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

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[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.

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/

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

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

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

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[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.

x Leveraging Quality Measurement to Improve Rural Health

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.

x 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.

x 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

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[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.

x 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.

x 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).

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)**