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Report to Congressional Committees

September 2019

HEALTH CARE QUALITY

CMS Could More Effectively Ensure Its Quality Measurement Activities Promote Its Objectives

GAO-19-628

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GAO Highlights

Highlights of GAO-19-628, a report to congressional committees

Why GAO Did This Study

To encourage greater value in health care, CMS adjusts its Medicare payments to many health care providers based on measures of the quality of care. Therefore, the decisions CMS makes to choose certain quality measures have significant consequences. These decisions may involve selecting specific existing measures for CMS to use, stopping the use of some measures, or identifying new measures to be developed.

The Bipartisan Budget Act of 2018 contains a provision for GAO to review CMS's quality measurement activities. For this report, GAO (1) assessed the information CMS maintains on funding of health care quality measurement activities, and (2) described and assessed how CMS makes decisions to develop and to use quality measures. GAO analyzed CMS funding data for 2009 through 2018 and data on CMS quality measurement selections for 2014 through 2018. GAO reviewed CMS documentation related to its decisions on quality measurement and interviewed program and contractor officials.

What GAO Recommends

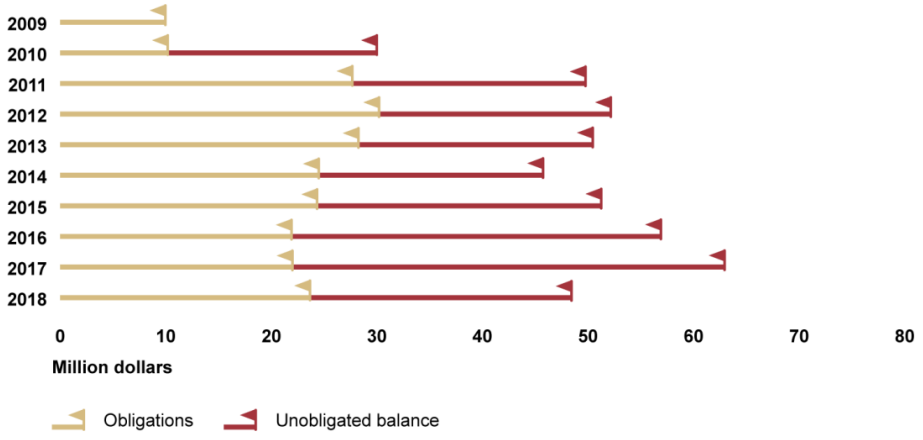
GAO recommends that CMS (1) maintain more complete and detailed information on its funding for quality measurement activities, (2) establish procedures to systematically assess measures under consideration based on CMS's quality measurement strategic objectives, and (3) develop and use performance indicators to evaluate progress in achieving its objectives. HHS concurred with all three recommendations.

View GAO-19-628. For more information, contact Jessica Farb at (202) 512-7114 or farbj@gao.gov.

What GAO Found

The Centers for Medicare & Medicaid Services (CMS), within the Department of Health and Human Services (HHS), maintains information on the amount of funding for activities to measure the quality of health care provided under Medicare. CMS's information shows it has carried over from each year to the next large amounts of available funding—known as unobligated balances—for quality measurement activities from fiscal years 2010 through 2018 (see figure). CMS officials said they maintained such available funding to ensure there were no gaps in funding for future years. However, CMS officials also told GAO that the information it maintains does not identify all of the funding the agency has obligated for quality measurement activities. Further, it does not identify the extent to which this funding has supported CMS's quality measurement strategic objectives, such as reducing the reporting burden placed on providers by CMS's quality measures. With more complete and detailed information, CMS could better assess how well its funding supports its quality measurement objectives.

CMS Obligations and Unobligatated Balances for General Medicare Quality Measurement Appropriations by Fiscal Year



Source: GAO analysis of Centers for Medicare & Medicaid Services information. | GAO-19-628

CMS takes different approaches for deciding which quality measures to develop and to use. However, CMS lacks assurance that the quality measures it chooses address its quality measurement strategic objectives. This is because CMS does not have procedures to ensure systematic assessments of quality measures under consideration against each of its quality measurement strategic objectives, which increases the risk that the quality measures it selects will not help the agency achieve those objectives as effectively as possible. These procedures, such as using a tool or standard methodology to systematically assess each measure under consideration, could help CMS better achieve its objectives. In addition, CMS has not developed or implemented performance indicators for each of its quality measurement strategic objectives. Establishing these indicators and using them to evaluate its progress towards achieving its objectives would enable CMS to determine whether its quality measurement efforts are sufficient or changes are warranted.

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Abbreviations

BBA	Bipartisan Budget Act of 2018
C3	Communication, Coordination, and Collaboration Forum
CBE	consensus-based entity
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
eCQM	electronic clinical quality measure
HHS	Department of Health and Human Services
HIGLAS	Healthcare Integrated General Ledger Accounting System
IMPACT	Improving Medicare Post-Acute Care Transformation Act of 2014
MACRA	Medicare Access and CHIP Reauthorization Act of 2015
MAP	Measure Applications Partnership
MIDS	Measure & Instrument Development and Support
MIPPA	Medicare Improvements for Patients and Providers Act of 2008
MUC	Measures under Consideration
NQF	National Quality Forum
PAMA	Protecting Access to Medicare Act of 2014
PPACA	Patient Protection and Affordable Care Act
SSA	Social Security Act

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441 G St. N.W.
Washington, DC 20548

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Both the federal government and private payers, such as health plans, increasingly use health care quality measures to encourage providers to improve health care quality. This often involves measuring the performance of physicians and other providers to hold them accountable for the health care they deliver and to adjust their payments accordingly. The Centers for Medicare & Medicaid Services (CMS) uses a range of quality measures to assess the care furnished by Medicare providers.[1] For example, CMS collects data to measure the rates at which a hospital's patients acquire certain infections while receiving care. CMS also funds the development of new measures when it determines they are needed. Quality measures used in Medicare can also be used by private payers, so CMS's decisions to select quality measures or develop new ones have a major influence over what is known about the quality of care provided to patients, and over how health care providers are paid. For example, in fiscal year 2019, CMS's Hospital Value-based Purchasing program was expected to adjust approximately $1.9 billion in Medicare Part A payments to hospitals—shifting payments from hospitals that scored lower on CMS's quality measures to hospitals that scored higher.

Providers and others have questioned some of the measures CMS has chosen to use in Medicare. For example, some providers and other stakeholders believe that many of the measures that CMS uses are not good indicators of the quality of care that patients receive.[2] Similarly, providers and other stakeholders believe they must devote too many financial and other resources on reporting the data required for many of these quality measures.

[1]CMS collects and reports quality information for certain other programs. For example, it encourages states to report measures from the Medicaid and Children's Health Insurance Program (CHIP) Child and Adult Core Sets of quality measures. It also reports star ratings for Medicare Advantage plans that are based on different sets of measures from those used to assess providers that participate in Medicare Parts A and B (also known as original Medicare).

[2]See C. H. MacLean, et al., "Time Out – Charting a Path for Improving Performance Measurement," *The New England Journal of Medicine,* vol. 378, no. 19 (2018).

In recent years, CMS has taken steps intended to improve its process for developing and selecting quality measures. Since 2011, CMS has incorporated a formal process to obtain stakeholder input into its annual review of the quality measures it uses for Medicare. In addition, in 2017, CMS began its Meaningful Measures Initiative, which set strategic objectives to guide its development and use of quality measures. These objectives include focusing on developing and using the quality measures that are most likely to produce substantial improvement in health care and reducing provider burden associated with reporting information on the measures.

The Bipartisan Budget Act of 2018 required CMS to report annually on a comprehensive plan for its quality measurement activities, as well as on funding for these activities.[3] The Act also included a provision for us to examine CMS's funding and planning for its quality measurement activities.[4] In this report we

1. assess the information that CMS maintains on its funding of health care quality measurement activities, and
2. describe and assess how CMS makes decisions to develop and to use quality measures in Medicare to promote its quality measurement strategic objectives.

To assess the information CMS maintains on its funding of health care quality measurement activities, we reviewed CMS summaries of Medicare appropriations and spending for fiscal years 2009 through 2018 and planning documents for future spending provided by CMS, as well as information for those years drawn from CMS's central funding database, the Healthcare Integrated General Ledger Accounting System (HIGLAS). We also examined CMS documents that describe the procedures CMS follows in entering and checking these data, explain the content of the information recorded in HIGLAS, and indicate how CMS officials use the data for planning and conducting quality measurement activities. In addition, we interviewed CMS officials about the strengths and limitations

[3]Pub. L. No. 115-123, § 50206(b), 132 Stat. 64, 184 (2018) (adding Social Security Act § 1890(e)) (codified at 42 U.S.C. § 1395aaa(e)).

[4]Pub. L. No. 115-123, § 50206(d), 132 Stat. 185. This provision refers to quality measurement activities undertaken by the Secretary of Health and Human Services, which includes CMS. This report focuses on CMS because it conducts a large proportion of these quality measurement activities.

of these data as well as how they are used by CMS officials in conducting quality measurement activities. We assessed the available information on funding against federal internal control standards to use complete and accurate information to achieve agency objectives.[5] We also assessed the reliability of the HIGLAS data by reviewing relevant documentation provided by CMS, checking the data extracts for missing information and inconsistencies, and interviewing CMS officials. We determined that the data were sufficiently reliable for the purposes of our report.

To describe and assess how CMS makes decisions to develop and to use quality measures in Medicare, we reviewed CMS guidance and other documentation related to developing new measures and selecting the measures for CMS to use. Because CMS contracts with outside organizations to perform some of these activities, we also reviewed CMS contract documents, such as task orders and statements of work for its contractors. We interviewed CMS officials and officials from CMS contractors regarding their roles in the process. We compared CMS's procedures for making decisions on measures to develop and to use against federal internal control standards, including those related to control activities. We also analyzed data for 2014 through 2018 from CMS's Issue Tracking System, which CMS uses to keep track of quality measures under consideration for selection in one or more of its quality programs. To assess the reliability of the Issue Tracking System data, we reviewed data documentation, checked the data for missing information and obvious errors, and asked CMS officials about any data issues we identified. We determined the data to be sufficiently reliable for the purposes of our report.

We conducted this performance audit from July 2018 to September 2019 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[5]GAO, *Standards for Internal Control in the Federal Government*, GAO-14-704G (Washington, D.C.: September 2014). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

Background

CMS and private payers use a variety of quality measures to assess different aspects of health care quality. Process measures assess the extent to which providers effectively implement clinical practices (or treatments) that have been shown to result in high-quality or efficient care, such as the percentage of patients with a myocardial infarction who receive an aspirin prescription on discharge. Others are outcome measures, which track the results of health care, such as mortality, infections, and patients' experiences of that care.

To calculate providers' performance on quality measures, CMS and private payers ask providers to report a variety of clinical data. Historically, providers have collected data for quality measures through a detailed, manual review of paper medical records. Other quality measures use data from billing records and patient surveys. More recently, a limited number of electronic quality measures have been developed to allow providers to report data electronically using electronic health records.

Medicare Quality Programs

Since the early 2000s, CMS has created a number of distinct quality reporting programs within Medicare. These programs generally focus on different sites of care, such as hospitals, physician offices, and nursing homes. Beginning in the early 2000s, CMS launched a number of related programs that offer financial incentives to providers receiving Medicare payments to report their performance on specified quality measures. Some of these programs, such as the Hospital Inpatient Quality Reporting program, are pay-for-reporting programs, in which providers may receive higher payments if they report their performance on the quality measures used in the programs. Others, such as the Hospital Value-based Purchasing program, are pay-for-performance programs, in which the level of providers' performance on the quality measures affects the amount of the payment they receive. CMS also incorporates pay-for-performance in various alternative payment models, such as accountable care organizations—where CMS pays groups of providers based in part on the collective performance of those providers, rather than the fee-for-service traditionally paid in Medicare.

Developing and Adopting New Quality Measures

At any given point in time, CMS has a set of quality measures it is currently using in its various Medicare quality programs as well as efforts underway to identify different quality measures to better meet program needs. These quality measures may either already have been developed or potentially could be developed. A variety of different entities may develop new health care quality measures, such as the Joint

Commission, the National Committee for Quality Assurance, and various medical specialty societies.[6] In some cases CMS itself contracts with entities for the development of measures for use in its Medicare quality programs.

CMS has developed a set of guidelines for developing new quality measures that are described in its *Blueprint for the CMS Measures Management System*. The *Blueprint* lays out the steps measure developers should follow to first identify health care topics or conditions where new measures are needed, and then develop and test specific new measures to fill those identified gaps.[7] According to CMS estimates, it can take 2 years or more to complete all of these steps. As part of this process, CMS encourages entities that develop measures to submit them to the National Quality Forum (NQF), a nonprofit organization that evaluates and endorses measures—that is, determines which measures should be recognized as the best available for a given aspect of care. NQF has endorsed over 700 quality measures.

In addition, NQF plays a major role in CMS's process for determining which measures to use in its Medicare quality programs. Since 2009, NQF has been the sole organization to function under contract to CMS as the consensus-based entity as described by the provisions of sections1890 and 1890A of the Social Security Act (SSA).[8] The consensus-based entity manages the Measure Applications Partnership, which is a formal process for obtaining stakeholder input on proposed new measures for Medicare quality programs, along with other measure endorsement and maintenance activities. CMS also relies on other contractors to conduct analyses or disseminate information related to the

[6]The Joint Commission is a nonprofit organization that accredits and certifies nearly 21,000 health care organizations and programs in the United States, including hospitals. The National Committee for Quality Assurance is a nonprofit organization that accredits health plans and develops quality standards and performance measures for them.

[7]CMS, *Blueprint for the CMS Measures Management System* version 14.1, (Baltimore, Md.: 2019), accessed on April 19, 2019, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/Blueprint.pdf.

[8]Codified at 42 U.S.C. §§ 1395aaa and 1395aaa-1. These provisions include duties for a consensus-based entity to perform under contract with CMS, to provide support in developing, selecting, and maintaining health care performance measures for use in the Medicare program.

development and use of quality measures in its Medicare quality programs.

CMS Quality Measurement Strategic Objectives

CMS has established strategic objectives for the measures CMS develops or uses in its Medicare quality programs. CMS's quality measurement strategic objectives have evolved over the last decade as CMS has expanded Medicare quality programs and has collaborated with other organizations that use or develop quality measures, such as private insurance companies. In 2017 CMS announced a revised version of these objectives in its Meaningful Measures Initiative. These eight quality measurement strategic objectives are for CMS to adopt measures that

- are patient-centered and meaningful to patients, clinicians, and providers,
- address high-impact measure areas that safeguard public health,
- are outcome-based where possible,
- fulfill each program's statutory requirements,
- minimize burden for providers,
- create significant opportunity for improvement,
- address measure needs for population-based payment through alternative payment models, and
- align across programs and/or with other payers.

In addition, to provide greater specificity for its objective to address high-impact measure areas that safeguard public health, CMS has designated 19 specific meaningful measure areas. See appendix I for the list of these meaningful measure areas and the six broad quality priority areas that they address.

CMS Funding for Quality Measurement Activities

CMS's quality measurement activities are funded through the federal budget and appropriations process. Each appropriation includes language that describes an authorized purpose or purposes for which the funds may be used. Such language may specifically reference certain activities

such as quality measurement or could refer to a broad purpose under which activities such as quality measurement may have been authorized.[9]

Available funds are first obligated—that is, committed to a specific purpose—and then expended when an actual payment is made.[10] Expenditures can occur one or more fiscal years after the obligation was incurred. Funds that are available in a given fiscal year but not obligated during that year are known as unobligated balances. Unobligated balances can be carried over to the next fiscal year, unless their availability expires under the terms of their appropriation. Most CMS funding that is explicitly appropriated for quality measurement activities is available indefinitely, until obligated and expended.

CMS Lacks Complete Information on Its Quality Measurement Funding and on How It Uses Funding to Achieve Its Strategic Objectives

CMS maintains information in its core budget database on the amount of funding for its quality measurement activities, such as when funding for that purpose is specifically authorized by appropriations. However, CMS's database does not capture all of the funding the agency has obligated that pays for quality measurement activities or the extent to which this funding has supported CMS's quality measurement strategic objectives. Our review of CMS's quality measurement funding information also shows that CMS maintains a substantial amount of unobligated balances—funding that CMS has not yet used and remains available—for quality measurement activities.

[9]The Department of the Treasury, in collaboration with the Office of Management and Budget (OMB) and the affected agencies, establishes and maintains a system of accounts for appropriated funds. Financial transactions of the federal government are classified by these accounts for reporting to Treasury and OMB.

[10]An obligation is a definite commitment that creates a legal liability of the government for the payment of goods and services ordered or received, or a legal duty on the part of the United States that could mature into a legal liability by virtue of actions on the part of the other party beyond the control of the United States. Payment may be made immediately or in the future.

CMS Maintains Information on Funding for Some Quality Measurement Activities in CMS's Core Budget Database

CMS officials report that the agency records funding information for its quality measurement activities in its core budget database, HIGLAS.[11] CMS has information on quality measurement funding primarily when the appropriation is specifically authorized for that purpose. CMS officials identified eight appropriations that specifically designate funding for Medicare quality measurement activities over the 10-year period we reviewed (fiscal years 2009-2018). These include five appropriations that have funded the consensus-based entity established under sections 1890 and 1890A of the SSA, to carry out various activities under contract with CMS in accordance with those provisions.[12] CMS officials identified another three appropriations that focused on more discrete aspects of quality measurement, such as developing new quality measures for clinicians. From fiscal years 2009 through 2018, a total of $429.9 million was authorized for these eight appropriations (see table 1).

Table 1: Medicare Quality Measurement Funding Designated by Appropriations, Fiscal Years 2009-2018

Appropriation	Fiscal years	Funded activities	Appropriated funds
Appropriations used to fund the consensus-based entity (CBE)			
Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), Sec. 183[a]	2009-2013	Duties for the CBE, including the endorsement and maintenance of measures	$49,490,000
Patient Protection and Affordable Care Act (PPACA), Sec. 3014[b]	2010-2014	New CBE duties such as providing multi-stakeholder group input into measure selection; as well as the impact assessment and dissemination of measures	$97,540,000
Protecting Access to Medicare Act of 2014 (PAMA), Sec. 109[c]	2014-2015	Extension of 1890/1890A funding	$20,000,000
Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Sec. 207[d]	2015-2017	Extension of 1890/1890A funding	$72,930,000
Bipartisan Budget Act of 2018 (BBA), Sec. 50206[e]	2018	Extension of 1890/1890A funding	$7,500,000
Total appropriated funds:			**$247,460,000**

[11]HIGLAS is the repository for CMS's financial and budgetary information, including information related to quality measurement. Among the information that CMS records in HIGLAS are funding sources such as appropriations, dates and amounts of obligations and expenditures, the recipients of those funds (e.g., contractors or other agencies), and various codes to classify obligations and expenditures.

[12]These appropriations have also funded certain additional quality measurement activities under Sections 1890 and 1890A.

Appropriation	Fiscal years	Funded activities	Appropriated funds
Appropriations used to fund discrete quality measurement activities			
Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Sec. 102[f]	2015-2018	Measure gap analysis and development of clinician measures	$58,050,000
Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT), Sec. 2(a)[g]	2015-2018	Standardization of data and quality measures for post-acute care	$114,361,000
Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT), Sec. 2(d)[h]	2015	Assessment of socioeconomic risk factors on quality measures	$10,000,000
Total appropriated funds:			**$182,411,000**

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) information. | GAO-19-628

Notes: Amounts and descriptions of funded activities pertaining to each appropriation are provided as reported by CMS. The amount reported may be slightly less than the total appropriation amount, due to applicable sequestration(s). The information presented in this table is limited to the eight appropriations that CMS officials identified as being specific to Medicare quality measurement. Five of these appropriations fund various activities to carry out sections 1890 and 1890A of the Social Security Act, including those of the consensus-based entity to provide support to CMS in developing, selecting, and maintaining health care performance measures. The other three appropriations were used to fund more discrete quality measurement activities, such as developing new measures for clinicians.

[a]MIPPA, Pub. L. No. 110-275, § 183, 122 Stat. 2494, 2583 (as amended by Pub. L. No. 112-240, § 609(a)(1), 126 Stat. 2313, 2349 (2013)).

[b]PPACA, Pub. L. No. 111-148, § 3014(c), 124 Stat. 119, 387 (2010).

[c]PAMA, Pub. L. No. 113-93, § 109, 128 Stat. 1040, 1043.

[d]MACRA, Pub. L. No. 114-10, § 207, 129 Stat. 87, 145.

[e]BBA, Pub. L. No. 115-123, § 50206(a), 132 Stat. 64, 183.

[f]MACRA, Pub. L. No. 114-10, § 102, 129 Stat. 128.

[g]IMPACT, Pub. L. No. 113-185, § 2(a), 128 Stat. 1952.

[h]IMPACT, Pub. L. No. 113-185, § 2(d), 128 Stat. 1952, 1956.

In addition, CMS officials identified some funding used—that is, obligated—for quality measurement activities, from appropriations authorized for more general purposes. They obtained information on such usage from HIGLAS based on the presence of labels, such as “quality measure development,” in the project code and project description data fields in HIGLAS. According to CMS officials, these data fields provide the most detailed categorization of activities in HIGLAS.[13]

[13]Information about the characteristics of funded activities, including those related to quality measurement, can be recorded in HIGLAS through entries to a number of different data fields, each of which has its own set of codes or categories.

Table 2 shows the specific project codes and project descriptions used in HIGLAS to characterize use of quality measurement funding in fiscal year 2018. These obligations are from both appropriations that specifically authorize quality measurement activities and also from general appropriations whose authorized purposes do not specifically mention quality measurement activities. As shown in table 2, the project codes and their descriptions used in HIGLAS provide high-level information that largely matches the information known from the appropriation authorizing such use.

Table 2: Medicare Quality Measurement Funding by Project Description, Fiscal Year 2018

Project codes	Project description (in HIGLAS)	Associated appropriation	Total obligations
007510	PAC Assessment Standardization	IMPACT (Sec. 2(a))	**$19,177,866**
013032	Duties for Consensus Based Entity (Sec 207)	MACRA (Sec. 207)	**$13,162,157**
013086, 005077, 005310, 005313	Quality Measures Development	MACRA (Sec. 102) and general appropriations	**$8,232,644**
013030	Dissemination of Quality Measures (Sec 207)	MACRA (Sec. 207)	**$4,752,047**
013019, 013086	Development of Quality Measures - Strategy MACRA	MACRA (Sec. 102)	**$3,778,446**
013031	Program Assessment and Review (Sec 207)	MACRA (Sec. 207)	**$3,282,200**
013086	Dev of Quality Measures - Development MACRA 102	MACRA (Sec. 102)	**$1,777,166**
009001, 013033	Admin Ext of Funding for Quality Measurement	MACRA (Sec. 207)	**$986,170**
007513	Hospital Outcome Measures	IMPACT (Sec. 2(d))	**$733,762**
Total obligations:			**$55,882,458**

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) information. | GAO-19-628

Notes: The project descriptions in this table are presented as they are recorded in CMS's financial database the Healthcare Integrated General Ledger Accounting System (HIGLAS). PAC refers to post-acute care. MACRA refers to the Medicare Access and Children's Health Insurance Program Reauthorization Act of 2015, and IMPACT refers to the Improving Medicare Post-Acute Care Transformation Act of 2014. General appropriations are appropriations whose authorized purposes do not specifically mention quality measurement activities.

CMS Lacks Information on the Total Amount of Quality Measurement Funding and the Extent to Which This Funding Supports Its Strategic Objectives

Our review of the funding information in HIGLAS found that the data do not capture the total amount of funding CMS has obligated that pays for quality measurement activities. As we have noted, CMS officials identified funding obligated for quality measurement activities in HIGLAS either because 1) the funding came from appropriations specifically designated for quality measurement purposes, or 2) the funding came from appropriations for more general purposes but had specific HIGLAS project codes to identify its use for quality measurement activities. However, CMS officials told us that they thought there were additional

quality measurement activities funded from appropriations for general purposes that could not be identified by project codes in HIGLAS. As a result, they could not determine from HIGLAS what amount of these funds paid for quality measurement activities as opposed to other activities. CMS officials stated that while they do not have information on the amount of this unidentified quality measurement funding, they estimated that it was less than the amount of quality measurement funding identified in HIGLAS.

Furthermore, CMS's funding information in HIGLAS also is not sufficiently detailed to show the extent to which the funding was used for activities that support CMS's eight quality measurement strategic objectives. While some HIGLAS project descriptions—like "Hospital Outcome Measures"—correspond with one of these objectives, as shown in table 2 most do not. In addition, the documents that CMS uses to plan and monitor spending for quality measurement activities generally do not include information showing how much funding CMS has obligated for activities related to CMS's quality measurement strategic objectives.

CMS officials stated that they considered it unduly burdensome to attempt to use HIGLAS to track quality measurement funding according to their strategic objectives. First, they said that quality measurement activities overall constitute a small portion of the funding recorded in HIGLAS. In addition, officials noted that CMS's strategic objectives change over time. Finally, CMS officials stated their belief that all of CMS's quality measure activities help to address the agency's objectives. As a result, CMS cannot determine how its specific funding for quality measurement activities addresses each of its quality measurement strategic objectives and how possible changes in its funding allocations among those activities could help to promote its objectives more effectively.

Federal standards for internal control call for agencies to use complete and accurate information and to identify types or categories of information that enable the agency to achieve its objectives.[14] Without more complete information on the total amount of funding obligated to quality measurement activities, CMS officials cannot accurately assess the magnitude of resources they have provided for quality measurement. In addition, even if CMS quality measure activities generally address one or another of its strategic objectives, having information on the extent of

[14]GAO-14-704G.

funding for each quality measurement strategic objective could help CMS officials assess the amount of funding each of the agency's priorities is receiving. Doing so would enable CMS officials to make adjustments in accordance with their objectives.

While collecting more complete and detailed information on funding for quality measurement activities in HIGLAS—or using some other method that CMS determines is feasible—would require additional effort, CMS could realize corresponding benefits. CMS officials told us that at present, when they need to obtain a higher level of detail about funding for quality measurement activities, they do not use HIGLAS and instead typically conduct a manual review of any available underlying documentation, such as documents related to individual contracts. For example, in order to respond to a statutory requirement to report on its spending to develop certain quality measures for physicians, CMS officials told us they needed to review a set of individual contracts associated with those measures. [15] CMS officials noted that this process is often laborious and that the content of available documents may not enable them to obtain all the desired funding information for the specific quality measurement activities in question. Collecting more information routinely about funding for quality measurement activities has the potential to make such manual reviews of documents less necessary and burdensome.

The limitations in CMS's information on funding for quality measurement activities have implications for CMS's ability to communicate information outside the agency. As required by the Congress, CMS issued its first annual report on quality measurement funding in March 2019. In this report, CMS itemized information on such funding into four broad categories: "Duties of the consensus-based entity," "Dissemination of quality measures," "Program assessment and review," and "Program oversight and design."[16] CMS's report listed a number of more specific activities within these categories without providing the amount of funding it allocated for each of the described activities. More detailed funding information could help the Congress to better understand how CMS is

[15]See Pub. L. No. 114-10, §102, 129 Stat. 128 (codified in pertinent part at 42 U.S.C. § 1395w-4(s)(3)).

[16]See CMS, *Report to Congress: Identification of Quality Measurement Priorities – Strategic Plan, Initiatives, and Activities*, (March 1, 2019). This report focused on quality measurement activities authorized under sections 1890 and 1890A of the Social Security Act. See Pub. L. No. 115-123, 50206(b), 132 Stat. 184 (codified at 42 U.S.C. § 1395aaa(e)).

using appropriations for quality measurement, and could assist with effective oversight of these activities. Internal control standards call for agencies to consider the needs and expectations of external users, such as Congress, when collecting and communicating information.[17]

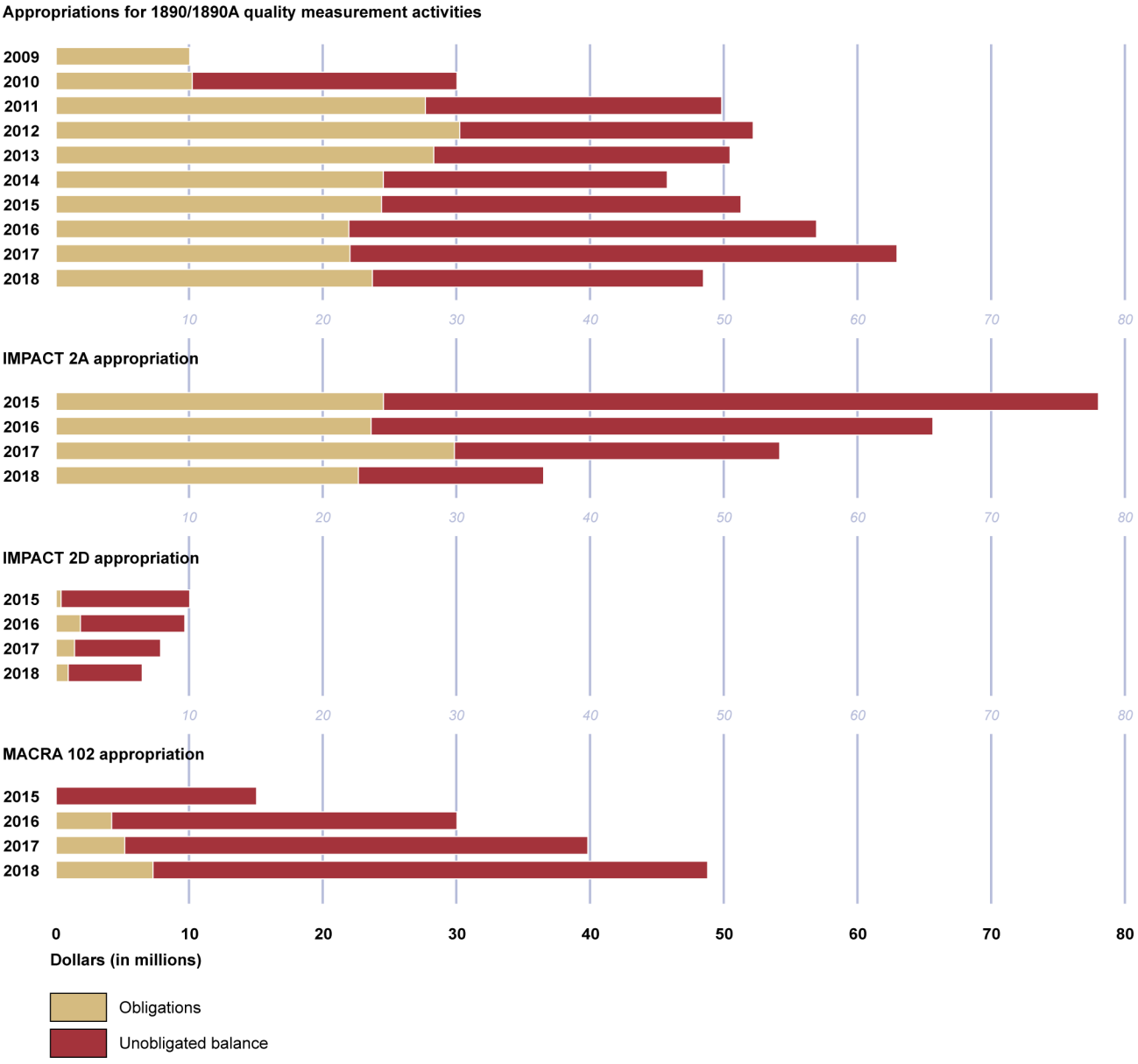
CMS's Funding Information Shows Substantial Unobligated Balances in Its Quality Measurement Funding

Our review of the funding information CMS provided determined that the agency has maintained substantial unobligated balances related to its quality measurement activities from fiscal years 2010 through 2018. Unobligated balances represent funding that CMS did not use in the year it was appropriated, and that remains available for use in future years. All but one of the eight appropriations that specifically authorize spending for quality measurement activities are available indefinitely.[18] Five of these appropriations funded quality measurement activities under sections 1890 and 1890A of the SSA. In the case of these five appropriations, with the exception of fiscal year 2009, CMS had unobligated balances each year that were larger than or similar to the total amount the agency had obligated from those appropriations that year (see figure 1). Figure 1 also shows three other appropriations more narrowly focused on developing new measures for clinicians and post-acute care providers under Medicare (appropriated by MACRA section 102 and the IMPACT Act sections 2a and 2d). Since 2015, unobligated balances for these appropriations also generally exceeded annual obligations. See appendix II for more detailed information.

[17]GAO-14-704G.

[18]While some appropriations are made available for obligation for a fixed period of time, these quality measure appropriations were generally made available indefinitely, or until obligated and expended by CMS. One such appropriation (MACRA 102) expires at the end of fiscal year 2022.

Figure 1: CMS Obligations and Unobligated Balances Related to Medicare Quality Measurement Funding



Source: GAO analysis of Centers for Medicare & Medicaid Services information. | GAO-19-628

Notes: Available funds are first obligated—that is, committed to a specific purpose—and then expended when an actual payment is made. Funds that are available in a given fiscal year but not obligated during that year are known as unobligated balances. The information presented in the figure is limited to the eight appropriations that Centers for Medicare & Medicaid Services (CMS) officials identified as being specific to Medicare quality measurement. Appropriations for 1890/1890A quality measurement activities refer to five appropriations that have funded the range of activities assigned to the consensus-based entity (currently the National Quality Forum) as described in sections 1890 and

1890A of the Social Security Act. The three additional appropriations focus on specific quality measurement activities. IMPACT 2A and 2D refers to sections 2(a) and 2(d) of the Improving Medicare Post-Acute Care Transformation Act of 2014. MACRA 102 refers to section 102 of the Medicare Access and CHIP Reauthorization Act of 2015.

CMS officials stated that unobligated balances reflect broader spending decisions—for quality measurement as well as other activities—the agency makes to meet its strategic objectives and any related legislative requirements. CMS officials said that in general, they chose to use the available quality measurement funds conservatively to ensure there were no gaps in funding to carry out their statutory responsibilities, in view of uncertainty about the availability and timing of funding in future years. They also said that they took into account the total amount of appropriated funds—including unobligated balances—in developing the scope and duration of quality measurement activities. The officials noted that it often takes more than one year to implement these activities, in order to gather information, select contractors, or solicit and award grant applications. Regarding the level of unobligated balances to be carried over from one fiscal year to the next, CMS officials told us that they work to obligate all appropriations in accordance with statutory requirements, and do not have thresholds for maximum unobligated balances.

Maintaining large unobligated balances means that CMS is retaining funds for future quality measurement activities rather than using them for current quality measurement activities. One example of how such choices can affect the scope and timing of CMS's quality measurement activities was the outcome of a CMS competition for cooperative agreements, announced in March 2018, to develop new clinician quality measures to address identified measurement gaps. Drawing on funds from the appropriation dedicated to developing, improving, updating, or expanding new clinician quality measures (MACRA 102) that were available for use until 2022, CMS set a maximum amount for the awards of $30 million over three years. CMS officials determined that the $30 million ceiling meant that there was adequate funding for seven awardees, while CMS indicated that additional applicants scored well on CMS's selection criteria and addressed areas of need. For fiscal year 2018, MACRA 102 had an unobligated balance of $42 million, with an additional $15 million appropriation in place for fiscal year 2019. As of May 23, 2019, CMS officials told us that they had not announced new competitions to develop clinician quality measures.

CMS Lacks Assurance That the Quality Measures It Decides to Use or Develop Effectively Promote Strategic Objectives

CMS takes different approaches in deciding which Medicare quality measures to use in its programs, which to remove, and which new measures to develop. However, CMS lacks procedures to ensure that these decisions are consistent with its quality measurement strategic objectives, and CMS has not yet developed or implemented performance indicators to evaluate its overall progress toward achieving these objectives.

CMS Takes Different Approaches in Deciding Which Quality Measures to Use and Develop

For selecting measures to be used in its Medicare quality programs, CMS has an annual process, as defined by the Patient Protection and Affordable Care Act.[19] CMS makes a number of decisions that influence measure selection throughout the process. Each year CMS asks measure developers to submit candidate quality measures to CMS for potential selection. CMS makes preliminary decisions on which of these measures to use in its quality programs, and it publishes this selection of measures in its annual Measures under Consideration list (MUC). The MUC list then undergoes public review by multiple stakeholders. After this review, CMS chooses which measures to include in the formal rulemaking processes that ultimately determine which measures are added to its quality programs. See table 3.

[19]Pub. L. No. 111-148, §§3013(b), 3014(b), 10303(b), 10304, 124 Stat. 383, 385, 938 (codified at 42 U.S.C. § 1395aaa-1).

Table 3: CMS Timeline for Selecting Measures to Be Added to One or More of Its Medicare Quality Programs Starting in Calendar Year 2018

Step	Description	Timeline
CMS solicits quality measures from measure developers	• CMS solicits measure submissions from measure developers. To nominate a measure, developers are asked to provide detailed information about the measure, including a description of its methodology and evidence justifying use of the measure. • CMS identifies the specific health care quality priorities and high-impact areas that it deems are its greatest need for measures for each of its individual quality programs. CMS also conducts outreach and education activities, such as webinars, to encourage measure developers to submit candidate measures that meet its quality measurement objectives.	March 1 through June 15, 2018
CMS reviews and selects quality measures for the annual Measures under Consideration (MUC) list	• A CMS contractor, Battelle, reviews each candidate quality measure submission to verify and validate that all information submitted is complete, valid, and accurate. Battelle also checks whether candidate measures submitted are similar to or duplicative with other measures. • According to CMS officials, measures are reviewed within CMS by the officials responsible for the particular quality program in which the measure may be used. According to CMS officials, these individuals receive input from workgroups involving officials from multiple CMS programs, and brief higher level officials on their recommendations to select or reject measures. • Once CMS approves a draft MUC list, it is shared with other Department of Health and Human Services component agencies, such as the Centers for Disease Control and Prevention and the Agency for Healthcare Research and Quality, to obtain their feedback, according to CMS officials. • CMS publicly issues a finalized MUC list. It includes information about each measure selected, including the methodology for calculating the measure, evidence that justifies that use of the measure can improve health care quality, and which quality priority and high-impact area the measure is intended to address.	March 1 through December 1, 2018
MAP meetings and public reports	The Measure Applications Partnership (MAP) workgroups—groups consisting of multiple public and private-sector stakeholders, including patients, providers, and payers—convene in meetings facilitated by the National Quality Forum to provide recommendations to CMS on its MUC list.	December 1, 2018, through March 15, 2019
Federal rulemaking process	CMS considers the recommendations of the MAP in selecting a final set of measures to be included in notices of proposed rulemaking in the Federal Register, which allows for public comment and further consideration before final rules are issued.	April through November, 2019

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) information. | GAO-19-628

To make decisions on which measures to include in the MUC list, CMS officials review the submissions. According to CMS, officials from each Medicare quality program, referred to as quality program leads, separately review each measure submitted for use in that program. CMS officials told us that as necessary, they consult with technical experts and with other CMS or Department of Health and Human Services (HHS) officials. According to CMS officials, the program leads make

recommendations to higher level officials, such as division directors, on whether CMS should accept or reject each measure. CMS internal guidance outlines factors that, among other things, officials should consider. Some of these factors reflect the strategic objectives laid out in the Meaningful Measures Initiative, and the guidance also indicates that officials may consider additional factors in their decision-making. CMS officials told us that, when making measure selection decisions, program teams are given the flexibility to develop criteria that best suits their programs' needs, noting that some programs are intended to address a broad range of areas, such as the Inpatient Quality Reporting Program, while others have a more limited focus, such as the Hospital Readmissions Reduction Program. CMS officials told us that the director of CMS's Center for Clinical Standards and Quality, which is responsible for quality measurement, makes the final measure selection decisions and, in doing so, generally accepts the recommendations of the program teams.

Our analysis of CMS's quality measures indicates that the number of candidate quality measures submitted to CMS for the MUC list has decreased from 335 measures in 2014 to 67 in 2018. CMS officials told us the decline in the number of candidate measures submitted reflected CMS efforts to more clearly define a targeted set of quality measurement priorities for measure developers and to reduce provider reporting burden. Minimizing provider burden is one of CMS's strategic objectives, and, according to CMS officials, it represents a priority communicated by the CMS administrator. For more information about CMS's measure selection decisions for its annual MUC list in 2014 through 2018, see appendix III.

CMS officials also make decisions annually about which existing measures CMS will remove from its Medicare quality programs. According to CMS officials, the process for deciding which measures to remove is an ongoing, iterative process, and discussions on which measures to remove generally occur in parallel with discussions for selecting measures, with discussions on both measure selection and removal coming to a conclusion in the drafting of the annual proposed and final rules for each program. For measures that are being used in its quality programs, CMS relies on measure developers to monitor the performance of their measures based on principles defined in CMS's *Blueprint*.[20] According to the *Blueprint*, information from developers'

[20]CMS, *Blueprint,* 2019.

monitoring efforts, including recommendations from technical experts, should be conveyed to and evaluated by CMS officials. CMS officials told us that their decisions to remove measures often take into account the recommendations made by technical experts. In addition, CMS has promulgated through federal rulemaking eight factors for determining whether to remove existing measures from its Medicare quality programs, some of which reflect its quality measurement strategic objectives.[21] CMS officials also said that in deciding to remove measures from CMS quality programs in 2018 they, in part, considered an assessment of the costs of reporting measures relative to the benefit of continued use of the measures. CMS decisions to remove measures have been included in notices of proposed rulemaking in the Federal Register, which allows for public comment and further consideration before issuance of final rules to that effect.[22]

In addition to making decisions on the selection and removal of measures, CMS officials also make decisions regarding which new measures to develop. Our review of CMS contract documents, including task orders, indicates that CMS typically awards multiple year contracts to conduct ongoing assessments of quality measures and to develop measures for specific Medicare quality programs, such as inpatient psychiatric facilities or post-acute care providers. Those task orders often call on contractors to convene technical expert panels and conduct additional analyses to assess what measures are currently available for use and what gaps exist in available measures. CMS officials told us they review these reports and provide informal feedback to the contractors. CMS also establishes parameters that guide these efforts.[23] For example, in its 2016 Measure Development Plan for Medicare's new physician payment system, after soliciting public input, CMS designated six medical specialty areas in which to focus its measure development efforts, and subsequently added five more specialties on which to focus the work of

[21]See, e.g., 83 Fed. Reg. 41144, 41441 (Aug. 17, 2018) (preamble IV.I.2.b.). Factors for removing a measure include, for example, that improvements in performance on the measure can no longer be achieved and the costs associated with reporting the measure outweigh the benefits.

[22]See, e.g., 83 Fed. Reg. 20164, 20409 (May 7, 2018) (preamble IV.I.2.c.); 83 Fed. Reg. 32340, 32442 (Jul. 12, 2018) (preamble V.E.).

[23]In some cases these parameters are established by statute. Notably, the IMPACT Act specified minimum domains for new quality measures to be developed by CMS for post-acute care providers. Pub. L. No. 113-185, § 2(a), 128 Stat. 1952 (codified in pertinent part to 42 U.S.C. § 1395lll(c)(1)).

its contractors.[24] For more information about outside entities that perform quality measurement activities under contract with CMS and the efforts CMS has taken to coordinate these activities across its contractors, see appendix IV.

CMS Lacks Procedures for Systematically Assessing Whether the Measures It Decides to Develop and Use Address Its Strategic Objectives

CMS has taken some steps that provide opportunities for CMS officials to consider how quality measures may help address the agency's quality measurement strategic objectives. CMS officials said that in 2018 they began using the Measure Review Template, a spreadsheet used to consolidate information on quality measures submitted to CMS by measure developers. CMS officials told us that they use the spreadsheet to inform their discussions, such as by considering how measures are distributed across the 19 meaningful measure high-impact areas. CMS is also developing another tool, the Quality Measure Index, that is intended to provide a standard methodology to score measures on dimensions that include several of CMS's eight quality measurement strategic objectives.

In addition, CMS officials told us that on occasion they have made limited assessments across measures concerning specific strategic objectives. CMS officials told us that these limited assessments across measures are generally performed when a measure submitted for use in its Medicare quality programs is closely related to another measure, which affects the CMS objective to increase measure alignment. In addition, they said they have identified a few indicators that they use to continuously assess their decision-making process, such as the percentage of outcome measures.

CMS also documents some information about its quality measurement decisions. For example, the agency announces its final selection of quality measures to be added to and removed from its Medicare quality programs in the annual federal proposed and final rules for each of those programs. The rationale for selecting each measure is provided as a summary of the peer-reviewed evidence of the impact that use of the measure will have on clinical care. In addition, CMS maintains an internal tracking system, which assembles the information that measure developers provide about the measures they submit to CMS. This system includes some information related to CMS's quality measurement

[24]CMS, *CMS Quality Measure Development Plan 2018 Annual Report* (Baltimore, Md.: 2018).

strategic objectives, such as the meaningful measures high-impact area the measure is intended to address.

While these steps provide some information about the linkages between certain quality measures and some of CMS's quality measurement strategic objectives, CMS lacks procedures to ensure systematic assessment of each quality measure against each of its eight quality measurement strategic objectives. For example, while CMS has implemented the Measure Review Template to consolidate some information on measures, the template does not provide procedures for systematically assessing how each measure will help CMS achieve all eight of its quality measurement strategic objectives. The Quality Measure Index—currently under development—has the potential to be used in a systematic assessment of each measure, but according to CMS officials, as of March 2019 the agency had not yet determined how it planned to use this tool once its testing was complete.

Furthermore, CMS lacks procedures to ensure a systematic assessment of whether the collective set of measures it decides to develop or use will help CMS achieve each of the objectives, which could help determine the extent to which each of the objectives is being effectively addressed. The limited assessments across measures that CMS officials said they perform do not consider whether each of CMS's objectives is being addressed. For example, one of CMS's eight quality measurement strategic objectives directs CMS to address 19 high-impact measure areas. CMS officials told us that, for each quality program, they look at whether measures generally address the high-impact measure areas, but gaps in these areas remain to be filled. In 2018, there were no measures used in CMS quality programs that addressed the high-impact area "equity of care" and 13 of 17 Medicare quality programs had no measures that addressed the "community engagement" area. Measure developers did not submit measures to CMS that addressed these areas, and CMS did not identify specific initiatives to address them. CMS officials told us, however, that CMS supports discussions of key methodological considerations for collecting and analyzing measure data that could help enable future development of these measures.

Last, CMS lacks procedures for documenting the consistent application of those systematic assessments. Federal internal control standards indicate the importance of documenting decisions to support achieving agency objectives. Specifically, CMS does not document, either in its public reporting or internal tracking system, how each measure it decides to use is expected to promote each of its eight quality measurement

strategic objectives. For decisions on developing new measures, the agency records less information. For example, CMS does not maintain a consolidated list of decisions to initiate the development of new quality measures across the various Medicare quality programs. CMS officials also told us that they generally do not maintain documentation of discussions on how or why they selected one measure for development over another. If CMS develops procedures to consider the effect of each of its quality measurement decisions on each of its quality measurement strategic objectives, then documentation of these procedures would help to show that they are implemented consistently.

Federal standards for internal control state that management should design and implement internal control activities, such as tools and documentation of decisions, to support the agency in achieving its objectives. Without procedures that ensure that its quality measures fully address its strategic objectives, CMS increases the risk that the measures it decides to develop and use will not help the agency achieve its quality measurement strategic objectives as effectively as possible.

CMS Has Not Established Performance Indicators to Determine Its Overall Progress in Achieving Its Quality Measurement Strategic Objectives

CMS has not developed and implemented performance indicators that would be needed to determine if it is making progress in meeting its quality measurement strategic objectives. Establishing these indicators and using them to evaluate its progress towards meeting each of its quality measurement strategic objectives would enable CMS to determine whether its quality measurement efforts are sufficient or whether changes in these efforts are needed. According to federal internal control standards, after agencies establish objectives, they should establish a set of performance indicators and use them to assess their effectiveness in achieving their objectives and identify improvements in their work, as needed. However, CMS has not established performance indicators for its strategic objectives that would provide a basis for determining its progress towards achieving these objectives. Such performance indicators would relate to each of CMS's quality measurement strategic objectives and provide information on interim progress toward achieving these objectives. For example, CMS could establish one or more indicators of its progress toward addressing the 19 high-impact measure areas that safeguard public health, and an indicator of providers' reporting burden for quality measurement to see if it showed an overall reduction.

CMS officials told us that they assess the impact of the agency's quality measurement activities by reviewing changes over time in health care providers' reported performance on selected quality measures. However,

these measures are for providers' quality of care, and are not indicators designed to determine the agency's progress in achieving its eight strategic objectives for quality measurement. Specifically, CMS has completed the *National Impact Assessment of Quality Measures* report every 3 years since 2012. These reports focus on trends in the performance of health care providers on a number of specific quality measures. Such analyses do not evaluate CMS's performance in developing and choosing to use measures that promote its quality measurement strategic objectives.

CMS has convened the Meaningful Measurement and Improvement Affinity Group, a workgroup of CMS officials involved in quality measurement. This workgroup's stated mission is to champion the Meaningful Measures Initiative and facilitate its implementation across the agency. CMS officials told us that the workgroup has begun to discuss potential ways to evaluate the agency's progress in achieving the eight strategic objectives laid out in the Meaningful Measures Initiative. However, the information CMS officials provided on the workgroup's activities, as of March 2019, indicated that the group had not yet determined how to gauge such progress, such as by establishing performance indicators.

Conclusions

CMS plays a leading role in the process of developing new quality measures and selecting measures for use in its various quality programs in Medicare. These programs in turn affect the quality of care the program's beneficiaries receive. However, CMS lacks complete information on the amount of resources it has obligated for its quality measurement activities and how its allocation of those resources relates to its quality measurement strategic objectives. The agency also lacks procedures to ensure that the decisions it makes to develop and use measures for its quality programs are consistent with those objectives. Finally, CMS has not developed and implemented performance indicators to evaluate its progress towards achieving these objectives. Taken together, these issues limit CMS's ability to determine whether its allocation of resources and quality measurement decisions are optimal or whether changes are needed in its approach.

Recommendations for Executive Action

We are making the following three recommendations to CMS:

The Administrator of CMS should, to the extent feasible, maintain more complete information on both the total amount of funding allocated for

quality measurement activities and the extent to which this funding supports each of its quality measurement strategic objectives. (Recommendation 1)

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

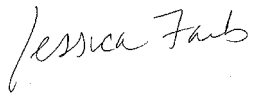
The Administrator of CMS should develop and use a set of performance indicators to evaluate the agency's progress towards achieving its quality measurement strategic objectives. (Recommendation 3)

Agency Comments

We provided a draft of this report to HHS for review and comment. In its written comments, which are reproduced in appendix V, HHS concurred with our recommendations. Regarding our first recommendation, HHS stated that it has undertaken a review of its fiscal accountability processes for its quality improvement activities and is implementing more granular tracking of funding specific to quality measurement to the extent it is feasible. Regarding our second recommendation, HHS stated that it will determine what steps may be needed to further document how its measure decisions impact the achievement of CMS's quality measurement strategic objectives. HHS's comments did not address the need to develop and implement procedures for systematically assessing measures against the strategic objectives, as we recommended. Regarding our third recommendation, HHS stated it would consider how best to evaluate its progress in meeting its quality measurement strategic objectives. In addition, HHS provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the appropriate congressional committees, the Secretary of Health and Human Services, the Administrator of the Centers for Medicare & Medicaid Services, and other interested parties. In addition, the report is available at no charge on the GAO website at http://www.gao.gov.

If you or your staff members have any questions about this report, please contact me at (202) 512-7114 or farbj@gao.gov. Contact points for our Office of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix VI.



Jessica Farb
Director, Health Care

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Appendix I: CMS Quality Priorities and Meaningful Measure Areas

As part of its Meaningful Measures Initiative, the Centers for Medicare & Medicaid Services (CMS) identified 19 meaningful measure areas to specify its priorities under its quality measurement strategic objective to address high-impact measure areas that safeguard public health. The 19 areas are linked to six broader health care quality priorities previously identified in the 2011 National Strategy for Quality Improvement in Health Care.[1] See table 4.

Table 4: CMS Quality Priorities and Meaningful Measure Areas

Quality priority	Meaningful measure area
Making care safer by reducing harm caused in the delivery of care	Healthcare-associated infections
	Preventable healthcare harm
Strengthen person and family engagement as partners in their care	Care is personalized and aligned with patient's goals
	End of life care according to preferences
	Patient's experience of care
	Patient reported functional outcomes
Promote effective communication and coordination of care	Medication management
	Admissions and readmissions to hospitals
	Transfer of health information and interoperability
Promote effective prevention and treatment of chronic disease	Preventive care
	Management of chronic conditions
	Prevention, treatment, and management of mental health
	Prevention and treatment of opioid and substance use disorders
	Risk adjusted mortality
Work with communities to promote best practices of healthy living	Equity of care
	Community engagement
Make care affordable	Appropriate use of healthcare
	Patient-focused episode of care
	Risk adjusted total cost of care

Source: Centers for Medicare & Medicaid Services. | GAO-19-628

[1]Agency for Healthcare Research and Quality, *2011 Report to Congress: National Strategy for Quality Improvement in Health Care*, (Rockville, Md.: 2011).

Appendix II: CMS Appropriations for Medicare Quality Measurement Activities, Fiscal Years 2009-2018

The Centers for Medicare & Medicaid Services (CMS) has identified five separate appropriations that for various fiscal years have funded the activities assigned to the consensus-based entity (currently the National Quality Forum), along with certain other quality measurement activities, as described in sections 1890 and 1890A of the Social Security Act. See table 5. Three additional appropriations focus on specific Medicare quality measurement activities, such as post-acute care measures. See table 6.

Table 5: Appropriations for 1890 and 1890A Activities

Appropriation	Fiscal year	New budget authority	Carryover[a]	Total budget resources	Obligations	Unobligated balance[b]
MIPPA	2009	$10,000,000	$0	**$10,000,000**	$10,000,000	$0
MIPPA	2010	$10,000,000	$0	**$10,000,000**	$10,000,000	$0
ACA	2010	$20,000,000	$0	**$20,000,000**	$194,475	$19,805,525
Total		**$30,000,000**	**$0**	**$30,000,000**	**$10,194,475**	**$19,805,525**
MIPPA	2011	$10,000,000	$0	**$10,000,000**	$10,000,000	$0
ACA	2011	$20,000,000	$19,805,525	**$39,805,525**	$17,637,764	$22,167,761
Total		**$30,000,000**	**$19,805,525**	**$49,805,525**	**$27,637,764**	**$22,167,761**
MIPPA	2012	$10,000,000	$0	**$10,000,000**	$8,156,022	$1,843,978
ACA	2012	$20,000,000	$22,167,761	**$42,167,761**	$22,043,859	$20,123,902
Total		**$30,000,000**	**$22,167,761**	**$52,167,761**	**$30,199,881**	**$21,967,880**
MIPPA	2013	$9,490,000	$1,843,978	**$11,333,978**	$9,214,582	$2,119,396
ACA	2013	$18,980,000	$20,123,902	**$39,103,902**	$19,043,474	$20,060,428
Total		**$28,470,000**	**$21,967,880**	**$50,437,880**	**$28,258,056**	**$22,179,824**
MIPPA	2014	$0	$2,119,396	**$2,119,396**	$0	$2,119,396
ACA	2014	$18,560,000	$20,060,428	**$38,620,428**	$22,377,292	$16,243,136
PAMA	2014	$5,000,000	$0	**$5,000,000**	$2,106,765	$2,893,235
Total		**$23,560,000**	**$22,179,824**	**$45,739,824**	**$24,484,057**	**$21,255,767**
MIPPA	2015	$0	$2,119,396	**$2,119,396**	$0	$2,119,396
ACA	2015	$0	$16,243,136	**$16,243,136**	$9,733,978	$6,509,159
PAMA	2015	$15,000,000	$2,893,235	**$17,893,235**	$14,612,157	$3,281,078
MACRA 207	2015	$15,000,000	$0	**$15,000,000**	$0	$15,000,000
Total		**$30,000,000**	**$21,255,767**	**$51,255,767**	**$24,346,135**	**$26,909,632**
MIPPA	2016	$0	$2,119,396	**$2,119,396**	$0	$2,119,396
ACA	2016	$0	$6,509,159	**$6,509,159**	$6,430,666	$78,493
PAMA	2016	$0	$3,281,078	**$3,281,078**	$3,281,078	$0
MACRA 207	2016	$30,000,000	$15,000,000	**$45,000,000**	$12,194,858	$32,805,142
Total		**$30,000,000**	**$26,909,632**	**$56,909,632**	**$21,906,602**	**$35,003,031**

Appropriation	Fiscal year	New budget authority	Carryover[a]	Total budget resources	Obligations	Unobligated balance[b]
MIPPA	2017	$0	$2,119,396	**$2,119,396**	$0	$2,119,396
ACA	2017	$0	$78,493	**$78,493**	$0	$78,493
MACRA 207	2017	$27,930,000	$32,805,142	**$60,735,142**	$21,993,058	$38,742,085
Total		**$27,930,000**	**$35,003,031**	**$62,933,031**	**$21,993,058**	**$40,939,973**
MIPPA	2018	$0	$2,119,396	**$2,119,396**	$0	$2,119,396
ACA	2018	$0	$78,493	**$78,493**	$0	$78,493
MACRA 207	2018	$0	$38,742,085	**$38,742,085**	$23,664,396	$15,077,688
BBA	2018	$7,500,000	$0	**$7,500,000**	$0	$7,500,000
Total		**$7,500,000**	**$40,939,973**	**$48,439,973**	**$23,664,396**	**$24,775,577**

Source: GAO analysis of Centers for Medicare & Medicaid Services information. | GAO-19-628

Notes: The appropriations included in the table are the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), Pub. L. No. 110-275, § 183, 122 Stat. 2494, 2583; the Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, § 3014, 124 Stat. 119, 385 (2010); the Protecting Access to Medicare Act of 2014 (PAMA), Pub. L. No. 113-93, § 109, 128 Stat. 1040, 1043; the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Pub. L. No. 114-10, § 207, 129 Stat. 87, 145; and the Bipartisan Budget Act of 2018 (BBA), Pub. L. No. 115-123, § 50206, 132 Stat. 64, 183. Numbers may not sum to totals due to rounding.

[a]Carryover refers to funds that were authorized but not obligated in prior fiscal years and remain available in the referenced fiscal year.

[b]Unobligated balance is the amount of total authorized funding (total budget resources) including both new budget authority and carryover from previous fiscal years that is not obligated in the referenced fiscal year.

Table 6: Other Appropriations

Appropriation	Fiscal year	New budget authority	Carryover[a]	Total budget resources	Obligations	Unobligated balance[b]
IMPACT 2a	2015	$78,000,000	$0	$78,000,000	$24,500,527	$53,499,473
IMPACT 2a	2016	$12,116,000	$53,499,473	$65,615,473	$23,572,367	$42,043,105
IMPACT 2a	2017	$12,103,000	$42,043,105	$54,146,105	$29,804,067	$24,342,038
IMPACT 2a	2018	$12,142,000	$24,342,038	$36,484,038	$22,618,695	$13,865,344
Total		**$114,361,000**			**$100,495,656**	
IMPACT 2d	2015	$10,000,000	$0	$10,000,000	$367,021	$9,632,979
IMPACT 2d	2016	$0	$9,632,979	$9,632,979	$1,815,480	$7,817,500
IMPACT 2d	2017	$0	$7,817,500	$7,817,500	$1,373,946	$6,443,554
IMPACT 2d	2018	$0	$6,443,554	$6,443,554	$906,101	$5,537,453
Total		**$10,000,000**			**$4,462,547**	
MACRA 102	2015	$15,000,000	$0	$15,000,000	$0	$15,000,000
MACRA 102	2016	$15,000,000	$15,000,000	$30,000,000	$4,155,174	$25,844,826
MACRA 102	2017	$13,950,000	$25,844,826	$39,794,826	$5,131,776	$34,663,050
MACRA 102	2018	$14,100,000	$34,663,050	$48,763,050	$7,255,924	$41,507,126
Total		**$58,050,000**			**$16,542,874**	

Source: GAO analysis of Centers for Medicare & Medicaid Services information. | GAO-19-628

Notes: The appropriations included in the table are the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT), Pub. L. No.113-185, §§ 2(a), 2(d), 128 Stat. 1952, 1956; and the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Pub. L. No. 114-10, § 102, 129 Stat. 87, 128. Numbers may not sum to totals due to rounding.

[a]Carryover refers to funds that were authorized but not obligated in prior fiscal years and remain available in the referenced fiscal year.

[b]Unobligated balance is the amount of total authorized funding (total budget resources) including both new budget authority and carryover from previous fiscal years that is not obligated in the referenced fiscal year.

Appendix III: Description of Quality Measures CMS Selected for Its Annual Measures under Consideration List, 2014-2018

Tables 7 to 12 below present descriptive information that the Centers for Medicare & Medicaid Services (CMS) collects through its issue tracking system on the measures submitted to CMS by measures developers for potential use in CMS's Medicare quality programs.

Table 7: Number of Quality Measures Submitted and Selected for Inclusion on CMS's Annual Measures under Consideration (MUC) List by Characteristics of the Measures, 2014-2018

	Number of quality measures submitted for one or more CMS quality programs					Number of quality measures selected for the annual MUC list for one or more CMS quality programs				
	2014	2015	2016	2017	2018	2014	2015	2016	2017	2018
Total	**335**	**235**	**191**	**184**	**67**	**202**	**118**	**111**	**32**	**39**
Type of Medicare quality program for which the measure was submitted[a]										
Clinician quality programs	234	198	102	141	44	131	62	29	22	25
Hospital quality programs	98	40	64	20	13	72	29	45	9	5
Post-acute or long-term care quality programs	16	33	42	24	10	9	25	38	1	9
Measure steward										
CMS	48	70	58	38	35	42	48	55	16	27
Other	287	165	133	146	32	160	70	56	16	12
Type of quality measure										
Process	208	108	121	122	29	114	42	55	9	16
Outcome	97	92	63	44	21	64	56	55	12	7
Cost or resource use	7	8	3	12	13	5	7	0	8	13
Composite	1	9	0	5	4	0	8	0	3	3
Efficiency	9	8	0	0	0	9	4	0	0	0
Patient engagement or experience	7	1	0	0	0	6	0	0	0	0
Structure	4	2	3	0	0	3	1	1	0	0
Other	2	7	1	1	0	1	0	0	0	0
Electronic clinical quality measure (eCQM)										
Measure is an eCQM	n/a	17	27	34	14	n/a	5	20	5	6
Measure is not an eCQM	n/a	218	164	150	53	n/a	113	91	27	33
Sources of data used for the measure[b]										
Administrative claims	66	18	18	67	17	44	14	11	4	8
Administrative clinical data	10	11	49	72	5	8	3	16	13	3
Claims	104	122	37	74	18	52	53	12	11	17
Electronic health records	126	23	89	98	21	65	6	38	15	10
Paper medical records	127	8	39	25	1	73	5	19	9	1
Record review	0	10	36	7	2	0	1	15	0	2
Registry	113	116	65	103	9	71	52	21	1	2

	Number of quality measures submitted for one or more CMS quality programs					Number of quality measures selected for the annual MUC list for one or more CMS quality programs				
	2014	2015	2016	2017	2018	2014	2015	2016	2017	2018
Survey	12	13	20	6	1	9	3	15	1	0
Other	61	35	49	34	10	38	24	37	7	10
Prior use of the measure in a CMS quality program[c]										
Never used	n/a	208	152	168	39	n/a	102	84	28	26
Currently used but the measure is undergoing substantial change	n/a	12	14	11	8	n/a	7	6	3	2
Currently used and is being submitted as-is for a new or different program	n/a	15	25	5	2	n/a	9	21	1	0

Legend: n/a = not applicable.

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-19-628

[a]Measure developers could submit a measure for potential use in more than one CMS program. As a result, the sum of measures by type of quality program may be greater than the total number of measures in that year.

[b]Measure developers could select more than one data source. As a result, the sum of measures by data source may be greater than the total number of measures in that year.

[c]In 2018, the following response option was added: “measure previously submitted to the Measures Application Partnership (MAP), refined and resubmitted per MAP recommendation.” Eighteen of the measures submitted that year and 11 of those selected were categories under this option.

Table 8: Number of Quality Measures Submitted and Selected for Inclusion on CMS's Annual Measures under Consideration (MUC) List by CMS Health Care Quality Priority, 2014-2018

	Number of quality measures submitted for one or more CMS quality programs					Number of quality measures selected for the annual MUC list for one or more CMS quality programs				
Health care quality priority	**2014**	**2015**	**2016**	**2017**	**2018**	**2014**	**2015**	**2016**	**2017**	**2018**
Promote effective communication and coordination of care	48	65	92	39	16	35	34	66	6	10
Promote effective prevention and treatment of chronic disease	129	112	62	100	14	73	55	30	12	7
Work with communities to promote best practices of healthy living	15	14	12	2	0	9	10	9	0	0
Make care affordable	24	12	4	17	16	20	10	1	9	14
Make care safer by reducing harm caused in the delivery of care	47	62	82	49	13	35	34	44	6	6
Strengthen person and family engagement as partners in their care	40	33	51	31	8	25	15	39	10	2
Measure not able to be categorized	0	3	1	6	0	0	0	0	0	0
Total	**335**	**235**	**191**	**184**	**67**	**202**	**118**	**111**	**32**	**39**

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-19-628

Notes: When submitting measures to CMS in 2014 through 2017, measure developers could select more than one health care quality priority that their measure was intended to address. As a result, the number of quality measures by health care quality priority do not add up to the total number of measures. In 2018, measure developers could select only one health care quality priority.

Table 9: Number of Quality Measures Submitted and Selected for Inclusion on CMS's Annual Measures under Consideration (MUC) List by CMS's High-Impact Measure Areas, 2018

Health care quality priority and high-impact measure area	Number of quality measures submitted for one or more CMS quality programs	Number of quality measures selected for the annual MUC list for one or more CMS quality programs
Promote effective communication and coordination of care		
Medication management	3	1
Admissions and readmissions to hospitals	5	1
Transfer of health information and interoperability	8	8
Promote effective prevention and treatment of chronic disease		
Preventive care	3	2
Management of chronic conditions	5	0
Prevention, treatment, and management of mental health	1	0
Prevention and treatment of opioid and substance use disorders	5	5
Risk adjusted mortality	0	0
Work with communities to promote best practices of healthy living		
Equity of care	0	0
Community engagement	0	0
Make care affordable		
Appropriate use of healthcare	3	1
Patient-focused episode of care	12	12
Risk adjusted total cost of care	1	1
Make care safer by reducing harm caused in the delivery of care		
Healthcare-associated infections	2	1
Preventable healthcare harm	11	5
Strengthen person and family engagement as partners in their care		
Care is personalized and aligned with patient's goals	0	0
End of life care according to preferences	4	0
Patient's experiences of care	2	0
Patient reported functional outcomes	2	2
Total	**67**	**39**

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-19-628

Table 10: Number of Quality Measures Submitted and Selected for Inclusion on CMS's Annual Measures under Consideration (MUC) List for One or More CMS Clinician Quality Program, by CMS's High-Impact Measure Areas, 2018

Health care quality priority and high-impact measure area	Number of quality measures submitted for one or more CMS clinician quality programs	Number of quality measures selected for the annual MUC list for one or more CMS clinician quality programs
Promote effective communication and coordination of care		
Medication management	2	0
Admissions and readmissions to hospitals	2	0
Transfer of health information and interoperability	0	0
Promote effective prevention and treatment of chronic disease		
Preventive care	2	2
Management of chronic conditions	5	0
Prevention, treatment, and management of mental health	1	0
Prevention and treatment of opioid and substance use disorders	5	5
Risk adjusted mortality	0	0
Work with communities to promote best practices of healthy living		
Equity of care	0	0
Community engagement	0	0
Make care affordable		
Appropriate use of healthcare	3	1
Patient-focused episode of care	12	12
Risk adjusted total cost of care	1	1
Make care safer by reducing harm caused in the delivery of care		
Healthcare-associated infections	1	0
Preventable healthcare harm	7	2
Strengthen person and family engagement as partners in their care		
Care is personalized and aligned with patient's goals	0	0
End of life care according to preferences	0	0
Patient's experiences of care	1	0
Patient reported functional outcomes	2	2
Total	**44**	**25**

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-19-628

Table 11: Number of Quality Measures Submitted and Selected for Inclusion on CMS's Annual Measures under Consideration (MUC) List for One or More CMS Hospital Quality Program, by CMS's High-Impact Measure Areas, 2018

Health care quality priority and high-impact measure area	Number of quality measures submitted for one or more CMS hospital quality programs	Number of quality measures selected for the annual MUC list for one or more CMS hospital quality programs
Promote effective communication and coordination of care		
Medication management	1	1
Admissions and readmissions to hospitals	1	0
Transfer of health information and interoperability	0	0
Promote effective prevention and treatment of chronic disease		
Preventive care	1	0
Management of chronic conditions	0	0
Prevention, treatment, and management of mental health	0	0
Prevention and treatment of opioid and substance use disorders	0	0
Risk adjusted mortality	0	0
Work with communities to promote best practices of healthy living		
Equity of care	0	0
Community engagement	0	0
Make care affordable		
Appropriate use of healthcare	0	0
Patient-focused episode of care	0	0
Risk adjusted total cost of care	0	0
Make care safer by reducing harm caused in the delivery of care		
Healthcare-associated infections	1	1
Preventable healthcare harm	4	3
Strengthen person and family engagement as partners in their care		
Care is personalized and aligned with patient's goals	0	0
End of life care according to preferences	4	0
Patient's experiences of care	1	0
Patient reported functional outcomes	0	0
Total	**13**	**5**

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-19-628

Table 12: Number of Quality Measures Submitted and Selected for Inclusion on CMS's Annual Measures under Consideration (MUC) List for One or More CMS Post-Acute or Long-Term Care Quality Program, by CMS's High-Impact Measure Areas, 2018

Health care quality priority and high-impact measure area	Number of quality measures submitted for one or more CMS post-acute or long-term care quality programs	Number of quality measures selected for the annual MUC list for one or more CMS post-acute or long-term care quality programs
Promote effective communication and coordination of care		
Medication management	0	0
Admissions and readmissions to hospitals	2	1
Transfer of health information and interoperability	8	8
Promote effective prevention and treatment of chronic disease		
Preventive care	0	0
Management of chronic conditions	0	0
Prevention, treatment, and management of mental health	0	0
Prevention and treatment of opioid and substance use disorders	0	0
Risk adjusted mortality	0	0
Work with communities to promote best practices of healthy living		
Equity of care	0	0
Community engagement	0	0
Make care affordable		
Appropriate use of healthcare	0	0
Patient-focused episode of care	0	0
Risk adjusted total cost of care	0	0
Make care safer by reducing harm caused in the delivery of care		
Healthcare-associated infections	0	0
Preventable healthcare harm	0	0
Strengthen person and family engagement as partners in their care		
Care is personalized and aligned with patient's goals	0	0
End of life care according to preferences	0	0
Patient's experiences of care	0	0
Patient reported functional outcomes	0	0
Total	**10**	**9**

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-19-628

Appendix IV: CMS-Contracted Organizations That Perform Quality Measurement Activities and Efforts to Encourage Coordination

The Centers for Medicare & Medicaid Services (CMS) has used the majority of its Medicare quality measurement funding for activities conducted by outside organizations under contract with CMS.[1] Between fiscal years 2009 through 2018, the amount of obligations to contracted organizations increased from $10 million to nearly $55 million. See table 13.

Table 13: Obligations to CMS-Contracted Organizations for Medicare Quality Measurement Activities, Fiscal Years 2009-2018

Dollars in Thousands

Fiscal year	Amount of obligations
2009	$10,000
2010	$10,194
2011	$26,010
2012	$22,892
2013	$30,941
2014	$28,338
2015	$57,424
2016	$56,154
2017	$62,714
2018	$54,679
Total	**$359,347**

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) information. | GAO-19-628

Note: Numbers may not sum to total due to rounding.

The total amount of funds obligated to each contractor in fiscal years 2009 through 2018 to perform Medicare quality measurement activities varied, ranging from $1,000 to $139,397,410. For fiscal years 2009 through 2018, 91 percent of funds obligated to contracted organizations for Medicare quality measurement activities went to 12 of 59 contracted organizations. See table 14.

[1]CMS also contracts with other federal government agencies, such as the Agency for Healthcare Research and Quality. Between 2009 through 2018, CMS obligated $19,882,129 funds for quality measurement activities conducted with the other federal government agencies.

Table 14: Total Cumulative Medicare Obligations to CMS Contractors to Perform Quality Measurement Activities, Fiscal Years 2009-2018

Dollars in Thousands

Contracted organization	Cumulative Medicare obligations	Percent of total cumulative obligations to contractors	Summary of key activities
National Quality Forum	$139,397	38.8	• Provides input to the Department of Health and Human Services (HHS) and CMS on quality measure priorities. • Analyzes gaps among existing measures. • Endorses quality measures. • Convenes stakeholders to recommend measures for use in federal programs.
Yale New Haven Health Services Corporation	$32,133	8.9	• Conducts analysis of gaps in quality measures and develops, implements, and re-evaluates claims-based outcome and efficiency measures for certain hospital and physician quality programs.
Health Services Advisory Group	$25,389	7.1	• Helps CMS prepare its triennial National Impact Assessment of Medicare Quality Measures and annual Measure Development Plan reports. • Conducts national surveys of health care providers on quality measurement. • Develops and tests the Quality Measure Index. • Develops, re-evaluates, and supports the implementation of outcome and process measures for inpatient psychiatric facilities.
RAND Corporation	$25,063	7.0	• Develops, implements, and maintains standardized post-acute care patient assessment data.
Battelle Memorial Institute	$22,347	6.2	• Maintains the MMS and the Blueprint.[a] • Provides technical assistance and educational outreach to measure developers on the MMS as well as CMS's quality measurement needs and objectives. • Conducts activities, such as monthly meetings, and maintains a repository of contractor deliverables to encourage coordination among CMS measure contractors. • Performs environmental scans of existing measures used in CMS quality programs. • Provides technical and administrative support to CMS by, for example, compiling information on the measure development activities of CMS's contractors, existing measures used in CMS quality programs, and expert input regarding measure planning activities, such as developing core sets of measures across programs. • Manages the CMS Measures Inventory Tool and conducts analysis of the Tool to identify, for example, gaps in measures and opportunities to harmonize measures.[b] • Assists CMS with its process for selecting measures to be included on its annual Measures under Consideration list.

Contracted organization	Cumulative Medicare obligations	Percent of total cumulative obligations to contractors	Summary of key activities
RTI International	$18,893	5.3	• Develops, maintains, implements, and re-evaluates post-acute care and hospice quality measures. • Supports the development of patient experience surveys for the long-term care hospital and inpatient rehabilitation facility settings.
The Mitre Corporation	$18,585	5.2	• Supports HHS and CMS by performing research and analysis on long-term health system problems in areas such as quality of care.
Abt Associates	$14,306	4.0	• Maintains, assesses, and implements changes to the Outcome and Assessment Information Set (OASIS) data item set. • Develops, maintains, and assesses home health measures, and develops nursing home quality measures.
Buccaneer Computer Systems & Service	$9,751	2.7	• Maintains and supports the Quality Improvement and Evaluation System, which is used by CMS to collect and validate data on provider- and beneficiary-specific outcomes of care and performance.
Econometrica	$9,505	2.7	• Adapts existing measures and develops, maintains, and implements new measures to evaluate the quality of care provided to certain elderly patients.
Mathematica Policy Research	$5,963	1.7	• Develops and maintains electronic clinical quality measures used in CMS quality programs. • Develops, maintains, reevaluates, and implements inpatient and outpatient process and structure measures for hospital quality programs.
Arbor Research Collaborative for Health	$5,013	1.4	• Supports CMS in aligning its quality reporting programs. • Develops a strategic framework and plan for the development of population health measures, conducts analysis of gaps in population health measures, and develops related measures.

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) information. | GAO-19-628

[a]The Measures Management System (MMS) is a standardized set of core business processes and decisions criteria for developing, implementing, and maintaining quality measures. Guidelines for these processes are documented in the *Blueprint for the CMS Measures Management System*, also referred to as the *Blueprint*.

[b]The CMS Measures Inventory Tool is a website designed to provide information to stakeholders regarding the quality measures developed or used by CMS.

CMS has undertaken efforts to coordinate the Medicare quality measurement activities performed by its contractors. For example, CMS works with a CMS contractor, Battelle, to facilitate monthly webinars with its Measure & Instrument Development and Support (MIDS) contractors. The purpose of the webinars is to provide contractors with a forum to discuss each other's quality measurement activities and to exchange

ideas. For more information about CMS's formal efforts to coordinate the quality measurement activities of its contractors, see table 15.

Table 15: Examples of Key Efforts to Coordinate the Quality Measurement Activities Performed by CMS Contractors

Effort	Description
CMS Measures Inventory Tool	An interactive tool that provides a compilation of measures currently used by CMS in various quality programs as well as measures that are in the process of being developed. CMS provides this information on measures under development to promote transparency, measure coordination and harmonization, and alignment of quality improvement efforts.
MIDS Deliverables Library	An online library where CMS's Measure & Instrument Development and Support (MIDS) contractors submit their respective deliverables. It is shared across contractors to promote the sharing of best practices and lessons learned as well as to avoid duplication of effort and reduce cost.
MIDS C3 Forum	The MIDS Communication, Coordination, and Collaboration (C3) Forum is a webinar that occurs roughly each month to allow CMS's MIDS contractors to learn about each other's work and exchange ideas.
Newsletters	To support the continued learning about quality measures and measure development topics to measure developers, including CMS's MIDS contractors, and to inform those developers of key events, such as trainings and rulemaking deadlines, that relate to CMS's measure development activities.
Spotlight Sessions	Meetings to allow measure developers interested in developing measures for CMS's Quality Payment Program, including MIDS measure developers, to showcase their measures and measure development activities and garner feedback from CMS.

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) information. | GAO-19-628

Appendix V: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

Jessica Farb
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

AUG 2 9 2019

Dear Ms. Farb:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*Health Care Quality: CMS Could More Effectively Ensure Its Quality Measurement Activities Promote Its Objectives*" (GAO-19-628).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Sarah Arbes
Acting Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED - HEALTH CARE QUALITY: CMS COULD MORE EFFECTIVELY ENSURE ITS QUALITY MEASUREMENT ACTIVITIES PROMOTE ITS OBJECTIVES (GAO-19-628)

The U.S. Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on the U.S. Government Accountability Office (GAO) draft report on its health care quality measurement activities.

In 2017, the Centers for Medicare & Medicaid (CMS) launched a new comprehensive "Meaningful Measures" initiative that identifies high priority areas for quality measurement to improve outcomes for patients, their families, and providers, while also reducing burden on clinicians and providers. This initiative aligns with CMS's Patients over Paperwork initiative, one of 16 strategic initiatives designed to transform the health care system to deliver better value and results for patients. Tracked via success measures, Patients over Paperwork has streamlined regulations to cut the red tape that takes clinicians away from their primary mission of caring for patients.

The Meaningful Measures initiative is moving payment toward value by focusing HHS and stakeholder efforts on the same quality areas and overarching principles for identifying measures. There are eight strategic objectives of the Meaningful Measures initiative, which focus on identifying measures that are patient-centered and outcome-based where possible, and on minimizing provider burden and achieving alignment across programs, among other key focus areas. In addition to these overarching principles, HHS has developed a Meaningful Measures Framework that ties to CMS's strategic goals as well as quality categories. Within this framework, HHS has specified six domains and 19 Meaningful Measures areas to guide measure development and use of quality measures.

Since the launch of the Meaningful Measures initiative, HHS has taken considerable steps to align efforts across CMS and solicit stakeholder feedback to identify and pursue high-priority areas for quality measurement and improvement, all with the goal of achieving better outcomes while reducing clinician burden. HHS has conducted a thorough review of existing measures, taking steps to remove those that do not meet the Meaningful Measures criteria, and notating how each measure aligns to Meaningful Measures areas on its CMS Measures Inventory. Through policies advancing Meaningful Measures, CMS has eliminated 79 overly burdensome, redundant, or low-value measures for a projected savings of $128 million and an anticipated reduction of 3.3 million burden hours through 2020.

As part of the focused efforts of the Meaningful Measures framework, including our outreach to stakeholders, HHS has seen a reduction in the number of candidate measures submitted for consideration in CMS's federal programs with increased focus on quality measurement priorities. These efforts support the Meaningful Measures priorities, while keeping the focus on improved outcomes for patients.

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED - HEALTH CARE QUALITY: CMS COULD MORE EFFECTIVELY ENSURE ITS QUALITY MEASUREMENT ACTIVITIES PROMOTE ITS OBJECTIVES (GAO-19-628)

HHS is committed to transparency throughout the measure development and selection process. HHS incorporates stakeholder input into its annual review of the quality measures, and also utilizes experts and stakeholder organizations to develop criteria to make measures meaningful to patients and actionable for providers. HHS seeks public feedback on proposed new measures through rulemaking. Public comment ensures that measures are selected using a transparent process with balanced input from relevant stakeholders and other interested parties. HHS uses this process for measure development and selection in multiple congressionally mandated quality reporting and pay-for-performance programs that affect different providers and clinicians. It is important to HHS to develop and implement meaningful quality measures that will incentivize performance improvement in high-priority areas and will be well understood by consumers.

HHS conducts all of its quality measurement activities in a fiscally responsible manner through detailed spending plans and obligating funds in alignment with statutory requirements and agency priorities to avoid wasteful spending. When funds are provided through a general appropriation, additional granularity is often used to distinguish specific areas for how funds are being allocated. In some cases, the specificity of how the funds are used is not detailed in HHS's accounting system. HHS has undertaken a holistic review of its quality improvement operations to determine areas in which fiscal accountability processes could be strengthened, to ensure full accountability.

GAO's recommendations and HHS's responses are below.

GAO Recommendation

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

HHS Response

HHS concurs with this recommendation. As stated above, HHS diligently tracks federal appropriations to ensure accountability and transparency of funds, and creates detailed spending plans for approval to obligate funds. When funds are provided through a general appropriation, additional granularity is often used to distinguish specific areas for how funds are being allocated. In some cases, the specificity of how the funds are used is not detailed in HHS's accounting system. HHS has undertaken a holistic review of its quality improvement operations to determine areas in which fiscal accountability processes could be strengthened, to ensure full accountability, and is implementing more granular tracking of funding specific to quality measurement work, to the extent feasible.

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED - HEALTH CARE QUALITY: CMS COULD MORE EFFECTIVELY ENSURE ITS QUALITY MEASUREMENT ACTIVITIES PROMOTE ITS OBJECTIVES (GAO-19-628)

GAO Recommendation

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

HHS Response

HHS concurs with this recommendation. HHS has implemented a rigorous review process for quality measures it is considering developing, using, or removing. HHS created the Blueprint for the CMS Measures Management System to document the core set of business processes and decision-making criteria for measure development, which includes alignment with the Meaningful Measures initiative.[1] HHS will review its current documentation of the process and work to determine what additional steps may need to be taken to further document how measure decisions impact the achievement of CMS's quality measurement strategic objectives.

GAO Recommendation

The Administrator of CMS should develop and use a set of performance indicators to evaluate the agency's progress towards achieving its quality measurement strategic objectives.

HHS Response

HHS concurs with this recommendation. HHS is committed to making progress towards achieving its quality measurement strategic objectives as laid out in the Meaningful Measures Framework. HHS will consider how best to evaluate this progress going forward.

[1] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/Blueprint.pdf

Appendix VI: GAO Contact and Staff Acknowledgments

GAO Contact

Jessica Farb, (202) 512-7114 or farbj@gao.gov

Staff Acknowledgments

In addition to the contact named above, Will Simerl, Assistant Director; Eric Peterson, Analyst-in-Charge, Jonathan Adams, George Bogart, Krister Friday, Cathy Hamann, Katie Mack, and Dan Ries made key contributions to this report. Also contributing were Vikki Porter and Ethiene Salgado-Rodriguez.

Related GAO Products

Health Care Quality: HHS Should Set Priorities and Comprehensively Plan Its Efforts to Better Align Health Quality Measures. GAO-17-5 (Washington, D.C.: October 13, 2016).

Patient Protection and Affordable Care Act: Procedures for Reporting Certain Financial Management Information Should Be Improved. GAO-14-697 (Washington, D.C.: September 22, 2014).

Budget Issues: Key Questions to Consider When Evaluating Balances in Federal Accounts. GAO-13-798 (Washington, D.C.: September 30, 2013).

Health Care Quality Measurement: HHS Should Address Contractor Performance and Plan for Needed Measures. GAO-12-136 (Washington, D.C.: January 13, 2012).

Program Evaluation: Improving the Flow of Information to the Congress. GAO/PEMD-95-1 (Washington, D.C.: January 30, 1995).