

July 2010

HEALTH CARE  
QUALITY  
MEASUREMENT

The National Quality  
Forum Has Begun a  
4-Year Contract with  
HHS



GAO

Accountability \* Integrity \* Reliability



Highlights of [GAO-10-737](#), a report to congressional committees

## Why GAO Did This Study

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) directed the Department of Health and Human Services (HHS) to enter into a 4-year contract with an entity to perform five duties related to health care quality measurement and authorized \$40 million from the Medicare Trust Funds for the contract. In January 2009, HHS awarded a contract to the National Quality Forum (NQF), under which HHS will reimburse NQF for its costs and pay additional fixed fees. Established in 1999, NQF is a nonprofit member organization that fosters agreement on national standards for measuring and public reporting of health care performance data.

This is the first of two reports MIPPA requires GAO to submit on NQF's contract with HHS. In this report, which covers the first contract year—January 14, 2009, to January 13, 2010—GAO describes (1) the status of NQF's work on the five duties under MIPPA; (2) the costs and fixed fees NQF has reported; and (3) what NQF and HHS do in order to help ensure that NQF's reported costs are proper.

GAO reviewed relevant MIPPA provisions and reviewed HHS and NQF documents, such as HHS's contract with NQF, monthly progress reports and invoices for the first contract year, and policies and other documents that describe how HHS and NQF review invoices. GAO also interviewed NQF and HHS officials responsible for implementing and overseeing the contract.

View [GAO-10-737](#) or [key components](#). For more information, contact Linda T. Kohn at (202) 512-7114 or [kohnl@gao.gov](mailto:kohnl@gao.gov).

## HEALTH CARE QUALITY MEASUREMENT

### The National Quality Forum Has Begun a 4-Year Contract with HHS

#### What GAO Found

NQF has begun work for each of five duties required by MIPPA related to quality measures: (1) make recommendations on a national strategy and priorities; (2) endorse quality measures, which involves a process for determining which ones should be recognized as national standards; (3) maintain—that is, update or retire—endorsed quality measures; (4) promote electronic health records; and (5) report annually to Congress and the Secretary of HHS. As of January 13, 2010—the end of the first contract year—NQF's work for four MIPPA duties was in progress and it had completed its first annual report for the fifth duty. For example, NQF had begun the duties related to endorsement and maintenance by initiating the endorsement process for three projects HHS selected and by starting maintenance reviews for a set of measures of interest to or used by HHS. While NQF began work for each of the duties in the first contract year, HHS determines on an annual basis the work NQF will be expected to perform under the five duties each contract year.

NQF reported costs and fixed fees totaling approximately \$6.5 million for the first contract year, including direct and indirect costs as well as fixed fees. Specifically, NQF reported about \$3.2 million in direct costs, or 49 percent of the total. These were costs specifically incurred for the NQF contract, such as direct labor for NQF employees. NQF also reported about \$2.9 million in indirect costs, which cover additional items such as employee benefits and overhead. Finally, NQF reported about \$360,000 in fixed fees for the first contract year. Over \$5 million of the reported costs and fixed fees were incurred in the second half of the contract year.

NQF and HHS rely on reviews of NQF invoices in order to help ensure that NQF's reported costs are proper. At NQF, officials told us that they review the invoices prior to submitting them to HHS and carry out other activities, such as using an electronic system to track labor hours, in order to help ensure that the costs they report in the invoices are proper. Like NQF, HHS relies on reviews of NQF invoices in order to help ensure NQF's reported costs are proper. These reviews are governed by HHS policies and procedures and by requirements applicable to federal contracts generally.

While NQF has begun work under the MIPPA contract, it is too early for GAO to assess whether, or to what extent, NQF will be successful in carrying out the five MIPPA duties. This report describes NQF's work for the first of 4 contract years. In the remaining 3 years of the contract, HHS will determine on an annual basis specific work for NQF to complete under each of the five MIPPA duties. Therefore, it is not yet known exactly what work NQF will be expected to complete during the remainder of the contract period. GAO's second report, which is due in January 2012, will provide another opportunity to review NQF's performance and costs. HHS and NQF reviewed a draft of this report and provided technical comments, which GAO incorporated as appropriate.

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## Abbreviations

APU program	Reporting Hospital Quality Data for Annual Payment Update Program
ASPE	Assistant Secretary for Planning and Evaluation
CMS	Centers for Medicare & Medicaid Services
CSAC	Consensus Standards Approval Committee
FAR	Federal Acquisition Regulation
HHS	Department of Health and Human Services
MIPPA	Medicare Improvements for Patients and Providers Act of 2008
NQF	National Quality Forum
PPACA	Patient Protection and Affordable Care Act of 2010
QDS	Quality Data Set

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United States Government Accountability Office  
Washington, DC 20548

July 14, 2010

## Congressional Committees

Health care quality measures are used to evaluate how health care is delivered, and information obtained from such measures can promote accountability among health care providers and help consumers make informed choices about their care. The Department of Health and Human Services (HHS) encourages use of quality measures through programs that provide financial incentives to health care providers who voluntarily collect and report information on certain quality measures, which HHS then makes publicly available.<sup>1</sup> For example, as part of one program, HHS reported that in fiscal year 2009, almost all—96 percent—of eligible hospitals participating in Medicare reported on their performance against certain quality measures. Recent legislation requires HHS to implement additional programs that will rely on quality measures, such as a pay-for-performance program under which HHS will pay incentives to hospitals based on their performance on selected quality measures.<sup>2</sup>

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) directed HHS to enter into a 4-year contract with an entity to perform five duties related to health care quality measurement: (1) make recommendations on a national strategy and priorities, (2) endorse quality measures, (3) maintain endorsed quality measures, (4) promote electronic health records, and (5) report annually to Congress and the Secretary of HHS.<sup>3</sup> MIPPA authorized \$10 million per year—\$40 million in total—from the Medicare Trust Funds for this 4-year contract, which covers the period from January 14, 2009, through January 13, 2013. In addition, the Patient Protection and Affordable Care Act (PPACA), which was enacted in March 2010, established additional duties for the entity.

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<sup>1</sup>These programs include the Medicare Physician Quality Reporting Initiative for physicians and the Reporting Hospital Quality Data for Annual Payment Update Program (APU program) for hospitals. For more information on the APU program, see GAO, *Hospital Quality Data: Issues and Challenges Related to How Hospitals Submit Data and How CMS Ensures Data Reliability*, [GAO-08-555T](#) (Washington, D.C.: Mar. 6, 2008).

<sup>2</sup>This program, known as a value-based purchasing program, is required by the Patient Protection and Affordable Care Act (PPACA). Pub. L. No. 111-148, 124 Stat. 119 (2010).

<sup>3</sup>Pub. L. No. 110-275, § 183, 122 Stat. 2494, 2583-86. The contract may be renewed at the end of the 4-year period after a subsequent bidding process.

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On January 14, 2009, HHS awarded the 4-year contract required by MIPPA, after issuing a solicitation seeking competitive proposals,<sup>4</sup> to the National Quality Forum (NQF), a nonprofit organization established in 1999 that fosters agreement on national standards for measurement and public reporting of health care performance data. NQF uses a process recognized under the National Technology Transfer and Advancement Act of 1995 that grants quality measures and other standards endorsed by consensus-based entities, such as NQF, standing as national voluntary consensus standards.<sup>5</sup> NQF uses its process to evaluate available quality measures to determine which ones are qualified to be endorsed—that is, recognized—as national standards. NQF-endorsed quality measures have been used by HHS in its quality measurement programs.<sup>6</sup> In 2008, prior to receiving the contract award, NQF’s revenue from all sources was approximately \$10 million. NQF staff told us that while NQF has previously received funding from HHS for some of its work related to quality measures, the \$10 million per year authorized by MIPPA for the contract is larger than previous funding.

HHS’s 4-year contract with NQF is a cost-plus-fixed-fee contract, under which HHS will pay NQF for its costs and additional fixed fees for its services.<sup>7</sup> The Federal Acquisition Regulation (FAR)<sup>8</sup> provides that cost-plus-fixed-fee and other types of cost-reimbursement contracts may only be used when the contractor’s accounting system is adequate for determining costs under the contract and appropriate government surveillance during performance will provide reasonable assurance that efficient methods and effective cost controls are used. For the purposes of

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<sup>4</sup>MIPPA required HHS to use full and open competition to enter into the contract. HHS received only one proposal for the contract.

<sup>5</sup>See Pub. L. No. 104-113, 110 Stat. 775 (1996). The act directs federal agencies and departments to use standards that are developed or adopted by voluntary consensus standards bodies, such as NQF, whenever possible.

<sup>6</sup>PPACA requires that HHS choose endorsed measures for certain quality measurement programs if it is feasible and practical to do so.

<sup>7</sup>HHS obligated \$10 million for the contract on the date of the award and plans to increase the obligated amount each year of the contract. Funds obligated but not actually paid for NQF’s costs and fees in a contract year remain available in subsequent contract years.

<sup>8</sup>48 C.F.R. ch. 1. The FAR establishes uniform policies for acquisition of supplies and services by executive agencies. Agency acquisition regulations may implement or supplement the FAR.

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this report, we refer to costs that are allowable under the contract as “proper.”<sup>9</sup>

MIPPA required GAO to study the performance of and costs incurred by NQF under its 4-year contract with HHS and submit a first report by July 14, 2010, and a second report by January 14, 2012.<sup>10</sup> This first report covers the first contract year that began January 14, 2009, and ended January 13, 2010. In this report, we describe (1) the status of NQF’s work on the five duties related to health care quality measurement required under MIPPA, (2) the costs and fixed fees that NQF has reported under its contract, and (3) what NQF and HHS do in order to help ensure that NQF’s reported costs are proper.

To describe the status of NQF’s work on duties related to health care quality measurement required under MIPPA, we focused our review on the status of NQF’s work related to the five MIPPA duties as of the end of the first contract year, January 13, 2010. We reviewed relevant provisions in MIPPA, and HHS and NQF documents related to implementing health care quality measurement duties in MIPPA. Specifically, we reviewed HHS’s contract with NQF and NQF’s 2009 annual work plan, which established specific activities for implementing these duties as well as scheduled time frames for the activities. We also reviewed the monthly progress reports NQF is required to submit to HHS on its efforts for the first contract year, and we reviewed NQF’s first annual report to HHS and Congress. We interviewed NQF officials responsible for implementing the contract and HHS officials responsible for managing the contract and overseeing NQF’s performance. For NQF activities in progress at the end of the first contract year, we gathered information about their planned completion dates as of January 13, 2010. Our finding is limited to the duties established under MIPPA and does not include additional duties mandated by PPACA, which was enacted after the end of the first contract year.

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<sup>9</sup>Cost principles applicable to contracts with nonprofit organizations are set forth in the Office of Management and Budget Circular A-122, the text of which is located at 2 C.F.R. pt. 230. See 48 C.F.R. § 31.702 (2009). Under these provisions, costs are allowable if they are reasonable and allocable, consistent with any limitations and applicable policies, accorded consistent treatment, determined in accordance with generally accepted accounting principles, not counted elsewhere, and adequately documented.

<sup>10</sup>MIPPA states that GAO’s reports shall be submitted by 18 months and 36 months, respectively, after the effective date of the contract.

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To describe the costs and fixed fees that NQF has reported under its contract, we reviewed NQF invoices submitted to HHS for the first contract year—January 14, 2009, through January 13, 2010. These invoices include the amounts of costs and fixed fees reported by NQF. We also reviewed NQF's monthly progress reports to HHS for the first contract year. We interviewed NQF officials responsible for reviewing and approving the costs and fixed fees submitted to HHS under the contract. We also interviewed HHS officials responsible for reviewing NQF's costs and fixed fees reported under the contract. Based on our review of relevant documents and interviews with NQF and HHS officials, we determined that the reported costs and fixed-fee data were sufficiently reliable for the purposes of this report.

To describe what NQF and HHS do in order to help ensure that NQF's reported costs are proper, we interviewed NQF and HHS officials and reviewed relevant policies and procedures. For NQF, we interviewed officials about their process for reviewing NQF invoices submitted to HHS and about the other policies and procedures that NQF has in order to help ensure that the costs they report to HHS in the invoices are proper. We focused our discussions on policies and procedures related to employee labor costs and payments to contractors and consultants, which are the majority of NQF's direct costs. We also reviewed the invoices that NQF submitted to HHS during the first contract year for evidence of NQF approval by NQF officials. Additionally, we examined the files that NQF maintained on its subcontracts to review documentation for the eight subcontractors and consultants that performed work related to the HHS contract in the first contract year. We compared documentation that NQF maintains for the eight subcontractors and consultants with the requirements in NQF's January 2010 procurement policy. For HHS, we interviewed officials responsible for reviewing NQF invoices, the project officer and the contracting officer for the NQF contract. We identified requirements in relevant HHS policies and procedures as well as relevant federal contracting requirements for oversight of cost-reimbursement contracts. We interviewed HHS officials about how they review NQF invoices. We also reviewed documentation in the file HHS maintained on the NQF contract for the first contract year to describe whether HHS officials followed the invoice review procedures they explained to us. Additionally, we reviewed documentation in the NQF contract file related to NQF's use of eight subcontractors and consultants that performed work under the contract for the first contract year. Our work was limited to describing what NQF and HHS do to help ensure that NQF's reported costs were proper and did not include a determination of whether the costs were proper.



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We conducted this performance audit from September 2009 through June 2010 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.

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## Background

NQF is a nonprofit organization established in 1999 that fosters agreement on national standards for measurement and public reporting of health care performance data. Its membership includes more than 400 organizations that represent multiple sectors of the health care system, including providers, consumers, and researchers.<sup>11</sup> NQF uses a consensus development process to evaluate and endorse consensus standards, including quality measures, best practices, frameworks, and reporting guidelines. NQF has endorsed over 600 quality measures in 27 areas, such as cancer and diabetes. NQF endorses quality measures developed by other organizations, such as the Joint Commission, the National Committee for Quality Assurance, and the American Medical Association, rather than developing quality measures itself. HHS has used a number of NQF-endorsed measures in initiatives to promote quality measurement, and NQF continues to endorse quality measures separate from this contract.

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## Duties Established in MIPPA

MIPPA established five duties related to the use of quality measures. See table 1 for a description of the duties.

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<sup>11</sup>NQF classifies its membership as being composed of the following groups: provider organizations, which include hospitals, pharmacies, and other organizations (33 percent); health professional organizations, such as those representing doctors, nurses, and clinicians (20 percent); organizations that conduct research, education, or initiatives to improve health care quality, measurement, and reporting (16 percent); supplier/industry groups that provide devices, medications, and other products (8 percent); public/community health agencies (7 percent); consumer advocacy groups (7 percent); purchasers, such as private organizations and government agencies (6 percent); and health plans and organizations involved in administration of health insurance programs (4 percent). These percentages add up to over 100 percent due to rounding. A list of NQF's member organizations is available at its Web site, [http://www.qualityforum.org/Membership/Membership\\_in\\_NQF.aspx](http://www.qualityforum.org/Membership/Membership_in_NQF.aspx).

**Table 1: Description of Quality Measurement Duties as Specified in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)**

MIPPA duties	Description of MIPPA duties
Make recommendations on national strategy and priorities	<p>(1) The entity shall synthesize evidence and convene key stakeholders to make recommendations, with respect to activities conducted under this Act, on an integrated national strategy and priorities for health care performance measurement in all applicable settings. In making such recommendations, the entity shall—</p> <p>(A) ensure that priority is given to measures—</p> <ul style="list-style-type: none"> <li>i. that address the health care provided to patients with prevalent, high-cost chronic diseases;</li> <li>ii. with the greatest potential for improving the quality, efficiency, and patient-centeredness of health care; and</li> <li>iii. that may be implemented rapidly due to existing evidence, standards of care, or other reasons; and</li> </ul> <p>(B) take into account measures that—</p> <ul style="list-style-type: none"> <li>i. may assist consumers and patients in making informed health care decisions;</li> <li>ii. address health disparities across groups and areas; and</li> <li>iii. address the continuum of care a patient receives, including services furnished by multiple health care providers or practitioners and across multiple settings.</li> </ul>
Endorsement of measures	<p>(2) The entity shall provide for the endorsement of standardized health care performance measures. The endorsement process under the preceding sentence shall consider whether a measure—</p> <p>(A) is evidence-based, reliable, valid, verifiable, relevant to enhanced health outcomes, actionable at the caregiver level, feasible to collect and report, and responsive to variations in patient characteristics, such as health status, language capabilities, race or ethnicity, and income level; and</p> <p>(B) is consistent across types of health care providers, including hospitals and physicians.</p>
Maintenance of measures	<p>(3) The entity shall establish and implement a process to ensure that measures endorsed under the second duty are updated (or retired if obsolete) as new evidence is developed.</p>
Promotion of the development of electronic health records	<p>(4) The entity shall promote the development and use of electronic health records that contain the functionality for automated collection, aggregation, and transmission of performance measurement information.</p>

MIPPA duties	Description of MIPPA duties
Annual report to Congress and the Secretary of Health and Human Services; Secretarial publication and comment	<p>(5)(A) The entity shall submit to Congress and the Secretary, by not later than March 1 of each year (beginning with 2009), a report containing a description of—</p> <ul style="list-style-type: none"> <li>i. the implementation of quality measurement initiatives under this Act and the coordination of such initiatives with quality initiatives implemented by other payers;</li> <li>ii. the recommendations made under the first duty; and</li> <li>iii. the performance by the entity of the duties required under the contract entered into with the Secretary under subsection (a)</li> </ul> <p>(B) not later than 6 months after receiving a report under subparagraph (A) for a year, the Secretary shall—</p> <ul style="list-style-type: none"> <li>i. review such report; and</li> <li>ii. publish such report in the Federal Register, together with any comments of the Secretary on such report.</li> </ul>

Source: GAO summary of MIPPA duties prior to amendments made by the Patient Protection and Affordable Care Act (PPACA).

## NQF Contract

For the NQF contract, HHS selected a cost-plus-fixed-fee contract—NQF’s first cost-reimbursement contract. Under the cost-plus-fixed-fee contract, HHS will reimburse NQF for costs incurred under the contract in addition to a fixed fee that is paid regardless of other costs. Cost-plus-fixed-fee contracts are used for efforts such as research, design, or study efforts where cost and technical uncertainties exist and it is desirable to retain as much flexibility as possible in order to accommodate change. However, this type of contract provides only a minimum incentive to the contractor to control costs. As we reported in 2009, these contracts are suitable when the cost of work to be done is difficult to estimate and the level of effort required is unknown.<sup>12</sup>

Under the FAR, cost-reimbursement contracts may only be used when the contractor’s accounting system is adequate for determining costs under the contract to help prevent situations where contractors bill the government for unallowable costs. One method an agency can use to determine if an accounting system is adequate is to perform a preaward survey of a potential contractor’s accounting system prior to awarding a

<sup>12</sup>For more information on cost-plus-fixed-fee contracts, see GAO, *Contract Management: Extent of Federal Spending under Cost-Reimbursement Contracts Unclear and Key Controls Not Always Used*, [GAO-09-921](#) (Washington, D.C.: Sept. 30, 2009).

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contract.<sup>13</sup> This review serves as a key control to determine whether the potential contractor has an adequate accounting system in place to accurately and consistently record costs and submit invoices for costs. HHS conducted two preaward surveys of NQF's accounting system. HHS's initial review, in November 2007, found that NQF's accounting system was inadequate because the system could not identify and separate unallowable costs, among other issues. NQF subsequently replaced its accounting system, and a second HHS review in November 2008 found that the system was adequate.

Under the FAR, contracts are to contain provisions for agency approval of a contractor's subcontracts.<sup>14</sup> HHS's contract with NQF contains this provision and also requires the approval of consultants. This review requires appropriate support documentation provided by the contractor to the agency, including a description of the services to be subcontracted, the proposed subcontract price, and a negotiation memo that reflects the principal elements of the subcontract price negotiations between the contractor and subcontractor.

Two HHS components are principally responsible for administering the NQF contract: the office of the Assistant Secretary for Planning and Evaluation (ASPE) and the Centers for Medicare & Medicaid Services (CMS)—an operational division within HHS.<sup>15</sup> To conduct oversight of the NQF contract, HHS assembled staff in these two units with experience in acquisitions, contract management, and program management. Specifically, the project officer for the NQF contract, responsible for program management and performance assessment, is a representative of ASPE.<sup>16</sup> The contracting officer for the NQF contract, responsible for

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<sup>13</sup>An agency's examination is to determine whether an accounting system is adequate. These reviews include a determination of whether the accounting system can meet generally accepted accounting principles and whether it provides for, among many things, proper segregation of direct costs from indirect costs. See 48 C.F.R. § 53.301-1408, FAR Form 1408; 48 C.F.R. § 9.106-4. The scope of HHS's review of NQF's accounting system was limited to determining whether the design of the system was acceptable for accumulating costs under a government contract.

<sup>14</sup>48 C.F.R. §§ 44.204(a)(1), 52.244-2 (2009).

<sup>15</sup>Within CMS, the Office of Acquisition and Grants Management is responsible for administering the NQF contract.

<sup>16</sup>The project officer serves as the technical representative of the contracting officer, and provides technical direction to NQF for all tasks described in the NQF contract. In addition, the project officer monitors NQF's performance and reviews invoices for payment.

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administering the contract, is a representative of CMS.<sup>17</sup> The contracting officer and project officer should perform a comprehensive review of contractor invoices to determine if the contractor is billing costs in accordance with the contract terms and applicable government regulations.

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## NQF Has Begun Work for Each of the Five Duties Required by MIPPA Related to Quality Measures

As of January 13, 2010—the end of the first year of HHS’s 4-year contract with NQF to implement the MIPPA duties—NQF had begun work for each of the five duties required by MIPPA related to health care quality measures: (1) make recommendations on a national strategy and priorities; (2) endorse quality measures; (3) maintain endorsed quality measures; (4) promote electronic health records; and (5) report annually to Congress and the Secretary of HHS. While NQF began work for each of the duties in the first contract year, HHS determines on an annual basis the specific work NQF will be expected to perform under the five MIPPA duties in each contract year.

**Recommendations on a National Strategy and Priorities for Quality Measurement.** NQF has taken steps to begin the duty of making recommendations on a national strategy and priorities for quality measurement. In October 2009, NQF established a committee of stakeholders that is expected to develop recommendations about a national strategy and priorities for quality measurement. NQF published the recommended priorities in May 2010. The committee’s recommendations are expected to be based on a synthesis of evidence that NQF has collected, using a subcontractor, on 20 conditions that account for the majority of Medicare’s costs.<sup>18</sup> The subcontractor collected evidence on existing quality measures for these conditions and identified gaps where quality measures did not exist. The subcontractor also collected evidence related to each condition, such as information on each condition’s prevalence, treatment costs, variability in providers’ treatment

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<sup>17</sup>The contracting officer enters into, administers, and terminates government contracts. The contracting officer negotiates and prepares contract documents, modifies terms or conditions of the contract, and approves payment of invoices, among other tasks.

<sup>18</sup>The 20 conditions are acute myocardial infarction, Alzheimer’s disease and related disorders, atrial fibrillation, breast cancer, cataract, chronic kidney disease, chronic obstructive pulmonary disorder, colorectal cancer, congestive heart failure, diabetes, endometrial cancer, glaucoma, hip/pelvic fracture, ischemic heart disease, lung cancer, major depression, osteoporosis, prostate cancer, rheumatoid arthritis and osteoarthritis, and stroke/transient ischemic attack.

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of the condition, disparities in treatment for patients with the condition, and potential to improve quality of care for the condition. The committee is expected to consider this evidence when developing recommendations on a national strategy and priorities for quality measurement. Under PPACA, NQF's recommendations<sup>19</sup> on a national strategy and priorities must be considered by HHS when it develops a national strategy for quality improvement, which HHS is required to submit to Congress by January 1, 2011.<sup>20</sup>

**Endorsement of Measures.** NQF has taken steps to provide for the endorsement of quality measures. Prior to its contract with HHS, NQF established a process for endorsing quality measures. Under this process, organizations that develop quality measures submit them to NQF for consideration, in response to specific solicitations by NQF.<sup>21</sup> NQF forms a committee of experts from its member organizations as well as other organizations and agencies to review these quality measures against NQF-established criteria, such as the usability and feasibility of the measure. After this committee evaluates the measures against these criteria, NQF's process allows for a period during which its member organizations and the public may comment on the committee's recommendation for each measure. The process also provides for a period for its member organizations to vote on whether the measures should be endorsed by NQF as a national standard. Ultimately, NQF's board of directors makes a final decision on whether NQF should formally endorse the measures. (See app. I for a detailed description of NQF's endorsement process.)

In order to provide for the endorsement of quality measures under this duty, NQF has taken several steps. Specifically, NQF initiated projects and solicited measures to be endorsed using its process for each of these projects. These projects relate to quality measurement in nursing homes, patient safety, and patient outcomes, and are scheduled to be completed between December 2010 and May 2011. In addition to endorsing measures, NQF also hired a subcontractor to evaluate its endorsement process and recommend ways to improve its efficiency and effectiveness. The

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<sup>19</sup>According to NQF officials, these recommendations to HHS will be based both on NQF's work under the contract and on other NQF initiatives.

<sup>20</sup>Pub. L. No. 111-148, § 3011, 124 Stat. 119, 378-80 (2010).

<sup>21</sup>Examples of organizations that have developed measures and submitted them to NQF include the Joint Commission, the National Committee for Quality Assurance, and the American Medical Association.

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subcontractor's report and NQF's approval of proposed enhancements to the process are due January 2011.

**Maintenance of Endorsed Quality Measures.** NQF has taken steps to ensure that endorsed measures are maintained—that is, updated or retired. Prior to its contract with HHS, NQF established a process for maintenance of measures. According to NQF, once a quality measure has been endorsed, updated information on the measure's specifications should be submitted to NQF annually and the measure should be comprehensively reviewed under the maintenance process every 3 years. NQF's maintenance process is similar to NQF's endorsement process, in that it involves a review of measures against NQF-established criteria, a period for public comment, and a final decision by NQF's board of directors. In order to implement this process under its contract with HHS, NQF began maintenance reviews for 191 measures in 14 areas such as diabetes and cardiovascular care. The measures were identified by HHS as being of interest to, or actually used by, HHS programs. By the end of the first contract year, NQF had not determined completion dates for maintenance of the 191 measures. As of May 2010, maintenance of the 191 measures identified by HHS is scheduled to be completed by the end of 2012.

**Promotion of the Development and Use of Electronic Health Records.** NQF has taken steps towards completing the duty of promoting the development and use of electronic health records for use in quality measurement.<sup>22</sup> As of January 13, 2010, NQF had begun to implement a framework that defines a standardized set of data that should be captured in patients' electronic health records. The framework, known as the Quality Data Set (QDS), is intended to allow data from electronic health records to be collected and used in quality measurement. Implementation and maintenance of the QDS is scheduled to continue through the end of the 4-year contract, which ends January 13, 2013. To further promote the

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<sup>22</sup>According to NQF, its efforts to promote the development and use of electronic health records for use in quality measurement support "meaningful use" of electronic health records under the American Recovery and Reinvestment Act of 2009. The American Recovery and Reinvestment Act authorizes CMS to provide reimbursement incentives for eligible professionals and hospitals who are successful in becoming "meaningful users" of electronic health records. The act states that one factor in determining if a provider is a "meaningful user" of electronic health records is whether it submits information on quality measures selected by HHS. The act also states that, in selecting these measures, HHS should give preference to measures endorsed by NQF. Pub. L. No. 111-5, §§ 4101-4102, 123 Stat. 115, 469-70, 479-80 (2009) (codified at 42 U.S.C. §§ 1395w-4(o), 1395ww(n)).

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development and use of electronic health records in quality measurement, NQF began additional activities. For example, NQF established a panel of experts to recommend additional capabilities to measure utilization. According to NQF officials, efforts under this duty are scheduled for completion between March 2010 and January 2013.

**Annual Report to Congress and the Secretary of HHS.** NQF submitted its first annual report to Congress and the Secretary of HHS on March 1, 2009.<sup>23</sup> HHS published this report, with its comments, in the Federal Register on September 10, 2009. NQF submitted its second annual report, which also covers activities it performed during the first contract year, to Congress and the Secretary on March 1, 2010.<sup>24</sup>

While NQF has begun work for each of the duties in the first contract year, HHS determines on an annual basis the specific work NQF will be expected to perform under the five MIPPA duties each contract year. Specifically, HHS gives direction for and then approves annual plans that NQF develops. These plans can include work begun in prior contract years that has not been completed. HHS can adjust work in the annual plans in support of each of the five duties. For example, HHS officials told us that in future contract years, they may select additional projects for the endorsement of quality measures, and additional measures for maintenance reviews.

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## NQF Reported about \$6.5 Million in Costs and Fixed Fees for the First Contract Year

NQF reported costs and fixed fees totaling approximately \$6.5 million for the first year of its contract with HHS, which ended January 13, 2010.<sup>25</sup> The amount NQF reported included direct and indirect costs, as well as fixed fees. Direct costs, which are costs incurred specifically for this contract, represented the largest percentage—about \$3.2 million, or 49 percent—of the amount NQF reported (see fig. 1). NQF's reported direct costs were largely labor costs for NQF employees and payments to subcontractors

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<sup>23</sup>NQF's first annual report to Congress and the Secretary of HHS covers a 6-week period, January 14, 2009, to February 28, 2009.

<sup>24</sup>NQF's second annual report to Congress and the Secretary of HHS covers the period March 1, 2009, through February 28, 2010, which includes a portion of the first contract year. NQF's annual reports can be found at <http://www.qualityforum.org/projects/ongoing/hhs/>.

<sup>25</sup>These are the costs and fixed fees that NQF reported for the first contract year as of May 31, 2010.



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and consultants. In addition to direct costs, NQF reported about \$2.9 million in indirect costs for the first contract year. Indirect costs cover additional items, such as employee benefits, overhead, and administrative costs.<sup>26</sup> NQF calculates its indirect costs based on a formula that takes into account an indirect-cost rate approved by HHS and the amounts of certain direct costs.<sup>27</sup> For example, the formula estimates indirect costs such as employee benefits by multiplying an indirect-cost rate by the amount of direct costs for labor. Finally, in addition to its direct and indirect costs, NQF reported fixed fees of approximately \$360,000 during the first contract year. HHS pays these fixed fees to NQF in addition to reimbursing the organization for its costs.<sup>28</sup>

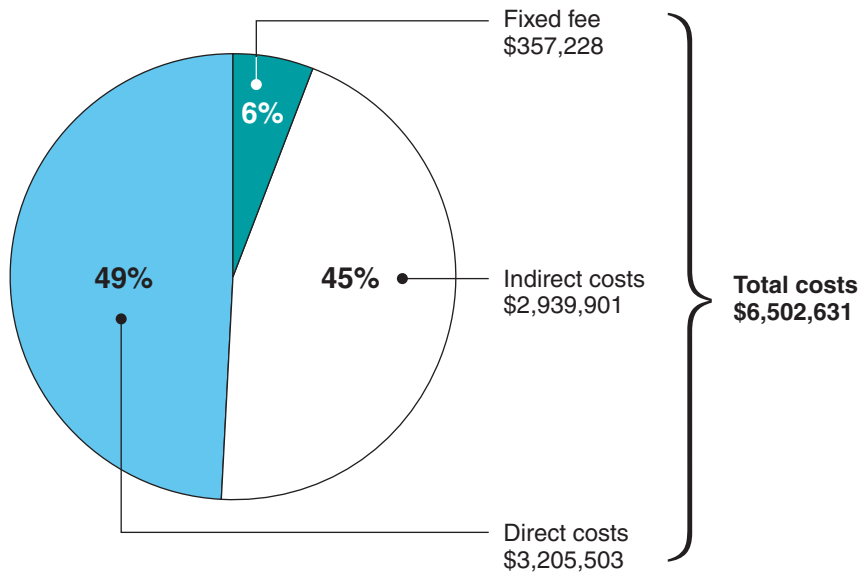
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<sup>26</sup>Employee benefits, known as fringe benefit costs, include items such as annual leave and holiday pay. Overhead includes items such as equipment rental and office supplies. Administrative costs, known as general and administrative costs, include bank fees, dues and subscriptions, and taxes.

<sup>27</sup>HHS approved provisional indirect rates for NQF to use during the first contract year. These rates are intended to help ensure that indirect costs are reasonable for the services provided and within limits specified in the contract. The rates are provisional, which means that they are used until final indirect-costs rates can be established, generally at the end of the contractor's fiscal year. For more information on provisional and final indirect cost rates, see GAO, *Centers for Medicare and Medicaid Services: Deficiencies in Contract Management Internal Controls Are Pervasive*, [GAO-10-60](#) (Washington, D.C.: Oct. 23, 2009).

<sup>28</sup>NQF's contract requires that, in accordance with 48 C.F.R. § 52.216-8, the payment of the fixed fee be paid monthly until fee payments reach 85 percent of the total amount of the fixed fee authorized, and after they reach 85 percent HHS may withhold a reserve up to 15 percent or \$100,000, whichever is less. At such time, the contracting officer may withhold further payment of the fee to protect the government's interest.

**Figure 1: National Quality Forum's (NQF) Costs and Fixed Fees Reported for the First Year of the Contract with HHS**



Source: GAO analysis of NQF data.

Note: Data are as of the end of the first contract year, January 13, 2010.

Of the approximately \$6.5 million in costs and fixed fees NQF reported for the first contract year, most were incurred in the second half of the contract year. Costs and fixed fees in the second half of the contract year, from July 1, 2009, to January 13, 2010, totaled over \$5 million.<sup>29</sup> NQF staff told us that costs in the first half of the contract year were primarily for activities such as development of solicitations for subcontractors. Costs in the second half of the contract year were primarily for activities related to quality measurement, such as endorsement of quality measures and promotion of electronic health records for use in quality measurement.

<sup>29</sup>The increase in costs and fixed fees throughout the year is due solely to increases in costs because NQF reported the same amount of fixed fees each month.

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## NQF and HHS Rely on Reviews of NQF Invoices in Order to Help Ensure That NQF's Reported Costs Are Proper

NQF reviews invoices and carries out other activities prior to submitting them to HHS in order to help ensure that reported costs are proper. HHS requires its officials to follow certain procedures when reviewing these invoices.

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## NQF Reviews Invoices and Carries out Other Activities in Order to Help Ensure That Its Reported Costs Are Proper

NQF officials told us their organization has several ways to help ensure that the contract costs it reports to HHS are proper. According to NQF officials, invoices are electronically generated using NQF's accounting system and then reviewed before submitting the invoices to HHS for payment. These reviews are conducted by two senior staff—the NQF Project Director, who manages the contract, and the Chief Financial Officer. These officials meet to review costs reported in each month's invoice. NQF officials told us that as part of their reviews, the two officials compare the current month's invoice to the previous month's invoice to identify discrepancies or cost trends that seem unusual and that the officials investigate such discrepancies or trends when necessary. After this review, the Chief Financial Officer signs the invoice. During our review of NQF's invoices for the first contract year, we found that the Chief Financial Officer signed the invoices as the officials described to us.

In addition to the review of invoices, NQF officials described other ways the organization helps to ensure that the costs it reports to HHS are proper. In particular, NQF officials told us NQF uses an electronic timesheet system in order to track employee labor hours.<sup>30</sup> NQF officials told us that the timesheet system allows NQF employees to track their labor hours by project and have their labor hours reviewed and approved by the appropriate NQF officials. In addition to the timesheet system, NQF officials told us that their organization established a written procurement policy in August 2009 and revised it in January 2010 to guide how they track other direct costs—specifically, payments to subcontractors and consultants—that are reported in NQF's invoices.<sup>31</sup> NQF officials told us

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<sup>30</sup>Labor costs represented NQF's largest category of direct costs during the first contract year.

<sup>31</sup>Costs associated with subcontractors and consultants accounted for over one-third of NQF's direct costs during the first contract year.

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that under its procurement policy, NQF officials are to obtain the appropriate approval signatures for payments on invoices as well as other payments for subcontractors and consultants once the services have been received. Furthermore, according to the policy, NQF officials are to document how key procurement decisions are made, such as the basis for setting an award cost or price for a subcontractor or consultant. Having a well-designed procurement policy can help reduce the risk of inappropriate payments or pricing related to subcontractors and consultants. During our review of NQF subcontractor and consultant files for the period prior to January 2010—before NQF revised its procurement policy—we found that NQF did not always document approvals for subcontractor payment and did not document that it had determined that its consultant pricing was reasonable.

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### HHS Requires Its Officials to Review NQF Invoices following Certain Procedures in Order to Help Ensure That Reported Costs Are Proper

Like NQF, HHS relies on reviews of NQF's invoices in order to help ensure that reported costs are proper.<sup>32</sup> Two HHS officials assigned to oversee the NQF contract, the project officer and the contracting officer, are responsible for these reviews.<sup>33</sup> When conducting their reviews, the two officials are required to follow certain procedures established in HHS policies.<sup>34</sup> For example, under these policies, the project officer is required to review NQF's invoices to determine whether billed services were actually provided and are supported with adequate documentation. Similarly, the contracting officer is required to review the invoices to determine whether NQF's reported costs are consistent with its contract, accurately calculated, and have adequate documentation. Both officials are required to document when they approve invoices for payment to NQF. When we reviewed HHS documentation and interviewed HHS officials during the course of our work, we found that the contracting officer and project officer had generally followed the review procedures required by HHS policy.

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<sup>32</sup>In addition to the review of invoices, HHS officials conducted two preaward surveys of NQF's accounting system in 2007 and 2008 prior to the start of the contract. As a result of these surveys, HHS found the design of the contractor's accounting system to be adequate for determining costs related to the contract. The FAR requires that this determination be made prior to the start of the contract to help ensure costs are proper and to reduce improper payments.

<sup>33</sup>Other HHS officials, such as the project manager and contract specialist, provide invoice review support to the project officer and contracting officer.

<sup>34</sup>These policies include those specified in the HHS Project Officer manual and CMS's May 2008 invoice review policy.

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Table 2 provides more detailed information on the procedures that the project and contracting officers are required to follow when reviewing NQF invoices. Table 2 also provides information we obtained from HHS officials on how they implemented these requirements.

**Table 2: Procedures Required under HHS Policy When Reviewing Invoices and Implementation of These Procedures for the NQF Contract**

Required procedure for reviewing invoices	Implementation of procedure for the NQF Contract
1. The project officer must review each of the cost categories reported in NQF's invoice to ensure that billed services were actually received, that they were appropriate, and that they are adequately supported with documentation submitted by NQF. The project officer can recommend to the contracting officer disapproval of costs that do not meet these criteria.	HHS officials told us that, as required, the project officer reviewed each of the cost categories in NQF invoices with the project manager, who works with the project officer to help provide technical direction to NQF. Officials told us that the project officer recommended the disapproval of certain costs to the contracting officer that were not appropriate. Our review of HHS documentation showed that the project officer questioned some of NQF's costs and recommended to the contracting officer disapproval of certain costs for services NQF should not have performed. For example, the project officer recommended disapproval of costs that NQF had billed for work on a project that had been placed on hold.
2. The project officer is to document his or her approval of an invoice for payment.	For the NQF contract, the project officer told us that she sends an e-mail each month to the contracting officer to document her approval of the invoice. We found this documentation during our review of the NQF contract file.
3. The contracting officer or the contract specialist, who provides support to the contracting officer, is required to review the invoices to determine if, among other things, (1) all costs are consistent with the requirements of the contract, (2), all necessary supporting documentation for costs are attached to the invoice, (3) all calculations are correct and there are no obvious errors.	The contracting officer told us that he reviews NQF's invoices with the assistance of the contract specialist to ensure that HHS pays only for completed work that had been authorized by the project officer. In particular, he stated that he reviews all costs reported in the invoices to ensure they are consistent with the requirements of the contract, and that he reviews supporting documentation for the costs provided by NQF. HHS officials told us that because NQF invoices can range from 100 to 200 pages, the contracting officer or the contract specialist perform checks on a selection of costs within each invoice to verify that calculations are correct. In addition, they may rely on contract audits to determine if costs are proper. <sup>a</sup>
4. Before approving costs associated with subcontractors and consultants, the contracting officer must confirm that the use of each subcontractor or consultant was approved. <sup>b</sup>	The contracting officer told us that he confirmed that NQF requests to use each subcontractor or consultant were approved. He stated that he reviews the NQF requests to approve subcontractors and consultants prior to reviewing the invoices. He also told us that he has disapproved costs associated with subcontractors. In our review of NQF and HHS's contract files, we found documentation of these reviews, including disapprovals.
5. The contracting officer or the contract specialist is required to certify whether an invoice is approved for payment by signing it.	Our review of NQF invoices found no evidence of signatures indicating approval. <sup>c</sup>

Source: GAO analysis of HHS data and interviews with HHS officials.

<sup>a</sup>As of February 2010, CMS officials told us that they had not determined whether they will conduct an audit of final indirect-cost rates each year or after the contract is complete in 2013. Furthermore, a CMS official reported in March 2010 that the agency had not determined whether CMS or another auditing entity, such as the Defense Contract Audit Agency, would perform the audit.

<sup>b</sup>According to the NQF contract, NQF must submit requests to use subcontractors and consultants to the contracting officer. The contracting officer must review NQF's request for subcontract or consultant approval and, while taking into consideration the project officer's recommendation, advise the contractor of the decision to consent to or dissent from the proposed subcontract or consultant arrangement in writing.

<sup>c</sup>Reviewing invoices prior to payment is a preventative control that may result in the identification of unallowable billings, especially on cost-reimbursement contracts, before the invoices are paid, and a signature provides evidence of review.

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## Concluding Observations

While NQF has begun work in the first year of its contract for the five duties related to quality measurement established by MIPPA, it is too early for us to assess whether, or to what extent, NQF will be successful in carrying out these duties. This report describes NQF's work for the first of 4 contract years, and HHS has flexibility to determine on an annual basis the specific work it expects NQF to perform for each of the MIPPA duties. Therefore, it is not yet known exactly what work NQF will be expected to complete during the remainder of the contract period. In addition, other events related to quality measurement, such as the completion of HHS's national strategy for quality improvement, are expected to occur before the end of the 4-year contract period and may have some influence on NQF's specific work for the five MIPPA duties. Our second report will provide another opportunity to review NQF's performance and costs.

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## Agency and Other External Comments

We provided drafts of this report to HHS and NQF for comment. Both HHS and NQF provided technical comments, which we incorporated as appropriate.

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We are sending copies of this report to the Secretary of Health and Human Services and other interested parties. In addition, the report will be available at no charge on GAO's Web site at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or at [kohnl@gao.gov](mailto:kohnl@gao.gov). Contact points for our Office of Congressional Relations and Office of Public Affairs can be found on the last page of this report. Other major contributors to this report are listed in appendix II.



Linda T. Kohn  
Director, Health Care

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# Appendix I: National Quality Forum's Endorsement Process and Example Project

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The National Quality Forum (NQF) established its endorsement process in 2000. NQF's process includes the nine steps described in table 3 below. The table also provides information on the endorsement process as applied to a project to endorse a number of measures related to home health care, such as measures on education provided to patients and caregivers on medications for care and increases in the number of pressure ulcers. This project was initiated prior to the NQF contract with the Department of Health and Human Services (HHS) that was required by the Medicare Improvements for Patients and Providers Act of 2008. NQF announced a call for nominations for steering committee members for this project in August 2008 and the final set of 20 endorsed measures was announced on March 31, 2009.

**Table 3: National Quality Forum's (NQF) Endorsement Process and Example Project**

Steps in NQF endorsement process	Home health measures project dates and details
<p><b>1. Notice of Intent to Call for Measures for Endorsement Consideration</b> At the beginning of a project where NQF seeks to endorse measures, NQF usually issues a public notice of its intent to call for measures for endorsement consideration. The notice includes a brief background on the project and a statement on the scope of the project's activities.</p>	<p>NQF did not issue a notice of intent for this project because this step was added to the process in April 2009, after the project's completion.</p>
<p><b>2. Call for Nominations for Steering Committee Members</b> NQF issues a call for nominations for experts to serve on a steering committee, which will oversee the endorsement project. Any interested party can submit nominations for the steering committee during this 30-day period. NQF selects members of a steering committee based upon their expertise, their potential contribution to the project, and the need for input from a particular stakeholder perspective. Generally, a steering committee is composed of individuals affiliated with NQF member organizations, unless a necessary stakeholder perspective or specific expertise is not available among NQF's membership.</p>	<p>In August 2008, NQF issued a call for nominations to serve on the steering committee for this project. NQF selected 20 individuals representing the following member organizations: 8 were from provider organizations (5 of which were home health providers); 2 were from consumer advocacy groups; 5 were health professional organizations; 3 were from quality measurement, research, and improvement groups; 1 was from a supplier and industry group; and 1 was from a health plan.</p>
<p><b>3. Call for Measures for Endorsement Consideration</b> Approximately 14 days after the Intent to Call for Measures notice is issued, NQF issues a formal call for submission of measures that are candidates for endorsement. Any organization or agency, such as the Centers for Medicare &amp; Medicaid Services (CMS), can submit measures for consideration during this 30-day period.</p>	<p>Between September 15 and October 14, 2008, 57 measures were submitted to NQF, all from CMS.</p>
<p><b>4. Steering Committee Review of Measures for Endorsement Consideration</b> After the end of the 30-day period for submission of measures, the steering committee conducts a detailed review of all submitted measures. The duration of the steering committee's review can vary depending on the scope of the project, the number of standards under review, and the relative complexity of the standards. Submitted measures are evaluated against four criteria, but the measures must meet the first of these criteria in order to be evaluated against the remaining criteria. The four criteria are:</p> <p><u>Importance to measure and report</u>: extent to which a measure is important for making significant gains in health care quality and for improving health outcomes within a high-impact aspect of health care where there is variation in or overall poor performance.</p> <p><u>Scientific acceptability of measure properties</u>: extent to which a measure produces consistent (reliable) and credible (valid) results about the quality of care.</p> <p><u>Usability</u>: extent to which intended audiences (e.g. consumers, purchasers, providers, policymakers) can understand the results of the measure and are likely to find them useful for decision making.</p> <p><u>Feasibility</u>: extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement.</p> <p>Based on its detailed evaluation, a steering committee can recommend either that (1) a measure continue through the process toward possible endorsement by NQF, or (2) a measure be returned for further development and refinement.</p>	<p>During October and November 2008, the steering committee reviewed the 57 measures and recommended endorsement of 22.</p>

**Appendix I: National Quality Forum's  
Endorsement Process and Example Project**

Steps in NQF endorsement process	Home health measures project dates and details
<p><b>5. Member and Public Comment Period</b></p> <p>After the steering committee completes its initial review of the submitted candidate measures, a draft of the committee's recommendations—or "draft report"—is posted on the NQF Web site for review and comment by NQF member organizations and the public. Member organizations have 30 days to comment on all submitted measures and the public has 21 days to comment.</p> <p>The comments are compiled by NQF staff and submitted to the steering committee for consideration. A steering committee may revise its draft report in direct response to these comments.</p>	<p>Between December 16, 2008, and January 14, 2009, the recommended measures were posted for comment, and 92 comments were submitted by a total of 22 individuals and organizations. Twenty-four comments were from the public and 68 comments were from NQF member organizations. Based on these comments and additional information received by the steering committee, the committee revised its recommendation to only include 20 measures.</p>
<p><b>6. Member Voting</b></p> <p>Member organizations have 30 days to vote on the final version of the steering committee's recommendations for each measure. Each NQF member organization may cast one vote in favor of or against a steering committee's recommendations. A member organization may also abstain from voting on a particular consensus development project. Only measures that are approved will proceed to the next step in the process.</p>	<p>Between January 28 and February 26, 2009, 20 measures were posted for voting. Fifty-eight member organizations voted on each of the 20 measures. These organizations included consumer advocacy groups; health plans; health professional organizations; provider organizations; purchasers; quality measurement, research, and improvement groups; and supplier/industry groups.</p>
<p><b>7. Review of Measures by Consensus Standards Approval Committee (CSAC)</b></p> <p>The CSAC, which is a subcommittee of NQF's Board of Directors, reviews the measures under consideration for endorsement and voting results prior to making a recommendation to the NQF Board of Directors about endorsement of the measure. After detailed review of each measure, the CSAC determines if consensus has been reached. In this context, NQF considers consensus to mean that general agreement has been reached across the various member organizations, such as consumers and health care professionals and, if there are dissenters, that those opinions have been taken into consideration during the review process. The CSAC may seek further input from members if there is a lack of consensus. The CSAC can recommend full endorsement, time-limited endorsement, or denial of endorsement for a measure.</p>	<p>On March 10, 2009, 20 measures were recommended by the CSAC.</p>
<p><b>8. Board of Directors Decision</b></p> <p>CSAC recommendations regarding endorsement are submitted to the Board of Directors. The board can affirm or deny a CSAC decision.</p>	<p>On March 31, 2009, 20 measures were endorsed by the Board of Directors.</p>
<p><b>9. Appeals</b></p> <p>Any interested party may file an appeal with the NQF Board of Directors of the decision to endorse a measure. An interested party may not file an appeal regarding the decision to deny endorsement for a measure.</p> <p>An interested party may file a concern about any measure (whether endorsed or not endorsed) in the NQF endorsement process and this concern will be reviewed by the CSAC.</p>	<p>Between April 1 and April 30, 2009, no appeals were filed.</p>

Source: GAO analysis of NQF data.

Note: Data are from documents, the Web site, and information provided during interviews.

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# Appendix II: GAO Contact and Staff Acknowledgments

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## GAO Contact

Linda T. Kohn, (202) 512-7114 or kohnl@gao.gov

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## Staff Acknowledgments

In addition to the contact named above, Will Simerl, Assistant Director; La Sherri Bush; Helen Desaulniers; Krister Friday; Natalie Herzog; Carla Lewis; Lisa Motley; Ruth S. Walk; Rasanjali Wickrema; and William T. Woods made key contributions to this report.

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