to COVID-19 timelier. 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.

[xxxiii] NQF. August 2017, *op.cit*

[xxxiv] NQF. June 2019, *op.cit*.

CQMC as well as quality measurement programs, a frequent, sometimes annual review of measure sets is necessary to ensure that new, emerging clinical findings, latest scientific evidence, and critical measure specification updates are addressed in each core set. In recent years, issues such as the opioid crisis, maternal morbidity, chronic co-morbidities have afflicted the general population and are found to be even more acute among the rural population. In addition, the 2018 core measure set includes NQF-endorsed measures only. State, tribal, and local health agencies also use quality measures that have not been submitted to the CBE for endorsement review for quality improvement purposes. To expand the arsenal of measures for improving rural health, CMS will require the contractor to consider measures that have not obtained CBE endorsement. The major deliverables include a broad environmental scan of measures, some of which that may not be endorsed, that can be considered for potential addition to the core set, and a final report on the Workgroup's recommendations.

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.

- Best Practices for Developing and Testing Risk Adjustment Models

Table 15: Best Practices for Developing and Testing Risk Adjustment Models Funding

Period of Performance	Funding Amount	Fiscal Year
Option Period 1 09/15/21-09/14/22	**$874,931**	**2021 (Negotiated)**
N/A	**N/A**	**2022 (N/A)**

This task order implements the statutory provision at section 1890(b)(7) of the Act. As CMS continues to expand program use of outcome measures, developers' need for guidance on risk adjustment modeling has become more urgent. Risk adjustment, done thoughtfully, can facilitate fair comparison of provider performance, which in turns strengthens value-based care. Health outcomes and resource use are often the results of provider performance along with a wide array of clinical and/or social risk factors. As a result, developing and testing the risk adjustment models for outcome and resource use measures is a complex, time-consuming, and resource-intensive effort. For CMS and its measure developers, guidance based on expert consensus in best practices for risk adjustment modeling may increase the return on investment in measure development. An outcome or resource use measure's risk adjustment model impacts the measure's reliability and validity, both of which are the sub-criteria of scientific acceptability, the must-pass criterion of measure endorsement.

This work builds on the recommendations of the ASPE Second Report to Congress on Social Risk Factors and Medicare's Value-Based Purchasing Programs[xxxv] and addresses three issues related to risk adjustment of outcome and resource use measures. The first issue focuses on best practices for social risk adjustment. This includes conceptualizing and operationalizing social risk factors in general and among specific population groups, like Medicare Advantage plan enrollees, Marketplace Qualified Health Plan enrollees, Medicaid recipients, or the non-Medicare population in general, identifying appropriate data sources (especially EHRs or digital apps) and variables, conducting exploratory analyses to narrow down the list of potential social risk factors to include in the model of an outcome or resource use measure, testing for reliability and validity, and finalizing the model for NQF endorsement review. Because CMS has adopted a digital measure strategy for measure development, this task order is interested in exploring promising data elements of social risk factors collected by EHRs or digital apps.

The second issue focuses on best practices for functional status-related risk adjustment for outcome and resource use measures. Similar to the first issue, expert guidance is needed for conceptualizing and operationalizing activities of daily living, mobility limitations, and cognitive impairment, identifying and exploring potential data sources and variables, testing for reliability and validity, and determining the final risk adjustment model. This task order is interested in exploring risk factors related to functional disability collected by EHRs or digital apps.

The third issue is related to the ASPE report's recommendation for the development of a standardized risk adjustment framework that includes functional risk factors. Expert input is needed on the combination of clinical and/or social risk factors for such a framework for resource use measures, and the functional risk factors for outcome measures.

This task order has a 12-month base period that ends in September 2021, when the CBE will publish a technical guidance for the 3 above-mentioned issues. This will be followed immediately by a 12-month option period, during which the CBE will collect and incorporate feedback from measure developers to provide an updated version of the technical guidance, which will be posted in September 2022.

- Device-Related Adverse Events

Table 16: Device-Related Adverse Events Funding

Period of Performance	Funding Amount	Fiscal Year
Base Award Date TBD	**$500,000**	**2021 (Estimated)**
N/A	**N/A**	**2022 (N/A)**

[xxxv] Office of the Assistant Secretary for Planning and Evaluation (ASPE). Second Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs. 06/29/2020. (https://aspe.hhs.gov/pdf-report/second-impact-report-to-congress, accessed 7/8/2020).

This task order implements the statutory provision of section 1890(b)(7) of the Act. This task order aims at identifying priorities and measure gaps related to adverse events (AEs) or near-misses resulting from medical devices for CMS quality reporting and value-based purchasing programs. Complications from cardiovascular or internal orthopedic devices were among the top 20 most expensive conditions for hospital stays paid for by Medicare. In 2017, hospital stays related to complications of cardiovascular device, implant, or graft cost Medicare almost $2.8 million; those related to complications of internal orthopedic device or implant cost Medicare nearly $2.4 million[xxxvi]. The U.S. Food and Drug Administration (FDA) has a passive reporting system for device-related AEs which is similar to reporting for adverse drug events. In the past, CMS funded the CBE to identify existing measures related to AEs linked to medication, diagnostic quality, and hand-off[xxxvii]. However, gaps remain in those related to medical devices. The patient safety measures currently used in CMS' Hospital Acquired Conditions Reduction Program[xxxviii] focus on infections[xxxix], injuries[xl], and complications that may not be device-related[xli]. However, none of these measures directly attribute AEs to medical devices. Through the work with the CBE, CMS can leverage expertise in quality measurement and convening of multi-stakeholder groups by identifying measure priorities and gaps related to reducing device-related AEs and to encourage providers to monitor and prevent device-related complications, injuries, or infections. This task order intends to address an important patient safety issue related to devices and aims to enhance transparency, accountability, and inform providers on investment decisions related to medical devices. CMS will request the multi-stakeholder group to recommend measures that are all-payer and digital to enhance their applicability and reduce provider burden.

- High-Reliability Organizations

[xxxvi] Liang, L. B. Moore, and A. Soni (July 2020). National Inpatient Hospital Costs: The Most Expensive Conditions by Payer, 2017. HCUP Statistical Brief #261. Month 2020. Agency for Healthcare Research and Quality, Rockville, MD. (www.hcup-us.ahrq.gov/reports/statbriefs/sb261-Most-Expensive-Hospital-Conditions-2017.pdf.)

[xxxvii] NQF (June 1, 2018) Ambulatory Care Patient Safety: Environmental Scan Report (http://www.qualityforum.org/Publications/2018/06/Ambulatory_Care_Patient_Safety_2017-2018_Final_Report.aspx, accessed 7/21/2020).

[xxxviii] Centers for Medicare & Medicaid Services. Hospital Acquired Conditions Reduction Program Fiscal Year 2020 Fact Sheet (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/HAC-Reduction-Program-Fact-Sheet.pdf, accessed, 7/21/2020).

[xxxix] The infection-related measures used in the Hospital Acquired Conditions Reduction Program include the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) hospital-associated infections (HAI) measure scores for Central Line-Associated Blood Stream Infection (CLABSI), Catheter-Associated Urinary Tract Infection (CAUTI), Surgical Site Infection (Abdominal Hysterectomy and Colon Procedures) (SSI) measure, Methicillin-resistant Staphylococcus Aureus (MRSA), Clostridium difficile infection (CDI), and the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicator (PSI) 13 – Postoperative Sepsis Rate, which is one of the component measures of PSI 90.

[xl] The injury-related measures used in the Hospital Acquired Conditions Reduction Program include PSI 03 - Pressure Ulcer Rate, PSI 06 - Iatrogenic Pneumothorax Rate, PSI 08 - In-Hospital Fall with Hip Fracture Rate, PSI 10 – Postoperative Acute Kidney Injury Rate, PSI 14 – Post operative Wound Dehiscence Rate, and PSI 15 – Unrecognized Abdominopelvic Accidental Puncture/Laceration Rate, all of which are among the component measures of the AHRQ PSI-90 composite.

[xli] These complication-related measures include PSI 09 – Postoperative Hemorrhage or Hematoma Rate, PSI 11 – Postoperative Respiratory Failure Rate, and PSI 12 – Postoperative Pulmonary Embolism or Deep Vein Thrombosis Rate, all of which are among the component measures of the AHRQ PSI 90 composite.

Table 17: High-Reliability Organizations Funding

Period of Performance	Funding Amount	Fiscal Year
Base Award Date TBD	**$618,000**	**2021 (Estimated)**
N/A	**N/A**	**2022 (N/A)**

This task order implements the statutory provision of section 1890(b)(7) of the Act. High reliability organizations (HROs) are organizations that operate in complex activities for extended periods without serious accidents or catastrophic failures. High reliability concepts are tools that an increasing number of health care providers are using to improve safety, quality, and efficiency, which are concepts that provide insights into how to think about and change complicated quality and safety issues faced by providers daily. HROs follow 5 key concepts as follows:

1. Sensitivity to operations – constant awareness by leaders and staff of the state of the systems and processes that affect patient care.
2. Reluctance to simplify – avoiding overly simple explanations of failure, and strife to understand the true reasons patients are placed at risk.
3. Preoccupation with failure – near-misses are viewed as symptomatic of areas in need of more attention.
4. Deference to expertise – Foster a culture of high reliability in which leaders and supervisors are willing to listen and respond to the insights of staff who know how processes work and the risks patients face; and
5. Resilience – Leaders and staff are trained and prepared to know how to respond when system failures occur.[xlii]

The concept of high reliability is attractive for health care, due to the complexity of operations and the risk of significant and even potentially catastrophic consequences when failures occur in health care[xliii]. High reliability has been defined by some as effective standardization of health care processes. However, the principles of high reliability go beyond standardization; high reliability is better described as a condition of persistent mindfulness within an organization. High reliability organizations cultivate resilience by relentlessly prioritizing safety over other performance pressures.

This task order will explore the elements needed to make our healthcare ecosystem 'high reliability' and identify quality measures that reflect domains and sub-domains of the concept of HROs. These quality measures would enable stakeholders to track an organization's progress to becoming more reliable, to monitor performance over time, and to provide timely feedback to leaders and staff on potential opportunities for improvement. Multi-stakeholder input will also be obtained on potential data sources for

[xlii] Hines, S., Luna, K., Lofthus, J. et al. Becoming a High Reliability Organization: Operational Advice for Hospital Leaders. (Prepared by the Lewin Group under Contract No. 290-04-0011.) AHRQ Publication No. 08-0022. Rockville, MD: Agency for Healthcare Research and Quality. April 2008.

[xliii] Agency for Healthcare Research and Quality (AHRQ) (September 2019). High Reliability (https://psnet.ahrq.gov/primer/high-reliability, accessed 7/22/2020).

measure development, their strengths and limitations, and data collection approaches. This work builds on previous efforts by the CBE to develop measurement approaches related to patient safety and health information technology[xliv], diagnostic accuracy and quality[xlv] [xlvi], ambulatory care patient safety[xlvii], and the Patient Safety Project[xlviii] of previous measure endorsement review cycles. As health care providers across the nation strive to protect their communities from adverse events, this work represents CMS' on-going efforts to improve patient safety and population health.

- A Public Health Approach for Improving Health Care System Readiness

Table 18: Public Health Approach for Improving Health Care System Readiness Funding

Period of Performance	Funding Amount	Fiscal Year
Base Award Date TBD	**$650,000**	**2021 (Estimated)**
N/A	**N/A**	**2022 (N/A)**

This task order implements the statutory provision of section 1890(b)(7) of the Act. This task order builds off the foundational work on health care system readiness that was completed in 2019[xlix]. The COVID-19 pandemic is transforming the way care is provided and highlighted opportunities for improving the nation's readiness for future emergencies. Quality measurement is crucial for improvement. Quality measures allow stakeholders to identify opportunities for improving readiness, monitor status and progress in general and among sub-populations, and track performance over time.

For example, the Emergency Department Transfer Communication measure (NQF # 0291) captures the percentage of patients transferred to another health care facility whose medical record documentation indicated that required information was communicated to the receiving facility prior to or within 60 minutes of transfer. This measure addresses response to and recovery from public health emergencies by encouraging timely communication of data elements that facilitate a better understanding of the patient's condition prior to arriving at receiving facility. This would improve care coordination, reduce errors and duplications of tests and procedures.

[xliv] NQF (February 2016). HIT Safety (http://www.qualityforum.org/HIT_Safety.aspx, accessed 7/22/2020).
[xlv] NQF (September 2017). Improving Diagnostic Quality and Safety (http://www.qualityforum.org/ProjectDescription.aspx?projectID=83357, accessed 7/22/2020).
[xlvi] NQF (2020). Reducing Diagnostic Error: Measurement Considerations (http://www.qualityforum.org/Reducing_Diagnostic_Error.aspx, accessed 7/22/2020).
[xlvii] NQF (June 2018). Ambulatory Care Patient Safety (http://www.qualityforum.org/Ambulatory_Care_Patient_Safety_2017-2018.aspx, accessed 7/22/2020).
[xlviii] NQF. Patient Safety Project (http://www.qualityforum.org/Patient_Safety.aspx, accessed 7/22/2020).
[xlix] NQF (June 2019), *op.cit.*

This work will re-examine the 2019 readiness framework and apply a population-based approach to identify and prioritize quality measures and measure gaps that could improve public health and strengthen system resilience against future national emergencies. In particular, this work will leverage multi-stakeholder input on lessons learned from the nation's experience with COVID-19 and prior national emergencies. These lessons learned may inform new measurement approaches to address disparities in health outcomes and social needs arising from national emergencies. It may shed light on using quality measurement to overcome dis-incentives against readiness. Multi-stakeholder input will also be elicited to identify opportunities to modernize the nation's infrastructure, including cybersecurity, support and protect the health care workforce, and safeguard the public when there is a high risk for mass casualty.

As the federal agency that finances and administers the Medicare and Medicaid programs, as well as the entity responsible for the management and oversight of the Marketplaces that use the Federal platform, CMS' responsibilities impact the health and well-being of an increasingly diverse population across all age groups. The complex chronic care needs of these patient populations could be exacerbated by acute care conditions inflicted by national emergencies. Funding this work reflects CMS' commitment to improving population health, supporting the health care workforce, and strengthening patient safety at the nation's time of need.

- Alignment: Streamlining Quality Measurement

Table 19: Alignment: Streamlining Quality Measurement Funding

Period of Performance	Funding Amount	Fiscal Year
N/A	**N/A**	**2021 (N/A)**
Base Award Date TBD	**$600,000**	**2022 (Estimated)**

This task order implements the statutory provision of section 1890(b)(7) of the Act. This task order will build on the 2016 NQF Variations in Measure Specifications – Sources and Mitigation Strategies Final Report[1]. CMS heeds multi-stakeholder feedback for the need to curb the proliferation of measures across programs and settings for the sake of reducing provider burden. However, through the years after the publication of the 2016 report, new quality programs and alternative payment models were developed, which furthered the need for new measures specific to the care settings, conditions/topics, or patient populations that these new programs or models focus on. The agency has also pushed to expand the use of digital measures in public reporting and value-based purchasing programs. This could give rise to multiple versions of the same measure that differ merely by data source. The COVID-19 pandemic has resulted in a surge in the

[1] NQF. Variations in Measure Specifications – Sources and Mitigation Strategies Final Report (http://www.qualityforum.org/Publications/2016/12/Variation_in_Measure_Specifications_-_Sources_and_Mitigation_Strategies_Final_Report.aspx, accessed 12/2/2020). This project was funded by CMS.

adoption of telehealth services, and CMS has recently finalized rules for permanent expansion of telehealth services[li]. This may further increase the need to update the specifications for some existing measures to incorporate telehealth delivery. All these activities may have inadvertently posed new challenges to measure alignment.

To address more effectively stakeholders' needs, the agency needs a new set of tools that built on the foundation of the 2016 report. The new task order will seek multi-stakeholder input on addressing these new challenges to alignment. It will elicit recommendations for strategies to weigh trade-offs. For example, what do we gain (or lose) by having a different patient safety measure on pressure ulcers for each care setting (e.g., hospital versus PAC/LTC)? How do we weigh any improvement in the reliability and validity of a PAC/LTC measure on pressure ulcers against the number of resources for development and testing, and the reporting burden on health care providers? Also, in what way should CMS consider alignment when combining multiple measures into a single composite or a domain? Existing measures will be employed as use cases for stakeholders to test strategies for trade-offs. These issues will be discussed from the point of view of endorsement and maintenance to inform efforts of developers and funders on more efficient use of resources, especially at the early stage of measure development.

- Using Measurement Systems to Reform the Quality Measurement Enterprise

Table 20: Using Measurement Systems to Reform the Quality Measurement Enterprise

Period of Performance	Funding Amount	Fiscal Year
N/A	**N/A**	**2021 (N/A)**
Base Award Date TBD	**$500,000**	**2022 (Estimated)**

This task order implements the statutory provision of section 1890(b)(7) of the Act. This work builds on the CBE's Measure Sets and Measurement Systems Project[lii], which began in 2019. A measurement system is a group of measures that, based on a predefined methodology, work together to assess quality or cost in relationship to a goal. The overall Hospital Star Rating program, the Merit-based Incentive Payment System (MIPS), and the Medicare Shared Savings Program are all examples of a measurement system. The selection and grouping of measures, along with scoring approaches, risk adjustment, and usability, are considered based on the system's objective, intended use, attribution method, the incentive structure of the program for which the measurement

[li] CMS. Trump Administration finalizes permanent expansion of Medicare Telehealth services and improved payment for time doctors spend with patients (https://www.cms.gov/newsroom/press-releases/trump-administration-finalizes-permanent-expansion-medicare-telehealth-services-and-improved-payment, accessed 12/2/2020).

[lii] NQF. Measure Sets and Measurement Systems (https://www.qualityforum.org/Measure_Sets_and_Measurement_Systems.aspx, accessed 7/22/2020). This project is not funded by CMS.

system is developed for, as well as the nature of the accountable entity. The design of a measurement system should reflect specific program intent, promote efficient use of measure resources, and be transparent, statistically appropriate, aligned across programs, and clearly communicated to stakeholders[liii].

The CBE's 2019 work holds promise for facilitating CMS' efforts to reduce provider burden for reporting measures, and to enhance the goals of VBP programs. CMS is interested in funding a follow-on project to leverage the recommendations of the earlier work. The public comments on the 2019 work highlighted several opportunities for further input from stakeholders. This could strengthen CMS' ability to leverage measurement systems to increase efficient use of program resources. For example, further investigations are needed on promising approaches for incorporating patients' voices in measurement system design. This would ensure that a measurement system is patient-centered, addresses social determinants of care, and reflects patients' experience. Stakeholder input is also needed on the design and implementation of the cost-related components of a measurement system that link cost to quality of care in CMS' value-based models.

- Public Private Vehicles for Stakeholder Engagement

Table 21: Public Private Vehicles for Stakeholder Engagement Funding

Period of Performance	Funding Amount	Fiscal Year
N/A	**N/A**	**2021 (N/A)**
Base Award Date TBD	**$500,000**	**2022 (Estimated)**

This task order implements the statutory provision of section 1890(b)(7) of the Act. This task order will address how CMS could broaden its outreach efforts by engaging with a wider range of quality measurement stakeholders in a timelier manner, which could improve its processes and communication. The CBE will elicit stakeholder input on how best to engage them early at critical decision points of measure development. Currently, CMS funds development contractors to conduct TEPs that are closed for public view until after deliberations resulting in an impression of a lack of transparency or accountability. The convening of open and transparent forums, such as CMS' successful experiences with the Hospital Stars methodology and the 30-day Risk Standardized Mortality measures, underscore the importance of accounting for diverse statistical input when developing measure models. This would increase stakeholder buy-in and enable CMS to leverage broad-based expertise to ensure the success of its measures and programs.

This task order aims at identifying promising modalities for CMS to collect input from multi-stakeholder groups to include front-line care providers, patients, and other

[liii] NQF (December 2019). Advancing Measure Sets and Measurement Systems to Drive Measurable Improvement. Issue Brief (https://www.qualityforum.org/ProjectMaterials.aspx?projectID=89799, accessed 7/22/2020).

stakeholders to better understand their needs and concerns during initial measure development, and to inform measure reevaluation works in a way that would strengthen transparency and facilitate timely input. The CBE has the ability to view the end-to-end process for measurement and recommend best practices for accounting for diverse statistical input when CMS develops models for measures so one developer's bias does not influence heavily when the measure is in CMS programs. CMS believes this project will align with CMS' transparency initiatives. This work will likely enhance efficiency for CMS measure development contracts and increase the agency's return on investment in measure development. Best practices will be incorporated into the CMS Measures BluePrint.

Total for Duties of the Consensus-Based Entity

Table 22: Consensus-Based Entity Funding

Funding Amount	Fiscal Year
$16,264,061	**2021**
$15,380,696	**2022**

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

- The Measures Management System (MMS)

Table 23: Measures Management System Funding

Period of Performance	Funding Amount	Fiscal Year
Option Period 2 mod 10/17/20-09/29/21 **Option Period 3 09/30/21-09/29/22** **Total**	**$800**[liv] **$3,664,948**[lv] **$3,665,748**	**2021 (Negotiated)**
Option Period 3 mod 10/17/21-09/29/22 **Option Period 4 09/30/22-09/29/23**	**$800**[lvi] **$4,294,795**[lvii]	**2022 (Negotiated)**

[liv] $800 is an annual IT cost for the SSL Certificate for CMIT.

[lv] The base amount for OP2 has been negotiated at $3,464,948, with an anticipated modification of $200,000.

[lvi] $800 is an annual IT cost for the SSL Certificate for CMIT.

[lvii] The base amount for OP3 has been negotiated at $3,544,795.00, with an anticipated modification of $750,000.

Period of Performance	Funding Amount	Fiscal Year
Total	**$4,295,595**	

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 will be expanded and enhanced to include industry measure submissions to support CMS' statutorily mandated pre-rulemaking process under section 1890A(a) of the Act.
- Enable the development of a web-based Blueprint and stakeholder engagement website to increase engagement, transparency, innovation, and accessibility. By moving the Blueprint online and combining the information with the MMS resources and engagement activities, stakeholders will find the information more easily and it will be more engaging and accessible for patients, caregivers, front-line clinicians, and others who are interested in quality measurement.
- 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 94,000 subscribers, bi-monthly webinars, and the MMS website.

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)

Table 24: Quality Measure Index Funding

Period of Performance	Funding Amount	Fiscal Year
Option Period 1 mod	**$882,000**	**2021 (Estimated)**

Period of Performance	Funding Amount	Fiscal Year
11/01/20-06/30/21		
Option Period 2 mod 11/01/21-06/30/22	**$825,000**	**2022 (Estimated)**

CMS has developed the Quality Measure Index (QMI), a transparent and reliable scoring instrument based on standardized definitions of quantifiable measure characteristics, to systematically assess individual clinician quality measures. 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 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. The addition of this funding will allow for expanded use of the QMI across healthcare settings and CMS quality reporting programs. The funding will also allow for implementing and analyzing feedback, testing results, and public comment on the QMI methodology. The funding 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.

- The Alignment of Quality and Public Reporting Programs and Websites

Table 25: The Alignment of Quality and Public Reporting Programs and Websites Funding

Period of Performance	Funding Amount	Fiscal Year
Option Period 2	**$1,179,287**	**2021 (Negotiated)**

Period of Performance	Funding Amount	Fiscal Year
03/22/21-03/21/22		
Option Period 3 03/22/22-03/21/23	**$1,216,318**	**2022 (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 will support coordination efforts across the current state of the existing Compare websites, through the transition to human centered design public reporting and the future steady state of a standardized website, allowing users to access information through a single point of entry and simplified navigation to find the quality-of-care information they need. The modernized compare sites launched in September 2020 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. The following is a link to the press release (https://www.cms.gov/newsroom/press-releases/cms-care-compare-empowers-patients-when-making-important-health-care-decisions.)

Significant work is needed to manage the existing Compare website environment, through the complex transition and retirement of legacy sites, including conducting and analyzing research, human centered design user and concept testing, development of industry best practice recommendations, and facilitation of meetings and trainings for internal and external stakeholders. Project management from this contract supports current state and future state operations to align project goals, objectives, timelines, and perceptions across all stakeholders with provision of effective communication, coordination, reporting, and development and maintenance of a master project management plan across contracts/tasks.

Although much work has been done to anticipate the needs of Medicare beneficiaries, patients, and stakeholders in accessing and using publicly reported data, CMS anticipates additional enhancements that require coordination as advocates, health care groups, health care providers, researchers and the larger clinical community preview new features and gather feedback. This task order is critical for ensuring 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

Table 26: Total for Dissemination of Quality Measures Funding

Funding Amount	Fiscal Year
$5,727,035	**2021**
$6,336,913	**2022**

(1) Program Assessment and Review

- Impact Assessment of CMS Quality and Efficiency Measures

Table 27: 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 (Negotiated)**
Option Period 3 07/01/22-06/30/23	**$2,735,496**	**2022 (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 statutory mandate 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 Impact Assessment report publishes in March 2021. Similarly, it is critically important to begin work on the 2024 Impact Assessment Report following posting of the Impact Assessment Report in 2021. The Impact Assessment is a comprehensive national evaluation encompassing 20 terabytes of data, as part of more than 800 measures and 27 reporting programs that inform CMS on the value of quality measures in improving strategic healthcare priorities, patient outcomes, and reducing healthcare costs. Specific tasks to support the 2024 Impact Assessment Report include:

- Develop a standardized and transparent methodology and full Analytic Plan to examine and quantify the impact of the COVID-19 pandemic on key quality indicators and decreased burden of reporting implemented by CMS for measure-related activities in CMS quality reporting programs.
- Systematically enhance the disparity analyses conducted for the Impact Assessment Report.
    - Include demographic information or available indicators of socioeconomic status (SES), such as dual eligibility for both Medicare and Medicaid.

- Use location data (i.e., rural versus urban) in combination with other variables, such as race/ethnicity and sex, for regional analyses and quantification of measure performance.
- Evaluate the impact of COVID-19 and measure performance at the system level related to disparities and health equity.

This work provides CMS with overall national performance rates, trends, and disparities. Importantly, CMS will also 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[lviii] 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 enables CMS to apply data-driven results to assess and evaluate the quality and value of healthcare provided to beneficiaries across quality programs and settings, and respond with timely and specific actions and initiatives, more possible now than ever before, to the national healthcare needs and trends.

- Evaluation of the Endorsement-Maintenance Process (FY 2021)

Table 28: Evaluation of the Endorsement-Maintenance Process (FY 2021) Funding

Period of Performance	Funding Amount	Fiscal Year
Base Award Date TBD	**$1,000,000**	**2021 (Estimated)**
N/A	**N/A**	**2022 (N/A)**

This task order is intended to be conducted by an independent entity to evaluate the current CBE's processes of endorsement and maintenance of quality measures. In an effort to simplify and modernize the endorsement and maintenance processes and improve accountability, this task order elicits recommendations to independently review and recommend appropriate performance metrics for evaluating resource use, timing, scheduling, communication, coordination, and other aspects of the Endorsement and Maintenance process to streamline these processes for quality and efficiency, and to reduce burden for developers and other stakeholders. CMS intends to use this independent input to improve and modernize this critical process to ensure that the highest quality measures are considered and incorporated in its quality programs.

Total for Program Assessment and Review

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

Table 29: Total for Program Assessment and Review Funding

Funding Amount	Fiscal Year
$3,308,102	**2021**
$2,735,496	**2022**

(4) Program Oversight and Design

- Future expenditures are not anticipated in this area.

Table 30: Estimated Expenditures and Anticipated Obligations for Consensus-Based Entity Activities – Congressionally Mandated

Consensus-Based Entity Activity – Congressionally Mandated	FY 2021	FY 2022
Endorsement/Maintenance	$10,083,335	$10,500,000
Measures Application Partnership	$1,543,483	$1,700,000
Annual Report	$133,836	$140,000
Total	$11,760,654	$12,340,000

Table 31: Estimated Expenditures and Anticipated Obligations for Consensus-Based Entity Activities

Consensus-Based Entity Activity	FY 2021	FY 2022
Task Orders of Consensus-Based Entity Activities	$4,503,407	$3,040,696
Total	$4,503,407	$3,040,696

Table 32: Estimated Expenditures and Anticipated Obligations for Secretarial Activities – Dissemination of Quality Measures

Secretarial Activities – Dissemination of Quality Measures	FY 2021	FY 2022
Measures Management System	$3,665,748	$4,295,595
QMI	$882,000	$825,000
Alignment of Compare Websites	$1,179,287	$1,216,318
Total	$5,727,035	$6,336,913

Table 33: Estimated Expenditures and Anticipated Obligations for Secretarial Activities

Secretarial Activities	FY 2021	FY 2022
Evaluation of the Endorsement and Maintenance Process	$1,000,000	N/A
Impact Assessment of CMS Quality & Efficiency Measures	$2,308,102	$2,735,496
Total	$3,308,102	$2,735,496

Table 34: Estimated Expenditures and Anticipated Obligations for Activities Under Sections 1890 and 1890 Activities

Activity	FY 2021 Total	FY 2022 Total
Consensus-Based Activities	$16,264,061	$15,380,696

Activity	FY 2021 Total	FY 2022 Total
Secretarial Activities	$9,035,137	$9,072,409
1890 and 1890A Activities	$25,299,198	$24,453,105

***Note:** *Section 3802 of the CARES Act 2020 provided CMS with $20,000,000 in new funding in FY 2020*[lix]*. In addition, CMS carried over previous funding under section 1890(d) of the Act in the amount of $7,493,304 for a total of $27,493,304 available to be spent on sections 1890 and 1890A activities in FY 2020.*

The upcoming work in FYs 2021 and 2022 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

Table 35: 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

[lix] Pub. L. 116-136 CARES Act (https://www.congress.gov/bill/116th-congress/house-bill/748/text)

Acronym/ Abbreviation	Name or Term
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
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)

Sections 1890 and 1890A of the Social Security Act:

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

Section 1890A (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 2020. 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 National Quality Forum Reports (http://www.qualityforum.org/Publications.aspx).

Details

2020

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:

Table 36: Endorsement and Maintenance Measures Funding

Period of Performance	Funding Amount	Fiscal Year
Option Year 3 09/27/20-09/26/21	**$9,956,081**	**2020**

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 26 new measures and 60 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

Table 37: The CBE's Annual Report to Congress and Secretary of HHS Funding

Period of Performance	Funding Amount	Fiscal Year
Option Year 3 09/27/20-09/26/21	**$133,543**	**2020**

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 2020 report outlined the accomplishments-to-date and outcomes for the following on-going task orders:
  - Endorsement and Maintenance,

        - MAP,
        - Social Risk Trial,
        - CQMC,
        - Maternal Morbidity and Mortality, and
        - Leveraging Quality Measurement to Improve Rural Health.
    - The 2020 report also discussed several task orders completed during the calendar year, including:
        - Person-Centeredness Planning,
        - Patient-Reported Outcomes,
        - EHR Data Quality, and
        - Diagnostic Error.
    - At the same time, for the five new task orders awarded in the calendar year of 2020, the report discussed the activities that occurred between the award dates through the end of the calendar year. These task orders include
        - 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.
        - Leveraging Electronic Health Record-sourced Measures to Improve Care Communication and Coordination; and
        - Attribution Models for Critical Illness and Injury.
    - The 2020 report is expected to align with previous financial and task order reporting requirements but will also contain linkages to how the work has been used to further healthcare quality measurement.

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

- Social Risk Trial

Table 38: Social Risk Trial Funding

Period of Performance	Funding Amount	Fiscal Year
Option Year 2 05/15/20-05/14/21	**$418,163**	**2020**

This task order implements a new phase of the Social Risk Factor Initiative to review outcome measures for endorsement or maintenance, with special focus on scientific acceptability, i.e., reliability and validity, and develop a final report on lessons learned and multi-stakeholder recommendations.

- The CBE evaluated the use of social determinants in the risk-adjustment methodology for outcome measures as part of the measure endorsement and maintenance review process. This work is critical because it will be used to inform the scientific standard for future endorsement and maintenance of measures. In FY 2020, the Disparities Committee met and reviewed the risk-adjusted measures for the Fall 2019 endorsement cycle submissions, reviewed the risk models in use, and weighed in on the implications of measure

endorsement and maintenance decisions on the appropriateness of social risk adjustment on outcome measures.
  - In Spring 2020, CMS worked with the CBE to reschedule Disparities Standing Committee meetings so that the clinicians on the multi-stakeholder group can focus on providing care for patients of COVID-19.
  - In early June 2020, the CBE published an updated list of measures under review for the Social Risk Trial on their website.

- Core Quality Measures Collaborative (CQMC)

Table 39: CQMC Funding

Period of Performance	Funding Amount	Fiscal Year
Option Year 2 09/14/20-09/13/21	**$264,013**	**2020**

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 2020, the CBE convened two additional workgroups for Behavioral Health and Neurology. The CBE continues to convene workgroup meetings for the original workgroups including: Accountable Care Organizations/Patient Centered Medical Homes/Primary Care, Cardiology, Gastroenterology, HIV & Hepatitis C, Medical Oncology, Obstetrics & Gynecology, Orthopedics and Pediatrics, which discussed the maintenance of the core sets.
  - In the Fall of 2020, all eight core sets were finalized, and the additional core sets of Behavioral Health and Neurology remain on track for completion. Under this contract, the selection criteria for new core sets were updated.
  - The CBE created the Prioritization Guide that provides standardization for considering measures to prioritize for the core sets.
  - Additionally, the CBE developed an Implementation Guide that can be used to guide organizations for core set adoption. The guide includes instructions and templates to assist with putting Core Measure Sets into practice.
  - The other workgroups continue to review and work on finalization of their core sets including the new core sets for Behavioral Health and Neurology. Early strategic work began in 2020 to design the two new core sets that will be established in 2021.

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

Table 40: Measurement Framework for Improving Opioid-related Behavioral Health and Quality Measurement for All-Payer Programs Funding

Period of Performance	Funding Amount	Fiscal Year
Base Award 06/30/20-09/29/21	**$655,345**	**2020**

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. This 12-month task order with the option of 12 additional months 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 completed a call for a multi-stakeholder group member and has started convening meetings with the newly seated multi-stakeholder group to begin the development of the measurement framework, based on the requirements set forth in the task order.

- Best Practices for Designing, Field-Testing, and Implementing PRO-PMs

Table 41: Best Practices for Designing, Field-Testing, and Implementing PRO-PMs Funding

Period of Performance	Funding Amount	Fiscal Year
Base Award	$774,625	2020

Incorporating the patient voice into measurement is an ongoing priority for CMS. To support ongoing measure development efforts across programs, this task order completes the following foundational work to be used by measure developers and CMS for consideration in developing measures for its programs. Additionally, this work will be considered for incorporation into the Measures Blueprint for best practices in measures development.

- The CBE convened a multi-stakeholder group to provide input on best practices for selecting reliable and valid patient-reported outcome data collection instruments (or PROMs), and using these instruments to develop high-impact, high-quality PRO-PMs that are digital, all-payer, appropriately risk-adjusted, suitable for use in Medicare VBP programs or alternative payment models (APMs) to differentiate provider performance and could meet the CBE's measure endorsement criteria.
- The CBE developed an Interim report on attributes shared by the PROMs used by CMS for VBP programs or APMs.
- The CBE developed an Environmental Scan report on existing guidance on best practices for development PRO-PMs.
- The CBE developed a final report that documented the multi-stakeholder group's technical guidance on using PROMS to develop PRO-PMs that could meet the CBE's measure endorsement criteria.
- Building a Roadmap from Patient-Reported Outcome Measures to Patient-Reported Outcome Performance Measures Report. (http://www.qualityforum.org/Building_a_Roadmap_from_Patient-Reported_Outcome_Measures_to_Patient-Reported_Outcome-Performance_Measures_.aspx)

- Best Practices for Developing and Testing Risk Adjustment Models

Table 42: Best Practices for Developing and Testing Risk Adjustment Models Funding

Period of Performance	Funding Amount	Fiscal Year
Base Award 06/15/20-09/14/21	**$1,096,931**	**2020**

This work focuses on both social and functional risk factors. It was designed to build on the recommendations of the ASPE Second Report to Congress on Social

Risk Factors and Medicare's Value-Based Purchasing Programs[lx] and focus on developing a Standard Risk Adjustment Framework for Outcome and Resource Use Measures in Medicare Programs. Although the work ASPE does in this area helps define the recommendations and framework of social and functional risk factors, this work with the CBE helps to address some of the major technical challenges confronting developers in their efforts to operationalize those recommendations Specifically, this task order addresses 3 issues related to risk adjusting outcome and resource use measures: (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. Consensus-based expert guidance on these issues could enhance the accuracy of measure estimates related to provider performance, increase stakeholder buy-in for Medicare programs that use risk-adjusted outcome or resource use measures, safeguard unintended consequences among underserved populations, and strengthen value-based care. The following occurred with 2020 funding:

  - The CBE convened a 15-member multi-stakeholder group to provide guidance on methodological considerations for building a robust risk adjustment models, including how to assess data sources, choice of data elements, measure types (e.g. outcome, resource use, process, composite, etc.), levels of risk adjustment (e.g. patient-, community-, or facility-level), approaches for measure-, program-, plan-, or payment-level risk adjustment and associated pros and cons, statistical tests for assessing adequacy of risk adjustment, value of using a standard risk adjustment model across measures.
  - The CBE conducted and facilitated multi-stakeholder web meetings to develop consensus on risk adjustment modeling; submitted meeting summaries to CMS for review and feedback, submitted finalized meeting summaries to CMS and posted these summaries on the project website.
  - The CBE developed an Environmental Scan report on existing guidance on risk adjustment modeling; and developed a final report that documented the multi-stakeholder group's technical guidance on considerations for risk adjustment modeling.
  - Risk Adjustment Guidance Report (http://www.qualityforum.org/Risk_Adjustment_Guidance.aspx)

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

[lx] Office of the Assistant Secretary for Planning and Evaluation (ASPE). Second Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs. 06/29/2020. (https://aspe.hhs.gov/pdf-report/second-impact-report-to-congress, accessed 7/8/2020).

Table 43: Leveraging Electronic Health Record-sourced Measures to Improve Care Communication and Coordination Funding

Period of Performance	Funding Amount	Fiscal Year
Base Award 09/25/20-09/24/21	**$774,999**	**2020**

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

- The CBE conducted expert interviews to identify relevant literature; provided feedback on the current activities and work being done to support care communication and coordination, as well as how EHR sourced measures are being used; gave their expert opinion; and helped shape the themes and questions brought to the multi-stakeholder meetings.
- The CBE convened a multi-stakeholder group of 20-25 individuals with expertise in care communication and coordination, EHRs, and measure development, including patients and patient advocates. Among other things, the multi-stakeholder group worked to:
  - define care communication and coordination.
  - establish the relationship between care communication and coordination and improved healthcare outcomes.
  - review existing care communication and coordination measures (both CQMs and EHR sourced measures).
  - describe challenges of measure provider performance on care communication and coordination in an all-payer, cross-setting, fully electronic manner.
  - outline recommendations for how EHRs could better facilitate care communication and coordination,
  - describe how EHR sourced measures can be leveraged to improve care communication and coordination; and
  - list possible EHR sourced care communication and coordination measure concepts or specific areas of measurement within care communication and coordination (either de novo or re-specified from existing measures) for development to respond to gaps within in current care communication and coordination and communication measurement.
- The CBE, with multi-stakeholder input, produced an environmental scan that reviewed, analyzed, and synthesized information regarding: similarities and difference between definitions of care communication and coordination; the relationships between care communication and coordination and improved healthcare outcomes; existing care communication and coordination measures (both CQMs and EHR sourced measures); the role of SDOH in care communication and coordination as it relates to care communication and coordination; and challenges of measure provider performance on care

communication and coordination in an all-payer, cross-setting, fully electronic manner. The report was based on original research and the feedback from the expert interview and multi-stakeholder meetings.

- Attribution Models for Critical Illness and Injury

Table 44: Attribution Models for Critical Illness and Injury Funding

Period of Performance	Funding Amount	Fiscal Year
Base Award 09/28/20-09/27/21	**$780,472**	**2020**

As CMS rapidly moves towards full value-based design, through its VBP programs and APMs, that promotes a team-based care approach, this task order provides essential foundational work to best attribute care and payments in areas that have not previously been addressed. For CMS, a major challenge is developing an attribution model that could incentivize team-based care to determine the amount of reward that is commensurate with each team member's contribution to a specific health outcome of the patient. In this way, attribution models could make a significant difference in market stability and provider buy-in for CMS value-based programs and models. The COVID-19 pandemic has shown that when an entire community or population is at risk of high-acuity and time-sensitive conditions, the barriers posed by care settings, insurance networks, hospital/health care systems, and even professional sectors may not be conducive to life-saving efforts. For quality measurement to drive readiness in times of national emergencies, a population-/geographic-based approach that clearly delineates the chain of accountability is crucial for averting poor outcomes. Currently, there are few studies in quality measurement with findings that inform attribution approaches in general, much less for high-acuity emergency care sensitive conditions like coronavirus infection, or blast or firearm injury. This work seeks to fill that knowledge gap. Specific work under this effort:

- The CBE convened a multi-stakeholder group in high-acuity emergency care sensitive condition-related health outcomes and population/geographic-based attributional approaches in quality measurement. Examples of high-acuity emergency care sensitive conditions include critical illness or injury, like trauma, stroke, cardiac arrest, high consequence infectious diseases, radiation or chemical exposure, mass shootings, bombings, natural disasters, etc. In these cases, care is unplanned, and patients are inherently linked to hospitals by geography rather than by health system network affiliations because of the time-sensitive nature of care.[lxi] Severity of injury or illness in these cases

[lxi] Carr BG, Kilaru AS, Karp DN, Delgado MK, Wiebe DJ. (September 2018) Quality Through Coopetition: An Empiric Approach to Measure Population Outcomes for Emergency Care-Sensitive Conditions. *Annals of Emergency Medicine.* 72(3):237-245.

similarly limits the ability of the patient to utilize established patient-provider relationships to receive time-critical care, and this extreme use case may provide a starting point for a framework development initiative. Improvement in health outcomes will require the coordination of care both within and between settings that supports accountability at the system or regional level rather than at the provider level. This work could inform CMS' efforts in adopting a population health approach to quality measurement.
    - The CBE conducted and facilitated multi-stakeholder group web meetings to build consensus on developing population/geographic-based attribution approaches for high-acuity emergency care sensitive condition-related quality measurement.
    - The CBE developed an Environmental Scan report that discussed existing attributional approaches for high-acuity emergency care sensitive condition-related quality measures and measure concepts for multi-stakeholder input.
    - The CBE developed a final report that documented the multi-stakeholder group's recommendations for development population/geographic-based attributional approaches for high-acuity emergency care sensitive condition-related quality measures.

    CMS sees this work as a key building block for future efforts to develop potential attributional approaches that encourage care coordination, that are population health-focused, and that can be used to gauge provider performance and strengthen accountability at the system level and across payers.

- Leveraging Quality Measurement to Improve Rural Health

Table 45: Leveraging Quality Measurement to Improve Rural Health Funding

Period of Performance	Funding Amount	Fiscal Year
Option Year 1 09/30/20-12/13/21	**$486,058**	**2020**

Rural America represents a substantial but sometimes invisible population within the U.S. These individuals are challenged by poor access to care and high rates of chronic conditions. Additionally, rural providers struggle to provide care while confronting staffing shortage, outdated infrastructure, and recurring financial uncertainty. These challenges, combined with geographical distance and limited transportation options, could significantly limit health care providers' ability to

deliver timely care, especially at times of national emergencies, like the COVID-19 pandemic[lxii] [lxiii].

Although telehealth offers the promises of overcoming geographical distance and healthcare professional shortage, adoption has been limited before the pandemic, partly due to poor broadband infrastructure in rural areas[lxiv] and lack of staff expertise among rural providers. The rapid adoption of telehealth during the pandemic may have allowed health care professionals to respond more effectively to victims of coronavirus infection, and to communicate and coordinate across health care networks in a timely manner. It also enables individuals with chronic conditions who need regular medical attention timely access to their providers when in-person visits may increase the risk for infections. At the same time, the phenomenon has also posed challenges for measuring quality of care delivered by telehealth appropriately. The health care industry has also begun to ponder whether telehealth is substitutional to in-person care or merely complementary, as the answer to that question could impact the future of health care. For rural providers who wish to participate in CMS quality measurement programs, if the ease of care delivery via telehealth becomes permanent, then it would be important to ensure that the measures in these programs are reflective of the new normal of care provision in rural America.

This work developed in collaboration with HRSA ensures that the measures developed or used by CMS reflect national efforts related to Rural America, providing foundational work on how to measure the impact of telehealth on system readiness and health outcomes in times of national emergencies, including, but are not limited to, pandemics, mass violence, and natural disasters. Specifically, this task order covered the following:

- The CBE convened a 25-member multi-stakeholder group in telehealth, health care system readiness, and rural health to build on foundational works from the 2017 Telehealth project[lxv] and the 2019 Healthcare System Readiness project[lxvi] to identify quality measures to assess the impact of telehealth on enhancing health care system readiness and improving health outcomes in national emergencies.
- The CBE conducted and facilitated multi-stakeholder web meetings to develop consensus on high-impact quality measures that could facilitate

[lxii] Garrity, M. (March 13, 2020). How Rural Hospitals are responding to Coronavirus. *Becker's Hospital Review* (https://www.beckershospitalreview.com/telehealth/how-rural-hospitals-are-responding-to-coronavirus.html, accessed 3/30/2020).

[lxiii] Read, R. (March 25, 2020). Cash-strapped Rural Hospitals face Imminent Closure as Coronavirus Bears Down. *Los Angeles Times* (https://www.latimes.com/world-nation/story/2020-03-25/rural-coronavirus-hospitals-call-for-emergency-funding, accessed 3/30/2020).

[lxiv] Terragnoli, A. (May 26, 2020). Rural Connection: Increasing Broadband Infrastructure to Meet 21st Century Needs. *Cornell Policy Review* (http://www.cornellpolicyreview.com/rural-connection-increasing-broadband-infrastructure/. Accessed 7/23/2020).

[lxv] NQF, August 2017, *op. cit.*

[lxvi] NQF, June 2019, *op. cit.*

efforts to assess the impact of telehealth on enhancing health care system readiness and improving health outcomes in national emergencies.
- The CBE developed an Environmental Scan report that discussed existing quality measures and measure concepts related to the project topic, identified measure gaps for multi-stakeholder input.
- The CBE developed a final report that documented the multi-stakeholder group's recommendations on priority measures that could enable stakeholders to measure the impact of telehealth on health care system readiness and health outcomes in national emergencies; submitted the draft version of the final recommendation report to CMS for review and feedback.

Section 1890A[lxvii] of the Act:

(1) Duties of the Consensus-Based Entity

- The Measure Applications Partnership (MAP)

Table 46: MAP Funding

Period of Performance	Funding Amount	Fiscal Year
Option Year 2 03/27/20-03/26/21	**$1,393,823**	**2020**

This task order enables HHS to receive input from several multi-stakeholder groups convened as part of the pre-rulemaking process. The multi-stakeholder groups, with the support of the federal liaisons including CDC, HRSA, IHS, ONC, and AHRQ, are expected to provide input on the selection of quality and efficiency measures considered by the Secretary under the MUC list for use in payment and public reporting programs for the Medicare program.

- The CBE convened the MAP, a multi-stakeholder partnership that provided recommendations to HHS on measure selection for federal quality reporting and VBP programs for hospitals, PAC/LTC, and clinician settings. During the 2019-2020 cycle:
  - Clinician: The MAP reviewed measures under consideration for the following programs: MIPS, Medicare Shared Savings Program, and Medicare Part C and D Star Ratings. The MAP emphasized the importance of shared accountability for performance measures of hospital admissions, readmissions, and emergency department use that are incorporated into public reporting and payment programs. Additionally, the MAP noted that the current phase of the opioid crisis is predominantly driven by an increased uptake of fentanyl-laced heroin leading to increases in overdose and death. The MAP acknowledged an important shared responsibility for individual providers, health systems, and health plans to address issues of pain management and function as well as to identify and address issues associated with OUD.

[lxvii] 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.

- Hospitals: The MAP Hospital Workgroup reviewed six measures for four hospital and setting-specific programs. The MAP emphasized that patients and consumers value patient safety measures in public accountability programs, and facilities can improve patient safety through quality improvement programs. Additionally, the MAP discussed the importance of a system-level measurement approach to identify priorities across settings, such as transfer of health information measures and eCQMs. The MAP expressed support for the CMS Meaningful Measures Initiative. The MAP recommended priority gaps to consider and monitoring for the shift of services traditionally delivered in the hospital into ambulatory settings.
- Post-Acute: The MAP reviewed two measures under consideration, one each for the following programs: Home Health Quality Reporting Program (HH QRP) and Hospice Quality Reporting Program (Hospice QRP). The MAP identified care coordination, interoperability, and PROs as the most important priorities for measurement for PAC and LTC programs. The MAP emphasized the importance of including the voice of the patient and patient-centered goals in quality measurement. The MAP noted the potential impact of technology and interoperability, especially on care coordination. Additionally, the MAP emphasized the need to engage with EHR vendors and PAC/LTC facilities, align measurement across the full continuum of care, and address quality measure gaps.

- During the 2020 pre-rulemaking cycle, CMS received approximately 41 submissions for the MUC List, which was a reduction from the 50 submissions in 2019. By focusing on cross cutting priority areas associated with improved outcomes, CMS proposed 18 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 quality priorities including Making Care Safer by Reducing Harm Caused in the Delivery of Care, Strengthen Person and Family Engagement as Partners in Their Care, Promote Effective Communication and Coordination of Care, Promote Effective Prevention and Treatment of Chronic Disease and Make Care Affordable.

Total for Duties of the Consensus-Based Entity

Table 47: Total for Duties of the Consensus-Based Entity Funding

Funding Amount	Fiscal Year
$16,734,053	**2020**

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

- The Measures Management System (MMS)

Table 48: MMS Funding

Period of Performance (Fiscal Year 2020)	**Funding Amount**
Option Year 1 mod 01/10/20-09/29/20	**$696,128**
Option Year 2 09/30/20-09/29/21	**$3,363,944**
Total	**$4,060,072**

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 the MMS Blueprint, MMS website and monthly newsletters to over 94,000 subscribers. To further support the alignment and harmonization of quality measures across CMS and with private payers, the MMS also supported and maintained the CMS Measures Inventory Tool (CMIT), as well as other innovative tools, like the CMS Environmental Scan Tool, to ease the burden of environmental scans throughout the measure development by providing the most recent publications relevant to existing measures.

The funds for the Option 1 modification supported:

- a simplified and streamlined Blueprint to make measure developer for CMS programs more accessible to specialty societies, patient advocacy groups, researchers, and other private sector entities.
- development of a measure submission tool to support pre-rulemaking efforts, making it especially easy for CMS to solicit and review measures from private industry.
- the analysis and write up of an independent statistical panel who reviewed and provided guidance on the interpretation of the recent publications and evaluated the effects of Hospital Readmissions Reduction Program on readmission and mortality rates.

The funds of Option Year 2 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

Table 49: The Alignment of Quality and Public Reporting Programs and Websites Funding

Period of Performance	Funding Amount	Fiscal Year
Option Year 1 03/22/20-03/21/21	**$1,143,408**	**2020**

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:

- Supported the transition to redesign the original eight compare tools into two user centric interfaces, namely the Provider Data Catalog (PDC) and Care Compare, to improve the stakeholder experience by enabling an intuitive searchable user interface, meaningful and streamlined content and public reporting of quality measures. CMS formed an integrated project team (IPT) comprised of cross-cutting subject matter experts and leaders. The contractor provided the IPT with project management tools and techniques including an executive level project charter, risk register, meeting scheduling, agendas and minutes, and meeting facilitation.
- Convened CMS leads to coordinate and strategically design cadence of focused meetings supportive of alignment, prioritization, risk assessment and mitigation, scheduling and timelines through transition and sunset of the original compare site tools into steady state readiness of the new interfaces. For example, established recurring weekly Public Reporting Alignment Coordination (PRAC) meetings to align and prioritize the tasks and activities across the body of stakeholders.
- Supported a standardized and simplified data set file transfer and formatting protocol using Application Programming Interface (API) code, provided project management and project administration. Established 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. Supported pre-launch activities by conducting user acceptance testing of a prioritized list of data elements comparing the original eight compare tools to the redesigned new Care Compare tool ensuring data integrity and consistency.
- Increased communication, coordination and alignment through development, consolidation and dissemination of a comprehensive 2020 calendar year refresh and release schedule including 64 release/refresh dates across all compare sites settings, a time-based workflow for planning resources around file creation, data validation and data deployment in the production environments. Additionally, developed a master project plan, timelines, weekly project stakeholder newsletter, and a comprehensive frequently asked questions document.

Total for Dissemination of Quality Measures

Table 50: Total for Dissemination of Quality Measures Funding

Funding Amount	Fiscal Year
$5,203,480	**2020**

(3) Program Assessment and Review

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

- Impact Assessment of CMS Quality and Efficiency Measures

Table 51: Impact Assessment of CMS Quality and Efficiency Measures Funding

Period of Performance (Fiscal Year 2020)	Funding Amount
Base period mod 01/15/20-06/30/20	**$298,732**
Option Year 1 07/01/20-06/30/21	**$2,581,075**
Total	**$2,879,807**

This work obtains the expert services needed to conduct Impact Assessment work. The statutory mandate at section 1890A(a)(6) requires CMS to conduct an assessment of 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 and 2018, and CMS intends to develop and post the upcoming Impact Assessment Report in 2021 and 2024.

- Conducted an assessment of the quality and efficiency impact of the use of endorsed measures in CMS reporting programs, engaged a TEP and FASC, both comprised of nationally credentialed experts, and published the statutorily required triennial report under section 1890A(a)(6) of the Act. The 2021 Impact Assessment Report, which has started clearance, includes a comprehensive analysis of more than 800 measures and 27 reporting programs to provide data-driven results, including measure performance trends, disparities, patient impact, and costs avoided, as well as identification of strategic quality improvement activities by leaders of Home Health Agencies related to the reporting of CMS quality measures, obtained through a National Provider Survey. Additionally, the CMS information systems modernization initiative successfully produced data migration of over 20 terabytes of quality measure data to a cloud environment where in future Reports, data acquisition

and analytics will be centralized and efficiently supported over multiple CMS reporting programs. The Impact Assessment team also developed critical enhancements and interactive features for CMS stakeholders using the National Quality Dashboard, which aligns with the aforementioned CMS quality measures and programs. The Dashboard has been enthusiastically received during internal and external stakeholder presentations, and will support real-time data analytics, results, and interpretation driving quality improvement across programs and settings.

Total for Program Assessment and Review

Table 52: Total for Program Assessment and Review Funding

Funding Amount	Fiscal Year
$2,879,807	**2020**