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January 2012

HEALTH CARE QUALITY MEASUREMENT

HHS Should Address Contractor Performance and Plan for Needed Measures

GAO-12-136

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Highlights

Highlights of GAO-12-136, a report to congressional committees

January 2012

HEALTH CARE QUALITY MEASUREMENT

HHS Should Address Contractor Performance and Plan for Needed Measures

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 various activities related to health care quality measurement. In January 2009, HHS awarded a contract to the National Quality Forum (NQF), a nonprofit organization that endorses health care quality measures—that is, recognizes certain ones as national standards. In 2010, the Patient Protection and Affordable Care Act (PPACA) established additional duties for NQF. This is the second of two reports MIPPA required GAO to submit on NQF's contract with HHS. In this report—which covers NQF's performance under the contract from January 14, 2010, through August 31, 2011—GAO examines (1) the status of projects under NQF's required contract activities and (2) the extent to which HHS used or planned to use the measures it has received from NQF under the contract to meet its quality measurement needs, as of August 2011. GAO interviewed NQF and HHS officials, reviewed relevant laws, and reviewed HHS and NQF documents.

What GAO Recommends

GAO recommends HHS: (1) use all monitoring tools required under the contract to help address NQF's performance, (2) complete testing of retooled measures, and (3) comprehensively plan for its quality measurement needs. HHS neither agreed nor disagreed with these recommendations. NQF concurred with many of the findings in the report and provided additional context.

View GAO-12-136. For more information, contact Linda T. Kohn at (202) 512-7114 or kohnl@gao.gov.

What GAO Found

NQF has made progress on projects under its contract activities, as of August 2011. Specifically, NQF has completed or made progress on 60 of 63 projects. For example, NQF has completed projects to endorse measures related to various topics, including nursing homes. However, for more than half of the projects, NQF did not meet or did not expect to meet the initial time frames approved by HHS. For example, NQF completed one project to retool measures—that is, convert previously endorsed quality measures to an electronic format. While the retooling project was expected to be completed by September 2010, its completion was delayed by 3 months. NQF and HHS officials identified various reasons that contributed to this delay, including an expansion of the project's scope and complexity. As a result of the delay, HHS did not have all the retooled measures it expected to include in its Electronic Health Records (EHR) Incentive Program. The delay of this project was also a contributing factor to NQF exceeding its estimated cost for its entire contract activity related to EHR by about $560,000 in the second contract year—January 14, 2010, through January 13, 2011. While HHS monitored NQF's progress through monthly progress reports and approved changes to time frames and costs, HHS did not use all of the tools for monitoring that are required under the contract. Specifically, HHS did not conduct an annual performance evaluation to assess timeliness and cost issues that could have helped to inform NQF's future scope of work. Until August 2011, HHS did not enforce the provision for NQF to submit a financial graph to compare monthly costs for each contract activity with cost estimates, which is information not included in monthly progress reports. These tools could have provided additional, more detailed information to help identify instances in which NQF might have been at risk of not meeting time frames or exceeding cost estimates, which could have provided HHS an opportunity to make any appropriate changes to NQF's activities.

HHS had used or planned to use about half of the measures—164 of 344—that it received from NQF under the contract, as of August 2011. For example, HHS used 44 measures that NQF retooled under the contract in its EHR Incentive Program. HHS officials stated that the 44 measures used in the program contained errors, which required corrections. HHS officials also have not yet tested the retooled measures to assess the feasibility of implementing them in the electronic format; therefore, HHS runs the risk that some of these measures may not work as intended when implemented. HHS officials told GAO they expect to evaluate if and how they could use all of the remaining measures HHS received under the contract. However, HHS has not determined how PPACA requirements for quality measurement may have changed its needs for endorsed quality measures. As a result, HHS has not established a comprehensive plan that identifies its measurement needs and time frames for obtaining endorsed measures and that accounts for relevant PPACA requirements. Without such a plan, HHS may be limited in its efforts to prioritize which specific measures it needs to develop and to have endorsed by NQF during the remainder of the NQF contract. As a result, HHS may be unable to ensure that the agency receives the quality measures needed to meet PPACA requirements, including time frames for implementing quality measurement programs.

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Abbreviations

ASPE	Assistant Secretary for Planning and Evaluation
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009
CDP	consensus development process
CMS	Centers for Medicare & Medicaid Services
EHR	Electronic Health Record
ESRD	end-stage renal disease
FAR	Federal Acquisition Regulation
HAC	Healthcare Acquired Condition
HHS	Department of Health and Human Services
IT	Information Technology
IEP	Internal Evaluation Plan
LTCH	Long-Term Care Hospitals
MAP	Measure Applications Partnership
MAT	Measure Authoring Tool
Mathematica	Mathematica Policy Research, Inc.
MIPPA	Medicare Improvements for Patients and Providers Act of 2008
NPP	National Priorities Partnership
NQF	National Quality Forum
National Quality Strategy	National Strategy for Quality Improvement in Healthcare
NTTAA	National Technology Transfer and Advancement Act of 1995
OMB	Office of Management and Budget
PPACA	Patient Protection and Affordable Care Act
PPS	Prospective Payment System
QDM	Quality Data Model
SRE	Serious Reportable Event

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The nation's health care spending was about $2.5 trillion in 2009. Health care spending has been increasing in recent years by an average of nearly 7 percent per year since 2000, and is projected to reach over $4.5 trillion by 2020.[1] However, higher levels of spending, such as spending more to increase the number or technical complexity of treatments, do not necessarily lead to a corresponding increase in the quality of care.[2] To better align quality and health care spending, the Department of Health and Human Services (HHS) has developed various programs and initiatives to measure health care quality and to provide financial incentives to health care providers to improve quality and to reduce the use of unnecessary and costly services. These programs and initiatives include, for example, pay-for-performance programs that rely on information collected on various health care quality measures.[3] 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. The Patient Protection and Affordable Care Act (PPACA), enacted in March 2010, directed HHS to expand its current programs and initiatives, such as pay-for-performance programs, and to implement new ones that will use health care quality measures. PPACA establishes specific time frames for HHS to implement these programs and initiatives that rely on various health care quality measures over the next several years. For example, PPACA requires HHS to establish a

[1]Office of the Actuary, Centers for Medicare & Medicaid Services (CMS), *National Health Expenditures Tables*, table 1, downloaded 09/2/11 from https://www.cms.gov/NationalHealthExpendData/downloads/tables.pdf. In 2009, the national spending on health care accounted for 17.6 percent of gross domestic product, which totaled $14.1 trillion. The federal government share of health care spending for that same year was $678 billion, or 27 percent.

[2]GAO, *Value in Health Care: Key Information for Policymakers to Assess Efforts to Improve Quality While Reducing Costs,* GAO-11-445 (Washington, D.C.: July 26, 2011).

[3]The Physician Quality Reporting System, for example, is an HHS quality reporting program that provides an incentive payment to eligible professionals, such as physicians, who satisfactorily report data on various quality measures for services that are covered by Medicare.

hospital value-based purchasing program.[4] HHS estimates that in fiscal year 2013 its Hospital Value-Based Purchasing Program[5] will provide $850 million in Medicare incentive payments to hospitals that meet certain performance measures.[6] Additionally, HHS is required under PPACA to establish value-based payments for physicians, develop a plan for value-based purchasing programs for skilled nursing home facilities and home health agencies, and create pilot programs that test the implementation of a value-based purchasing program for other providers—psychiatric, long-term care, inpatient rehabilitation, and cancer hospitals as well as hospice programs.

For many of HHS's health care quality measurement programs and initiatives, HHS is required to give consideration to the quality measures endorsed by a consensus-based entity, such as the National Quality Forum (NQF). NQF is the entity in the United States with the lead responsibility for endorsing health care quality measures—that is, determining which measures should be recognized as national standards. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) directed the agency to enter into a 4-year contract with an entity to endorse health care quality measures and conduct other activities, and HHS contracted with NQF in January 2009.[7] NQF is a nonprofit organization established in 1999 in order to foster agreement on national standards for measurement and public reporting of health care performance data. MIPPA provided $10 million per year for each of fiscal years 2009 through 2012—$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. PPACA provided an additional

[4]Value-based purchasing programs are pay-for-performance programs that require providers to collect and report information on health care quality measures and adjust payment levels based on providers' performance against the measures.

[5]For payment purposes, CMS divides hospital providers into various categories, including acute care inpatient hospitals, long-term care hospitals, and psychiatric hospitals, among others. The Hospital Value-Based Purchasing Program applies to acute care inpatient hospitals.

[6]See 76 Fed. Reg. 2454 (Jan. 13, 2011). PPACA specified that the total amount of value-based payments must be equal to the total amount of reductions to payments for all hospitals, so the program has a net budget-neutral impact. Also see Pub. L. No. 111-148, § 3001, 124 Stat. 119, 353-62 (2010).

[7]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.

$100 million—$20 million per year for each of fiscal years 2010 through 2014—for additional health care quality measurement work to be conducted by NQF and HHS through fiscal year 2014.[8] Because PPACA does not specify the proportion of this amount for NQF activities, HHS officials told us that they plan to obligate approximately $10 million per year for the NQF contract, beginning in 2011, and that they may extend the contract through fiscal year 2014.

MIPPA also directed us to submit two reports on the performance of and costs incurred by NQF under its 4-year contract with HHS.[9] On July 14, 2010, we issued the first report, which contained information about NQF's performance and costs during the first contract year, which began January 14, 2009, and ended January 13, 2010.[10] This second report covers NQF's performance and costs for the second contract year—January 14, 2010, through January 13, 2011—and part of the third contract year—January 14, 2011, through August 31, 2011. Specifically, this report examines (1) the status of projects under the activities NQF is required to complete under its contract with HHS, (2) the costs and fixed fees NQF reported under the contract from January 2010 through August 2011, and (3) the extent to which HHS used or planned to use the measures it receives from NQF under the contract to meet its quality measurement needs, as of August 31, 2011. In addition, appendix I of this report provides information about a framework for the various stages of a health care quality measure, including measure endorsement, as described by HHS and NQF officials and others.

To describe the status of projects under NQF's required contract activities from January 2010 through August 2011, we reviewed relevant provisions in MIPPA and PPACA and documents including the HHS contract with NQF, NQF's 2009, 2010, and 2011 final annual work plans that cover the

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

[9]MIPPA states that GAO's reports shall be submitted no later than 18 months and 36 months, respectively, after the effective date of the contract.

[10]GAO, *Health Care Quality Measurement: The National Quality Forum Has Begun a 4-Year Contract with HHS*, GAO-10-737 (Washington, D.C.: July 14, 2010). In this report, we found that (1) NQF had begun work for each of the five duties required by MIPPA related to quality measures, (2) NQF reported costs and fixed fees totaling approximately $6.5 million for the first contract year, and (3) NQF and HHS rely on reviews of NQF invoices in order to help ensure that NQF's reported costs are proper.

contract activities in response to MIPPA,[11] NQF's 2011 technical proposal for the contract activities in response to PPACA,[12] and NQF's monthly progress and monthly internal evaluation plan reports that NQF is required to submit to HHS.[13] For purposes of our work, we categorized the 16 tasks that NQF is required to perform under the contract from January 2010 through August 2011 into 9 contract activities. (See app. II for more detailed information on how we categorized these contract activities.) In addition, we identified the various projects NQF is required to perform under the 9 contract activities we identified. Specifically, for the purposes of our work, we identified 63 projects NQF is required to perform under the 9 contract activities, as shown in appendix III. We then compared the information we obtained from NQF on its progress on the 63 projects under the 9 activities to the requirements for NQF's performance under the contract with HHS and the expected time frames and cost estimates initially established by HHS and NQF in the final annual MIPPA work plans and other NQF documents for completing the work. We also interviewed NQF officials responsible for implementing the contract and HHS officials responsible for managing the contract and overseeing NQF's performance. We also compared evidence from HHS and NQF documents with evidence from discussions with HHS and NQF officials to corroborate any issues or challenges with NQF's performance. Based on our comparison and interviews with officials, we identified any changes to the work NQF is required to perform and changes to the time frames or cost estimates established in the final work plans developed annually to respond to MIPPA and a budget developed as part of NQF's technical proposal to respond to PPACA.

To assess the costs and fixed fees NQF reported under the contract from January 2010 through August 2011, we reviewed NQF documents that

[11]Under the contract, NQF is required to work with HHS to develop an annual work plan for each contract year that outlines the contract activities in response to MIPPA. The work plan also delineates scheduled time frames for the work NQF is expected to perform that contract year and cost estimates for the activities. NQF officials told us HHS obligates funds on a yearly basis following HHS's approval of the work plan.

[12]The technical proposal is submitted to HHS and incorporated into the scope of work.

[13]The contract requires that monthly progress reports include NQF's accomplishments for the month under each of the contract activities, any problems encountered or anticipated and the impact on project time frames, and a financial graph that compares NQF's monthly reported costs for each of the contract activities with initial cost estimates, among other things.

include financial information related to the contract, such as NQF's final work plans developed in 2010 and 2011 to respond to MIPPA and a budget developed as part of NQF's technical proposal to respond to PPACA that describe NQF's estimated costs for each of the nine activities we identified under the contract. We obtained and summarized information from NQF monthly invoices submitted to HHS from January 14, 2010, through August 31, 2011, for direct[14] and indirect[15] costs incurred by NQF under the contract and fixed fees.[16] We compared NQF's reported costs with its cost estimates for the activities in NQF's 2010 final annual work plan and determined whether or to what extent NQF's reported costs exceeded its cost estimates. We did not assess the accuracy of NQF's reported costs.[17] We also reviewed the HHS contract with NQF and any contract modification since January 14, 2010. We also interviewed NQF and HHS officials responsible for reviewing and approving the costs and fixed fees submitted under the contract. Based on our review of 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 examine the extent to which HHS used or planned to use measures it receives from NQF under the contract to meet its quality measurement needs, as of August 2011, we reviewed statutory requirements and documents related to HHS health care quality measurement efforts. We relied on HHS to identify programs and initiatives that use or will use health care quality measures, such as programs or initiatives established

[14]Direct costs are costs incurred specifically for the contract, such as labor costs and payments to subcontractors and consultants.

[15]Indirect costs are costs that are not directly attributable to a specific project or function. These costs cover additional items such as employee benefits, overhead, and administrative costs.

[16]NQF's contract requires that, in accordance with 48 C.F.R. § 52.216-8, the fixed fee be paid monthly until fee payments reach 85 percent of the total amount of the fixed fee authorized, and that after they reach 85 percent HHS may withhold a reserve up to 15 percent or $100,000, whichever is less, to protect the government's interest.

[17]NQF and HHS rely on reviews of NQF invoices in order to help ensure that NQF's reported costs are proper. 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. HHS also conducts reviews of NQF invoices, which are governed by HHS policies and procedures and by requirements applicable to federal contracts generally. For more information, see GAO-10-737.

by MIPPA, PPACA, and the Health Information Technology for Economic and Clinical Health Act.[18] As a result, the health care quality programs and initiatives mentioned in our report may not represent a comprehensive list of all those that use or plan to use measures received from NQF under the contract. We interviewed officials from various divisions within HHS that may use measures that were nationally recognized—or NQF-endorsed—in their various programs and initiatives related to health care quality measurement in order to corroborate the information we obtained from documentation. We obtained information about how HHS selects measures for its programs and initiatives from our interviews with HHS officials and reviews of HHS documents. We determined how HHS has used and planned to use measures that were received under the contract with NQF by identifying all the measures that HHS received under the contract and matching each measure to the quality measures being used or considered for use in HHS programs and initiatives.[19] For the purpose of this report, we defined a measure as used if the measure was identified by HHS and included in an HHS program or initiative as of August 31, 2011, and indicated as such by a final rule or other HHS documentation. We defined a measure as planned for use if the measure was identified by HHS for potential use in an HHS program or initiative as of August 31, 2011, and indicated as such by a proposed rule or other HHS documentation. In addition, we reviewed HHS documents and interviewed HHS officials to determine whether or to what extent HHS has plans for using work conducted under the NQF contract to meet PPACA requirements related to quality measures for HHS programs and initiatives. For example, we reviewed HHS plans or strategies such as the 2011 National Strategy for Quality Improvement in

[18]Pub. L. No. 111-5, div. A, title XIII, div. B, title IV, 123 Stat. 115, 226, 467 (2009).

[19]HHS officials explained that any measure developer can submit a measure to be considered for NQF endorsement. Each measure developer has its own purpose or plans for implementing a measure, which may or may not involve HHS quality and public reporting programs. Therefore, all measures submitted may not be applicable to a particular HHS health care quality program or initiative. HHS officials told us that they will review all the measures received under the contract to determine if they are applicable to their health care quality programs or initiatives.

Healthcare (National Quality Strategy),[20] that describe the agency's plans to help meet its quality measurement needs.

We conducted this performance audit from April 2011 through January 2012 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 objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

NQF is a nonprofit organization established in 1999 in order to foster agreement, or consensus, on national standards for measuring and public reporting of health care performance data.[21] Its membership includes more than 400 organizations that represent multiple sectors of the health care system, including providers, consumers, and researchers. NQF's mission focuses on three core areas: (1) building consensus on national priorities and goals for performance improvement and working in partnership to achieve them, (2) endorsing national consensus standards for measuring and publicly reporting on performance, and (3) promoting the attainment of national goals through education and outreach programs.

[20]The 2011 National Strategy for Quality Improvement in Healthcare, also referred to as the National Quality Strategy, focused on six priorities: (1) making care safer; (2) ensuring person- and family-centered care; (3) promoting effective communication and coordination of care; (4) promoting the most effective prevention and treatment of the leading causes of mortality, starting with cardiovascular disease; (5) working with communities to promote wide use of best practices to enable healthy living; and (6) making quality care more affordable. The National Quality Strategy was due on January 1, 2011, as required by PPACA, and was issued on March 21, 2011. HHS is expected to provide annual updates to the report.

[21]NQF is recognized as a consensus body under the National Technology Transfer and Advancement Act of 1995 (NTTAA) and the Office of Management and Budget (OMB) Circular A-119, which provides NQF the authority needed to facilitate its public/private partnership. OMB Circular A-119 defines "consensus" as a "general agreement, not necessarily unanimity" so that attempts may be made to resolve objections and members may have an opportunity to amend their votes after reviewing comments. In addition, the circular states that the voluntary consensus process must adhere to the following five elements: openness, balance, due process, consensus, and an appeal mechanism. See Pub. L. No. 104-113, 110 Stat. 775 (1996).

Prior to its contract with HHS, NQF established a consensus development process (CDP) to evaluate available health care quality measures to determine which ones are qualified to be endorsed—that is, recognized—as national standards. Under this process, organizations that develop quality measures submit them to NQF for consideration, in response to specific solicitations by NQF.[22] NQF forms a committee of experts from its member organizations as well as other organizations and agencies to conduct an objective and transparent review of these quality measures against four standardized criteria established by NQF, such as whether the measures are scientifically acceptable.[23] 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.

As of October 2011, NQF has endorsed over 600 health care quality measures in 27 areas, such as cancer and diabetes. HHS uses NQF-endorsed measures in its programs and initiatives to promote quality measurement, and NQF continues to endorse quality measures separate from its contract with HHS.

NQF's Contract with HHS

NQF's work under the contract includes endorsement of quality measures and other activities that are expected to support HHS's quality measurement efforts, such as through value-based purchasing programs. Specifically, NQF's work under the contract consists of various projects under the nine contract activities related to health care quality measurement. The work plans developed annually to respond to MIPPA and NQF's technical proposal to respond to PPACA delineate the projects

[22]NQF does not develop quality measures itself; rather, NQF endorses quality measures developed by other organizations, such as the Joint Commission, the National Committee for Quality Assurance, and the American Medical Association.

[23]A review for scientific acceptability includes an assessment of data from measure testing conducted by measure developers to help ensure that the measure produces consistent and credible results about the quality of care when implemented. The remaining three criteria NQF established for its CDP process are (1) importance to measure and report, (2) usability, and (3) feasibility.

NQF is required to conduct under the nine contract activities, as well as expected time frames and cost estimates for the projects for each year. Table 1 provides more detailed information on the nine contract activities. Some of these activities are required by either MIPPA or PPACA, while others are quality measurement activities established by HHS or administrative activities.

Table 1: Description of the Nine NQF Contract Activities Categorized by GAO

NQF contract activity categorized by GAO	Description of activity
Contract activities required by MIPPA or PPACA	
Recommendations on a National Strategy and Priorities for Quality Measurement (as required by MIPPA)	NQF will synthesize evidence and convene key stakeholders to make recommendations on a national strategy and priorities for health care performance measurement.
Endorsement of Health Care Quality Measures (as required by MIPPA)	NQF will conduct endorsement of quality measures using its consensus development process to determine which ones should be endorsed as national standards. Specifically, it will provide for the endorsement of quality measures through projects that focus on priority areas identified by HHS, such as patient outcomes and patient safety. In addition to endorsing measures, this activity includes an evaluation of NQF's endorsement process to identify ways to improve its efficiency and effectiveness.
Maintenance of Endorsed Quality Measures (as required by MIPPA)	NQF will use its process to ensure that endorsed measures are maintained—that is, updated or retired. This process is similar to NQF's endorsement process, in that it involves a review of measures against established criteria, a period for public comment, and a final decision by NQF's board of directors.[a] Under this activity, NQF will conduct maintenance projects using its 3-year review cycle that compares previously endorsed measures against new measures submitted for endorsement. In addition to the 3-year review cycles, NQF can also maintain measures through: (1) annual updates, which is a process where NQF annually reviews and receives information on a measure to determine whether the measure has undergone any changes; (2) ad hoc reviews where NQF reviews an endorsed measure at any time based on justifiable evidence to substantiate the review; and (3) time-limited endorsement reviews, which is a process where NQF will review time-limited endorsed measures—measures that have been endorsed for a limited period of time to allow for testing by measure developers.
Promotion of the Development and Use of Electronic Health Records (as required by MIPPA)	NQF will undertake projects to promote the development and use of electronic health records for use in quality measurement, including to "retool" measures—that is, convert previously endorsed quality measures to an electronic format that is compatible with electronic health records. In addition, NQF will undertake projects related to developing tools to capture data for performance measurement, creating a framework that defines a standardized set of data that should be captured in patients' electronic health records, and providing data to providers to support clinical decisions. These efforts had not been performed by NQF prior to the contract.

NQF contract activity categorized by GAO	Description of activity
Annual Report to Congress and the Secretary of Health and Human Services (as required by MIPPA and amended by PPACA)	NQF is required to submit an annual report to Congress and the Secretary of HHS that provides a summary of NQF's progress on activities under the contract during the year. PPACA established additional requirements that NQF must perform for this activity that include providing additional information in its annual report to Congress and the Secretary of HHS, beginning with its report due March 1, 2012. Specifically, NQF will include additional information in the report on gaps in endorsed and nonendorsed health care quality measures and a summary of activities conducted by multistakeholder groups during the third contract year (January 14, 2011 – January 13, 2012).
Multistakeholder Input into HHS's National Strategy for Quality Improvement in Health Care (as required by PPACA)	In 2010, NQF convened a multistakeholder group to provide input on national priorities for improvement in population health and in the delivery of health care services for consideration under HHS's National Strategy for Quality Improvement in Healthcare, or the National Quality Strategy.[b] In 2011, NQF will continue to engage a multistakeholder group to provide input on a plan for measuring and improving health and health care focusing on the six priorities identified in HHS's 2011 National Quality Strategy.[c] In addition, NQF will conduct endorsement projects for cross-cutting measures[d] that can support national implementation of these priorities.
Multistakeholder Input on the Selection of Quality Measures for use in Payment Programs and Value-Based Purchasing Programs Under PPACA, Other Private/Public Payers, and Other Programs (as required by PPACA)	NQF will convene a multistakeholder group to provide input on the selection of measures for use in various public programs, including measures for use in quality reporting programs for physicians, postacute care programs under Medicare, Prospective Payment System (PPS) exempt cancer hospitals,[e] and hospice care. In addition, the group will provide input on measures that address quality issues identified for vulnerable populations, such as dual-eligible beneficiaries.
Other health care quality measurement activities not identified in MIPPA or PPACA	
Other health care quality measurement activity	NQF will work on additional health care quality measurement projects established by HHS to fill immediate areas of need, including two white papers related to resource use and efficiency; efficiency and resource use endorsement projects; and projects related to measure harmonization.[f]
Administrative activities	
Administrative activity	NQF will perform a number of administrative activities that focus on project planning and contract management: (1) conduct an opening meeting between HHS and NQF, (2) develop an annual work plan, (3) develop a monthly internal evaluation plan for quality assurance, (4) develop a monthly progress report, (5) conduct weekly conference calls, and (6) develop a public website.[g]

Source: GAO analysis of MIPPA, PPACA, and the NQF contract as well as the 2010 and 2011 NQF final annual MIPPA work plans and 2011 PPACA technical proposal.

[a]Prior to its contract with HHS, NQF established a process for maintenance of measures. In May 2010, NQF updated this process by requiring all previously endorsed measures to go through a comprehensive review every 3 years that will include a comparison against newly submitted measures submitted for endorsement. For example, NQF will review all previously endorsed and newly submitted measures related to cardiovascular health simultaneously.

[b]NQF convened the National Priorities Partnership to complete this work.

[c]The six priorities identified in the National Quality Strategy are: (1) making care safer; (2) ensuring person- and family-centered care; (3) promoting effective communication and coordination of care; (4) promoting the most effective prevention and treatment of the leading causes of mortality, starting with cardiovascular disease; (5) working with communities to promote wide use of best practices to enable healthy living; and (6) making quality care more affordable.

[d]Cross-cutting measures are those that affect all or most patients, such as patient safety.

[e]PPS-exempt cancer hospitals are those exempt from the Prospective Payment System (PPS), which is a system of Medicare reimbursement in which providers receive a predetermined, fixed payment based on the service provided and its classification, such as the patient's diagnosis at the time of hospital admission.

[f]Harmonization is a process where related measures are standardized in a manner by which they can be used in multiple settings when relevant. NQF defines "related measures" as those that either (1) address the same concepts for measure focus (target process, condition, event, outcome) but a different target population; or (2) address different concepts for measure focus (target process, condition, event, outcome) but the same target population.

[9]Development of a public website was part of the 2010 final annual MIPPA work plan but this work was canceled in 2011.

To help determine the activities and the projects under the nine contract activities that NQF is expected to perform during each contract year, HHS has established an interagency workgroup that comprises officials from multiple divisions within HHS, including the Agency for Healthcare Research and Quality, the Centers for Medicare & Medicaid Services (CMS), and the Office of the National Coordinator for Health Information Technology. The workgroup is responsible for prioritizing and selecting the activities and projects under each activity that NQF is expected to perform during each contract year.[24] HHS officials told us that the representatives from these various HHS agencies provide input on the work NQF is expected to perform, including determining quality measures requested from NQF for their respective programs. The activities and projects selected by the interagency workgroup become part of NQF's scope of work under the contract.[25] Some of the projects under the contract activities that NQF is expected to perform during the year will be ongoing from the previous contract year while new work will be incorporated into the work plan as necessary.

For the NQF contract, HHS selected a cost-plus-fixed-fee contract, under which HHS reimburses NQF for actual costs incurred under the contract in addition to a fixed fee that is unrelated to costs. Cost-plus-fixed-fee contracts are used for efforts such as research, design, or study efforts where costs and technical uncertainties exist and it is desirable to retain

[24]The office of the Assistant Secretary for Planning and Evaluation (ASPE)—a component of HHS—is responsible for facilitating the workgroup discussions, which occur at least biweekly.

[25]The contract requires NQF to develop a work plan for each contract year that describes the MIPPA projects under the activities that NQF is required to perform. The MIPPA workplan includes expected time frames and cost estimates for projects under the contract activities. The work NQF is required to perform in response to PPACA is outlined in a technical proposal submitted to HHS and incorporated into the scope of work.

as much flexibility as possible in order to accommodate change.[26] 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.[27] This cost-plus-fixed-fee contract is NQF's first cost-reimbursement contract. For cost-reimbursement contracts, the Federal Acquisition Regulation (FAR)[28] requires appropriate government surveillance[29] during performance to provide reasonable assurance that efficient methods and effective cost controls are used. Under the FAR, contracts are to contain a provision for agency approval of a contractor's subcontracts.[30] HHS's contract with NQF contains this provision and also requires the approval of consultants engaged under the contract. The review and approval of NQF's use of subcontractors and consultants require appropriate support documentation provided by NQF to HHS, including a description of the services, the proposed price, and a negotiation memo that reflects the principal elements of the price negotiations between NQF and the subcontractor or consultant. Under its contract with HHS, NQF has utilized 31 subcontractors and 16 consultants since January 14, 2010, to provide support to NQF on many of the contract activities and associated projects.

Two HHS components are principally responsible for administering the NQF contract: the office of the Assistant Secretary for Planning and Evaluation (ASPE) and CMS—an agency within HHS.[31] Specifically, the

[26]See 48 C.F.R. §§ 16.301-2, 16.306 (2010).

[27]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).

[28]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.

[29]Surveillance includes oversight of a contractor's work to provide assurance that the contractor is providing timely and quality goods or services and to help mitigate any contract performance problems.

[30]48 C.F.R. §§ 44.204(a)(1), 52.244-2 (2010).

[31]Within CMS, the Office of Acquisition and Grants Management is responsible for administering the NQF contract.

project officer for the NQF contract is a representative of ASPE.[32] This individual is responsible for program management and works with the contracting officer to oversee the contract. The contracting officer for the NQF contract, responsible for administering the contract, is a representative of CMS.[33] The contract outlines various activities that the contracting officer is required to perform, such as conducting an annual evaluation of the contractor's performance.

NQF Made Progress on Projects under Each of Its Contract Activities but Has Not Met Expected Time Frames and Has Exceeded Cost Estimates

From January 14, 2010, through August 31, 2011, NQF made progress on projects under its contract activities. However, our review of NQF documents found that NQF had not met or did not expect to meet time frames on more than half of the projects, and it exceeded its cost estimates for projects under three of the contract activities. HHS did not use all tools for monitoring that are required under the contract.

[32]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. Another HHS official within ASPE, the project manager, also provides support to the project officer for the NQF contract.

[33]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.

NQF Made Progress on Projects under Each of the Contract Activities as of August 31, 2011

From January 14, 2010, through August 31, 2011, NQF has made progress on 60 of the 63 projects under the activities required under its contract with HHS. Specifically, NQF had completed 26 projects and was continuing to work on the remaining 34 projects.[34] (App. III provides the status of all contract activities and the projects under each activity NQF was expected to perform during our reporting period.) Examples of projects under the contract activities include both completed and continuing projects:

- **Endorsement of Measures Activity**. NQF endorsed 101 measures since the beginning of the second contract year by conducting work on endorsement projects on different topic areas.[35] Specifically, NQF completed two projects to endorse 38 outcome measures related to 20 high-priority conditions identified by CMS that account for the majority of Medicare's costs,[36] and mental health and child health conditions; and 21 performance measures for chronic and postacute care nursing facilities. NQF also worked on two projects related to child health quality and patient safety. As of August 2011, NQF endorsed 41 child health quality measures and 1 patient safety measure under these projects. NQF expected to complete the child health quality project in September 2011 and the patient safety project

[34]The contract activities and related projects that NQF is expected to perform during each year are determined by HHS and NQF, as they develop NQF's scope of work. As a result, the number of projects varies by year, and some project time frames may extend beyond 1 contract year. For our reporting period, we determined that NQF is conducting work on 63 projects. As of August 31, 2011, of the 63 projects we identified, 26 have been completed, 34 are in progress, 2 have been canceled, and 1 has not yet started. See app. III for more details on each of these projects.

[35]HHS told us that they consider an NQF measure to be endorsed when the NQF Board ratifies the measures. However, NQF is required to submit a final report to HHS following ratification to complete an endorsement project. For purposes of our report, we considered an endorsement project to be completed when the board ratifies the measures that are the subject of the project.

[36]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.

in December 2011.[37] In addition, NQF completed a contractually required review of its endorsement process, subcontracting with Mathematica Policy Research, Inc. (Mathematica). The review focused on the timeliness and effectiveness of the endorsement process;[38] identified inefficiencies, including those that may contribute to delays; and recommended, among other steps, that NQF create a schedule for its endorsement process for measure developers and develop feasible time lines that include clear goals for each endorsement project. HHS officials stated that Mathematica's recommendations were valuable because much of the work under the NQF contract needs to be completed in an accelerated timeline to help fill critical measurement gaps associated with HHS's health care quality programs and initiatives. For more information about this review, see appendix IV.

- **Maintenance of Endorsed Quality Measures Activity**. NQF maintained—that is, updated or retired—124 measures under the contract since the beginning of the second contract year.[39] These included 41 measures reviewed under NQF's 3-year review cycle related to diabetes, mental health, and musculoskeletal conditions.[40] In addition, 83 measures were maintained under NQF's other maintenance review processes.[41] NQF was also continuing to work on maintenance projects it initiated in 2010 for measures related to cardiovascular and surgery measures. As of August 2011, the two

[37]NQF completed the child health quality project by endorsing three additional child health quality measures in September 2011, as scheduled. As of November 2011, NQF was continuing to conduct work on the patient safety project, such as through the endorsement of an additional patient safety measure in September 2011. NQF expected to complete additional review of measures under this project by December 2011.

[38]Mathematica reviewed 23 projects in its analysis, including 7 endorsement projects conducted under the HHS contract.

[39]Under NQF's maintenance process, NQF can retire a measure, or remove its endorsement status for various reasons, such as if the board determines a measure is obsolete.

[40]Although these measures were reviewed under the contract, they were not reviewed under NQF's updated Endorsement Maintenance Process because the reviews began prior to its implementation.

[41]During our reporting period, NQF maintained 80 measures using its time-limited endorsement review process in areas such as infectious diseases and neurology. NQF also maintained 3 measures under its ad hoc review process related to various conditions, including patient safety.

projects were expected to be completed by December 2011 and January 2012, respectively.[42]

- **Promotion of the Development and Use of Electronic Health Records Activity**. NQF has made progress on three projects related to retooling—that is, converting previously endorsed quality measures to an electronic format that is compatible with electronic health records (EHR). First, NQF completed initial retooling of 113 measures. This work is intended to allow data from EHRs to be used for quality measurement, which is a part of HHS's long-term goal to use health information technology to exchange information and improve quality of care. Second, as of August 2011, NQF convened an expert review panel to review the retooled measures to ensure that each retooled measure is properly formatted, the logic is correctly stated, and the intent of the measures is maintained in the electronic format that will use data obtained from EHRs, instead of from claims as originally formatted. Third, as of August 2011, NQF was expected to complete another project to provide an updated list of the 113 retooled measures to HHS by December 2011, which would incorporate any revisions identified by the expert review panel and others involved in the retooling process. After these updated measures are completed, HHS officials told us that they will contract with other entities to conduct testing of some of the 113 retooled measures to assess the feasibility of implementing the measures in the electronic format. Although NQF's endorsement process requires that measure developers submit data on validity and reliability testing of measures they submit for endorsement, this testing does not include feasibility testing for implementing the measures in an electronic format for performance measurement. As of December 2011, HHS officials did not provide an expected date of completion for this feasibility testing but told us that they have awarded two contracts that include this in their scope of work.[43] In addition to the retooling

[42]As of November 2011, NQF was still completing the cardiovascular and surgery projects and expected to complete the work by December 2011 and January 2012, respectively, as scheduled.

[43]HHS officials told us that they awarded contracts to Mathematica Policy Research, Inc., and Abt Associates to conduct feasibility testing on 69 of 113 retooled measures. These contracts were awarded on June 8, 2011, and July 8, 2011, respectively. For the remaining 44 retooled measures, HHS officials told us that HHS issued a solicitation for a contract to conduct feasibility testing of the measures; however, they did not receive any bids. As of December 2011, they said that they will not be issuing a solicitation for a new contract to test the 44 retooled measures.

projects, NQF is developing a software tool—the Measure Authoring Tool—to allow measure developers to create standardized electronic measures that help capture information in EHRs so that less retooling would be needed in the future. As of August 2011, NQF was completing final testing of the beta, or initial, version of this tool. NQF expected to complete testing and publish an updated version for public use by January 2012.[44]

- **Multistakeholder Input into HHS's National Quality Strategy Activity**. NQF convened the National Priorities Partnership (NPP), a multistakeholder group expected to provide annual input on national priorities, among other things, to be considered in the National Quality Strategy.[45] As of August 2011, the NPP was completing a report on this input, which was then published in September 2011. The report noted the need for a national comprehensive strategy that identifies core sets of standardized measures to meet each of the national priorities HHS identified in the 2011 National Quality Strategy, among other things. The NPP noted in the report that a common data platform, core measure set, and public reporting mechanism are key components of the infrastructure for performance measurement. It also highlighted that a strategic plan, road map, and timeline for establishing an infrastructure should be accelerated to allow for rapid implementation over the next 5 years. Additionally, the NPP reported that it was critical that all federal programs drive toward the establishment of a common platform for measurement and reporting.

- **Multistakeholder Input on the Selection of Quality Measures Activity**. NQF has convened the Measure Applications Partnership (MAP). The MAP is a multistakeholder group that is expected to conduct work in two areas. First, the MAP is expected to provide input to the Secretary of HHS on the selection of quality measures for use in payment programs and value-based purchasing programs required by PPACA, among others. The MAP will review a list of measures published by the Secretary of HHS on December 1 of each year, and

[44]As of October 2011, NQF completed testing of the beta version that was made available for public use in September 2011 and expected to publish an updated version in January 2012, as scheduled.

[45]The National Priorities Partnership (NPP) represents over 48 major national organizations from the public and private sectors, including consumers, purchasers, clinicians, and communities. Under PPACA, HHS is required to solicit annual input from such a group on the National Quality Strategy.

develop a report that contains a framework to help guide measure selection. The MAP will provide its annual input beginning February 1, 2012, for measures used in the following 11 programs: hospice, hospital inpatient, hospital outpatient, physician offices, cancer hospitals, end-stage renal disease (ESRD) facilities, inpatient rehabilitation facilities, long-term care hospitals, hospital value-based purchasing, psychiatric hospitals, and home health care. Second, the MAP is expected to publish reports that provide input on the selection of measures for use in various quality reporting programs, including those for physicians. As of August 2011, the MAP had held meetings and initiated its work for reports due October 1, 2011.[46]

- **Other Health Care Quality Measurement Activity**. NQF completed a project to endorse six imaging efficiency measures. NQF was also continuing to work on a project to identify existing quality measures and gap areas related to measurement of regionalized emergency care services.[47]

NQF Did Not Meet Expected Time Frames and Exceeded Cost Estimates

Our review of NQF documents found that NQF had not met or did not expect to meet time frames on more than half of the projects under the contract activities that were completed or ongoing, as of August 2011. Specifically, our review of documents found that NQF had not met expected time frames on 18 of the 26 projects it completed under the nine contract activities. Further, NQF did not expect to meet time frames on 14 of the 34 projects on which it was continuing to work. The delays of these projects under the contract activities varied in time from about 1 to 12 months. HHS officials told us they approved all changes to the time frames, which were established by HHS and NQF in NQF's 2010 and 2011 final annual MIPPA work plans and the PPACA technical proposal. Appendix III provides the status for all projects related to each of the nine contract activities, including information on their expected and actual time frames for completion during our reporting period. Examples of projects under the contract activities for which NQF did not meet or did not expect to meet expected time frames include the following:

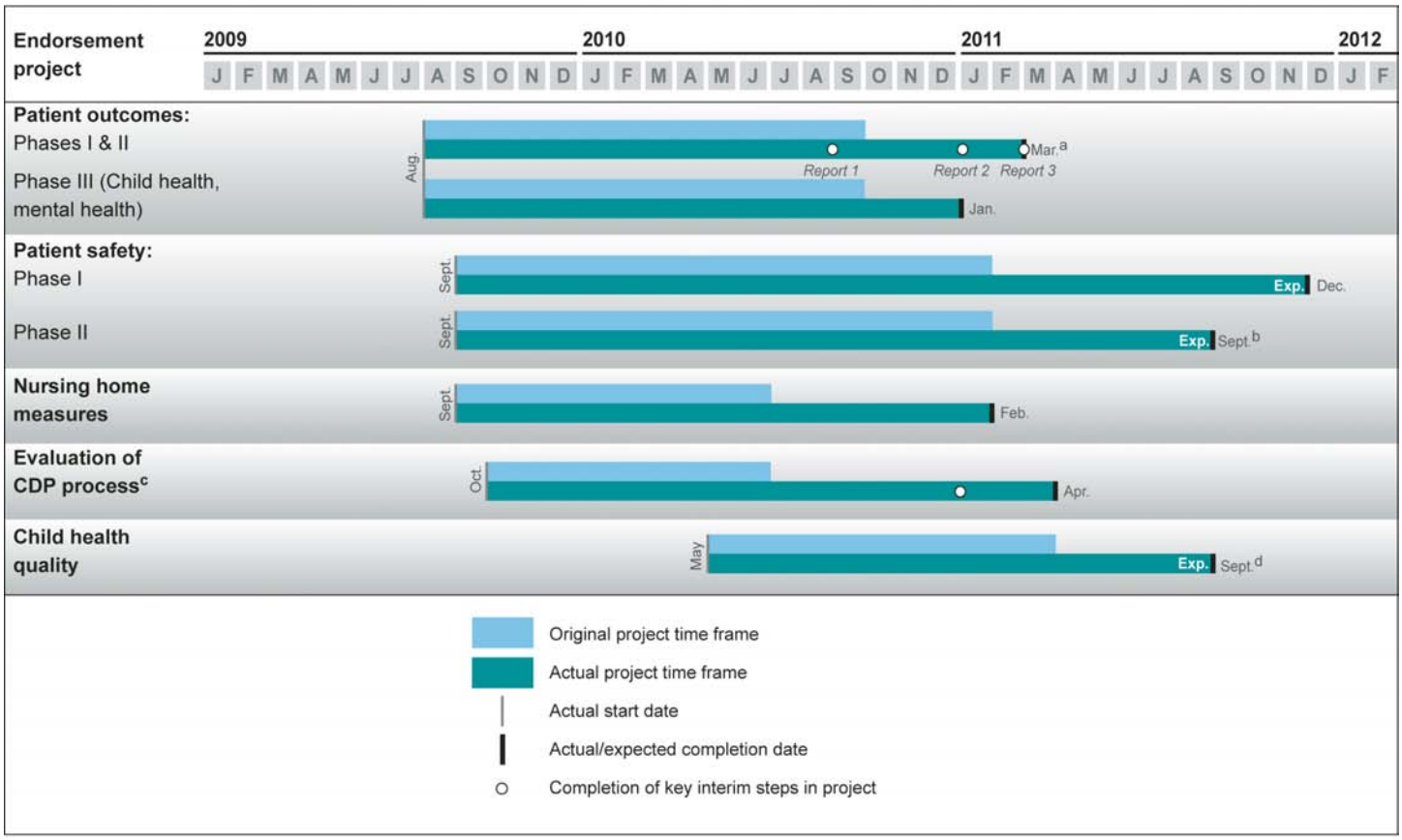
[46]On October 4, 2011, NQF reported that it submitted these reports to HHS on October 1, 2011, as scheduled.

[47]Regionalized emergency medical care refers to directing patients to emergency facilities with optimal capabilities for a given type of illness or injury to help coordinate emergency care across a region.

- **Endorsement of Measures Activity**. NQF did not meet or did not expect to meet time frames for all five endorsement projects under the endorsement contract activity.[48] (See app. III for details on the five projects.) For example, NQF was expected to complete an endorsement project for nursing home quality measures in July 2010; however, the measures were not endorsed until February 2011. (See fig. 1 for estimated time frames and actual completion dates for all projects related to the endorsement contract activity.)

[48]As of August 2011, three of these five projects had been completed. However, NQF was still completing the patient safety project, which was delayed approximately 10 months to allow for harmonization of measures, and the child health quality project.

Figure 1: Estimated Time Frames and Completion Dates for All Five Projects under NQF's Endorsement Contract Activity, as of August 31, 2011



Source: GAO analysis of NQF and HHS data.

Note: For purposes of our report, we consider an endorsement project completed when the board ratifies its measures.

[a]NQF had three separate reviews of measures during Phases I and II, resulting in three separate board endorsements. The circles reflect those three reviews.

[b]NQF endorsed one out of two patient safety measures under phase II of the patient safety project. The remaining measure was still under consideration by the board and is scheduled to be reviewed for endorsement on September 15, 2011.

[c]Mathematica's report on its evaluation of NQF's CDP process, or the endorsement process, and NQF's response to Mathematica's recommendations in the report were published in January 2011. NQF solicited comments on its proposed revisions and additions to its endorsement process, as a result of the Mathematica evaluation, through April 2011.

[d]NQF endorsed 41 out of 44 child health quality measures on August 15, 2011. As of August 2011, the remaining 3 measures were still under consideration by the board and were scheduled to be reviewed for endorsement on September 15, 2011.

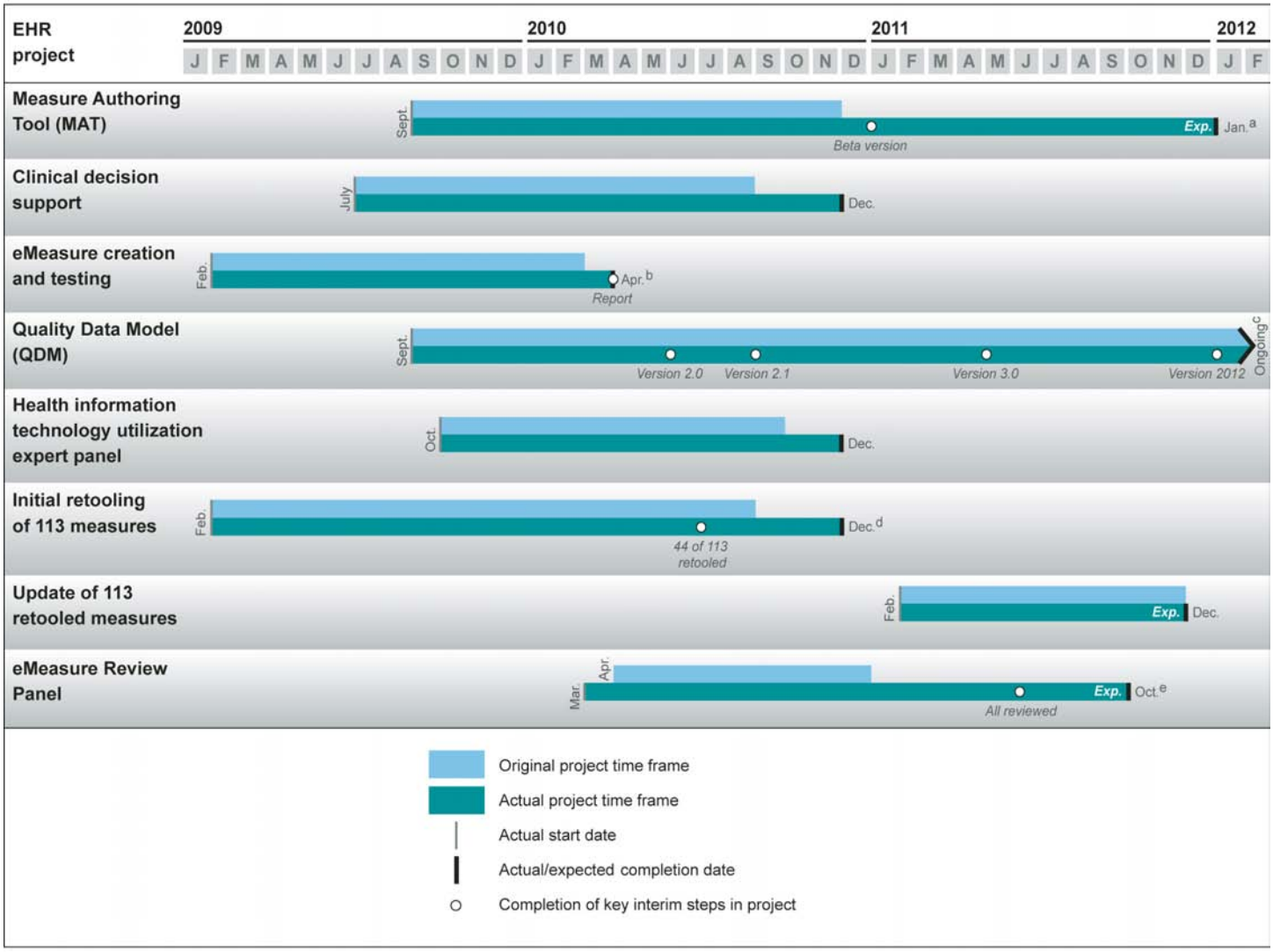
NQF officials stated that several factors contributed to NQF exceeding the expected time frames for the five endorsement projects, including the high volume of measures submitted for review, the amount of time it took to harmonize measures[49] between measure developers, and a need for additional technical expertise on review panels.

- **Promotion of the Development and Use of Electronic Health Records Activity**. NQF did not meet or did not expect to meet expected time frames for five out of eight projects related to the EHR contract activity.[50] For example, NQF was expected to complete its initial retooling of 113 endorsed quality measures into electronic formats by September 2010, but this effort was not completed until December 2010. (See fig. 2 for estimated time frames and actual completion dates for all projects related to the EHR contract activity.) In addition, NQF was expected to complete the project to convene an expert panel to review the 113 retooled measures by January 2011. However, the panel did not complete its review of the 113 measures until June 2011.

[49]Harmonization is a process where related measures are standardized in a manner by which they can be used in multiple settings when relevant. NQF defines "related measures" as those that either (1) address the same concepts for measure focus (target process, condition, event, outcome) but a different target population; or (2) address different concepts for measure focus (target process, condition, event, outcome) but the same target population. NQF officials stated in some instances NQF needed to facilitate harmonization discussions between measure developers to help ensure that the most appropriate measure was being used, and that the measure portfolio did not include duplicative measures, and to avoid confusion within the health care community.

[50]Two of the five projects that have not met expected time frames are still in progress and are expected to be completed by the end of the third contract year. The remaining three have been completed.

Figure 2: Estimated Time Frames for Eight Projects Related to NQF's Contract Activity on the Promotion and Use of EHRs, as of August 31, 2011



Source: GAO analysis of NQF and HHS data.

[a]In January 2011, NQF completed a version of the tool that was released for beta testing (reflected by the circle). NQF is now updating the version, which it expects to release in January 2012.

[b]NQF officials told us that the final report was completed in April 2010; however, additional work was required to complete the project through the beginning of July 2010.

[c]NQF is expected to publish several versions of the QDM throughout the contract term to allow for ongoing review and updates. The circles indicate the versions that have been published or are expected to be published, as of August 2011.

[d]NQF was unable to complete all 113 retooled measures by September 2010, as initially scheduled. NQF submitted versions of 44 measures in July 2010, as requested by HHS. The final versions of all 113 measures were not completed until December 2010.

[e]NQF officials told us the eMeasure Review Panel was not able to complete its review of the retooled measures by its initial due date of January 13, 2011, because all 113 measures were not retooled until December 2010. As a result, the review was not completed until June 2011. As of August 2011, the review panel was expected to submit its final report in October 2011. NQF officials told us in October 2011 this report was completed, as scheduled.

According to HHS and NQF officials, several factors contributed to NQF exceeding expected time frames for the retooling project under the EHR contract activity. HHS officials stated that the first set of 44 retooled measures submitted had errors that required correction. For example, HHS officials stated that they found errors in the electronic coding of these 44 retooled measures requiring NQF and its subcontractors who retooled the measures to make corrections. In addition, HHS and NQF officials stated that after starting the retooling project, they quickly learned that the estimated time frames for the retooling project, as well as other projects related to the EHR activity, were overly ambitious, given the scope and complexity of the work. For example, HHS officials noted that retooling of quality measures into electronic format had never been attempted before and the technical complexity and labor required to complete the project were greater than anticipated. NQF officials also told us that HHS's requests to modify the scope of work for this project often required changing the time frame for completing the retooled measures. These factors resulted in an extension of the project that delayed the final delivery of the 113 retooled measures as well as contributed to the need for additional staff at NQF.

- **Other Health Care Quality Measurement Activity**. NQF was expected to complete two projects under the other health care quality measurement activity related to efficiency and resource use—one white paper on resource use[51] and another on geographic-level efficiency[52] by July 2010. These white papers were intended to provide information for an endorsement project on resource-use measures that began in January 2011. However, as of August 2011, the resource-use paper was still under review by HHS, and NQF

[51]Resource-use measures compare resources used (i.e., cost of care) with either (1) a specific population, (2) a specific service, or (3) a series of related services over time, to help identify the resources necessary for delivering high-quality care and to promote greater efficiency in delivery of health care services.

[52]Geographic-level efficiency measures would be used for quality measure reporting at the geographic and population level.

officials stated they expected to receive comments in September 2011.[53] The geographic-level efficiency paper was canceled in June 2010 at the request of HHS. NQF initially intended to subcontract the work on these two projects, but officials told us that they were unable to identify a subcontractor at the level of funding approved for this project. As a result, HHS approved NQF's proposal to complete this work internally. HHS officials stated that the drafts NQF submitted on both topics were poor in quality and did not meet its needs, resulting in HHS requesting additional revisions for the resource-use white paper that delayed its completion, and requesting the cancellation of the geographic-level efficiency white paper.

- **Administrative Activity**. NQF did not meet the expected time frames for completing one of the required projects under the administrative activity—finalizing its annual work plan. Specifically, the NQF contract requires NQF to develop an annual work plan and to receive final approval from HHS within the first 4 weeks of each contract year; however, NQF did not meet this requirement in 2010 or 2011. For example, the final 2011 MIPPA annual work plan was not developed by NQF and approved by HHS until April 1, 2011. According to NQF and HHS officials, the 2011 MIPPA work plan was not developed and approved on time due to extended discussions on the scope and cost estimates of NQF's EHR activities. HHS officials told us that the primary reason for the extended discussions was that they expected the costs to reflect all the work needed to complete the Measure Authoring Tool (MAT) by the end of the second contract year. However, they said that NQF only submitted a beta version of the tool by the end of the second contract year, which was not the version expected by HHS. NQF officials told us that the version was never intended to be final but rather a beta version, consistent with their understanding of HHS's expectations. As a result, HHS and NQF officials needed to evaluate the scope of work and cost estimates for this and other projects. Further, NQF officials told us the delay in completing the 2011 MIPPA annual work plan resulted in the interruption of NQF's ongoing work related to the MAT under the EHR contract activity. The delay also delayed its receipt of funding for some new or ongoing work under the contract. In some instances, NQF chose to start new or continue ongoing work with its own funding. For example, NQF officials stated that NQF began work

[53]HHS officials told us that they accepted the final version of this paper in October 2011.

related to the MAP using its own funds until HHS authorized the work. In addition, the delay in completing the 2011 MIPPA work plan resulted in the need to set the start date for fall 2011 rather than earlier in the contract year for some of the projects under the maintenance activity.

NQF also exceeded its cost estimates for projects under three of the contract activities. HHS officials told us they approved the changes to the cost estimates and in some cases modified NQF's scope of work to help ensure that NQF's costs did not exceed the amount HHS had obligated for the contract activities. NQF officials stated that in certain cases, not meeting expected time frames contributed to NQF exceeding these cost estimates. For example, the delays in projects related to the EHR contract activity, including expanding the scope of the retooling project, contributed to NQF exceeding its cost estimate of about $3.8 million for the entire EHR contract activity by about $560,000 in the second contract year.[54] In another example, the delays in finalizing the 2010 and 2011 MIPPA work plans contributed in part to NQF exceeding its cost estimate for developing and finalizing these plans, which is a project under the administrative contract activity. Specifically, while NQF estimated that completion of the annual work plan would cost approximately $77,000, NQF reported an actual cost of $176,590. In addition, NQF also exceeded its cost estimate for the endorsement contract activity during the second contract year for various reasons, including a need for additional technical experts for review panels. Specifically, NQF exceeded estimated costs of about $3.1 million for the entire endorsement activity by about $146,000 in the second contract year.[55] While HHS officials told us they approved all changes to the cost estimates, in certain cases they reduced the scope of NQF's work in 2011 to ensure that total available funding for the contract year was not exceeded and that sufficient funding was available for ongoing projects. For example, HHS officials told us that they had hoped to start several new endorsement projects beginning in 2011;

[54]NQF officials told us that it was originally required to retool 44 measures under the contract; however, HHS expanded the scope of work in 2010 to 113 measures. This required additional labor and other resources that increased the costs associated with the retooling project.

[55]Our previous work shows that without the ability to generate reliable cost estimates, programs are at risk of experiencing cost overruns, missed deadlines, and performance shortfalls. GAO, *GAO Cost Estimating and Assessment Guide: Best Practices for Developing and Managing Capital Program Costs,* GAO-09-3SP (Washington, D.C.: March 2009).

however, these projects were not included in the 2011 final annual MIPPA work plan so that funding would be available for NQF to complete its ongoing projects, including work that was delayed under the EHR contract activity. In addition, HHS requested that NQF discontinue its work on one project related to the development of a public website for 2011, which is associated with the administrative contract activity.

HHS Did Not Use All Monitoring Tools Required under the NQF Contract

HHS officials told us that to help monitor NQF's performance on the projects under the contract activities, they rely on NQF to report any issues, including those related to time frames or cost estimates, in the monthly progress reports that NQF is required to submit to HHS or during phone calls held at least monthly. While HHS monitored NQF's progress and approved changes to the time frames and cost estimates for the projects under the contract activities, HHS did not use available tools for monitoring that are required under NQF's contract. These tools could have helped to provide an opportunity for HHS to make any appropriate changes to NQF's projects. For example, HHS did not conduct an annual performance evaluation required by the contract that would assess timeliness and cost control issues, among other things, for the previous contract year.[56] The results of such an evaluation could help HHS officials to consider potential timeliness and cost issues when determining NQF's scope of work for the next year. Further, while monthly progress reports and invoices include information on NQF's costs, these documents do not compare reported costs to initial cost estimates. HHS officials told us that, prior to August 2011, they had not enforced a contractual requirement for NQF to submit—nor had it received from NQF—a financial graph in its monthly progress reports that provides information comparing NQF's monthly incurred costs for each of the contract activities with initial cost estimates. Instead, HHS officials informally requested that NQF provide them with the financial status of the contract activities in midyear 2010, which helped them to plan for NQF's work under the contract for 2011. Having a financial graph in the monthly progress report could have helped HHS officials to identify instances where any contract activity was approaching or exceeding NQF's initial cost estimates prior to HHS's midyear review. This, in turn, could have provided HHS and NQF an opportunity to adjust estimates of future costs for these or related

[56]The requirement in the contract to conduct annual performance evaluations is consistent with a FAR provision that provides that agencies may specify that interim performance evaluations be performed for multiyear contracts. See 48 C.F.R. § 42.1502(a) (2010).

activities earlier in the contract year. HHS officials had asked NQF to begin to include such a financial graph in its monthly progress reports beginning in August 2011.

NQF Reported Costs and Fixed Fees of over $20 Million from January 2010 through August 2011

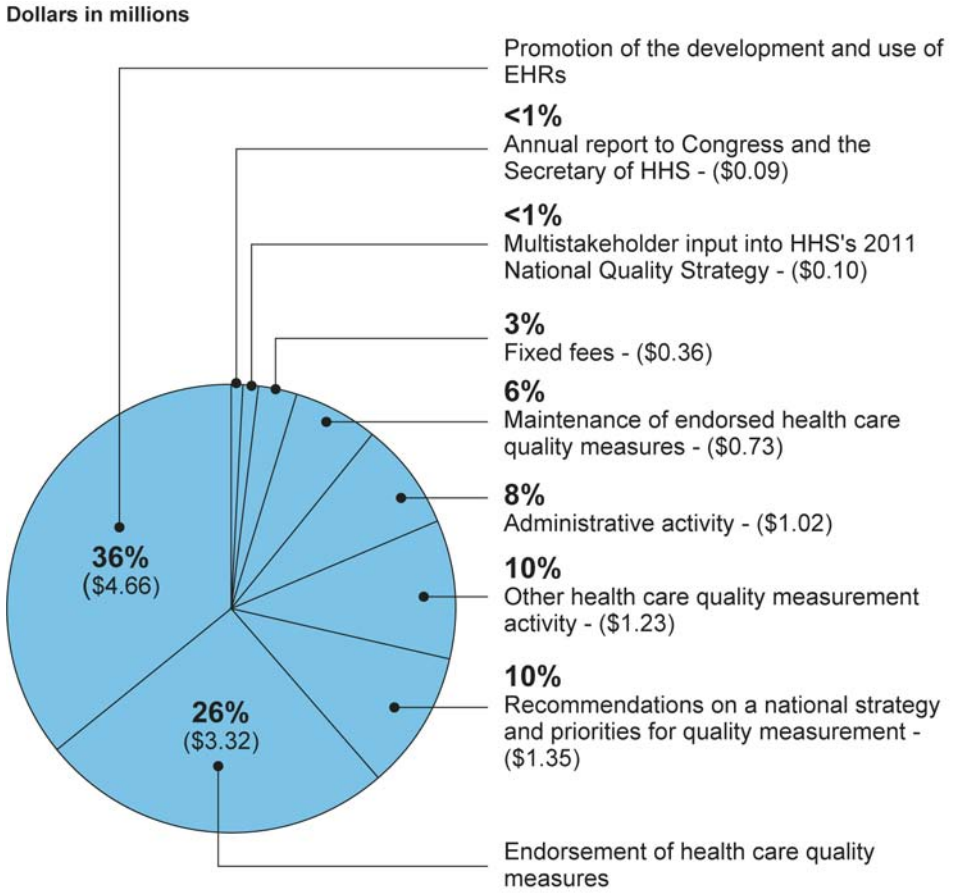
From January 14, 2010, through August 31, 2011, NQF reported a total of approximately $22.4 million in costs and fixed fees on monthly invoices submitted to HHS for projects under activities conducted in response to MIPPA and PPACA. Specifically, NQF reported about $12.8 million in total costs and fixed fees for the contract activities it performed during the second contract year—January 14, 2010, through January 13, 2011.[57] From January 14, 2011, through August 31, 2011, part of the third contract year, NQF reported an additional $9.6 million in total costs and fixed fees.[58]

During the second contract year, the majority of NQF's reported costs were related to the promotion of the development and use of EHRs (36 percent, or $4.6 million) and endorsement of health care quality measures (26 percent, or $3.3 million). Figure 3 illustrates the costs and fixed fees NQF reported for eight of the nine contract activities we reviewed that occurred during the second contract year. The ninth contract activity relates to multistakeholder input on the selection of quality and efficiency measures, as directed by PPACA. This contract activity did not begin until after January 14, 2011, which is the start of the third contract year.

[57]According to HHS, total funding obligated was approximately $13.6 million for the second contract year, which covered January 14, 2010, through January 13, 2011.

[58]According to HHS, total funding obligated was approximately $25 million for the third contract year, which covers January 14, 2011, through January 13, 2012.

Figure 3: NQF's Reported Contract Activity Costs and Fixed Fees Totaling Approximately $12.8 Million during the Second Contract Year (Jan. 14, 2010—Jan. 13, 2011)

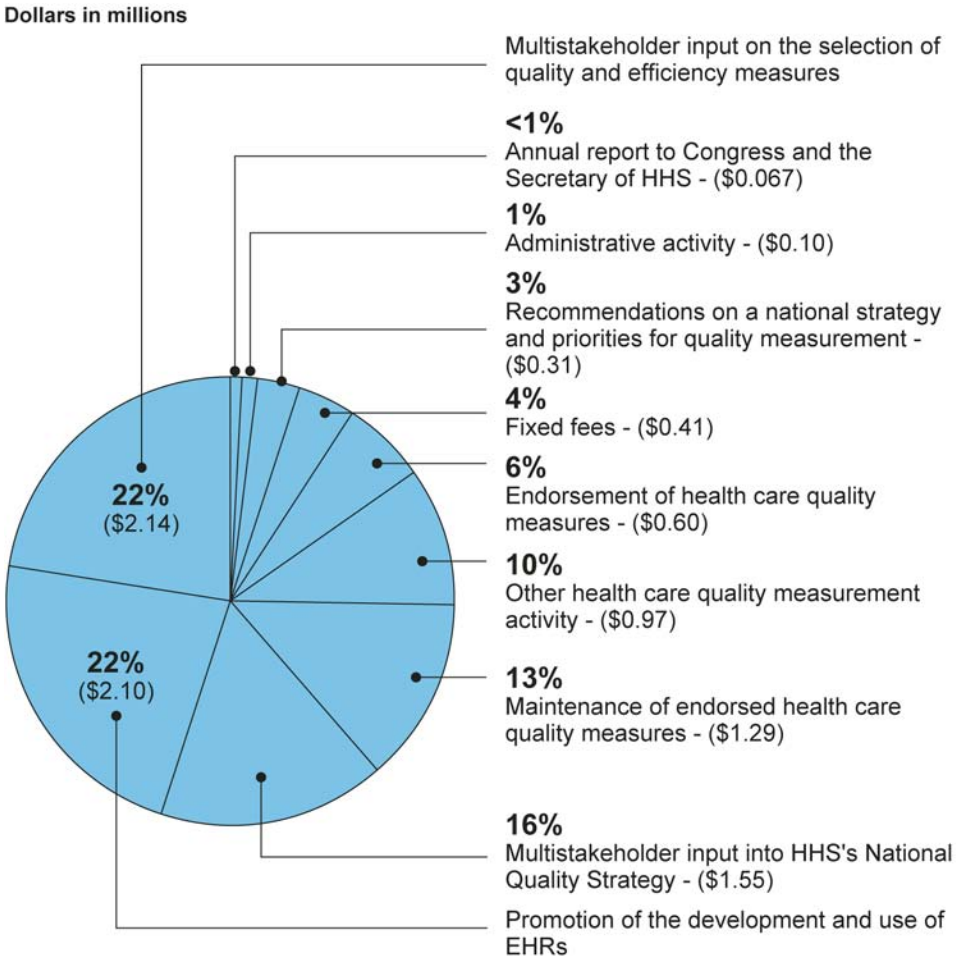


Source: GAO analysis of NQF data.
Note: The figure describes eight of the nine contract activities we reviewed.

For the part of the third contract year covered in our review—January 14, 2011, through August 31, 2011—almost one-half of NQF's reported costs were for the activity to promote the development and use of EHRs and for the activity to provide multistakeholder input on the selection of quality and efficiency measures. Each of these activities accounted for 22 percent, or about $2.1 million of NQF's reported costs. Other costs reported by NQF include those for the activity related to providing multistakeholder input into HHS's annual National Quality Strategy ($1.55 million, or 16 percent) and those for the activity related to the maintenance of endorsed quality measures activity (13 percent, or

$1.29 million). Figure 4 illustrates the costs and fixed fees NQF reported for the part of the third contract year covered in our review for each of the nine contract activities we reviewed.

Figure 4: NQF's Reported Contract Activity Costs and Fixed Fees Totaling Approximately $9.6 Million during the Period of the Third Contract Year Covered in Our Review (Jan. 14, 2011—Aug. 31, 2011)



Source: GAO analysis of NQF data.

According to HHS, as of August 2011, about $55.2 million remains available for the NQF contract.[59] About $15.1 million in MIPPA funding remains available for work to be conducted through January 13, 2013. In addition, HHS plans to obligate approximately $40.1 million of its PPACA funding through 2014 for NQF's activities related to health care quality measurement in response to PPACA.[60]

HHS Used or Planned to Use Some NQF Measures Received under the Contract but Has Not Comprehensively Planned for Other Measurement Needs to Implement PPACA

For its various programs or initiatives, HHS has used or planned to use about one-half of the quality measures that NQF has endorsed, maintained, or retooled under the contract, as of August 31, 2011, and HHS officials expect to evaluate if and how the remaining measures will be used. However, HHS has not comprehensively determined how it will use NQF's work under the contract to implement PPACA requirements related to quality measures.

[59]As of August 2011, NQF had reported costs and fixed fees totaling $28.9 million since the contract was awarded in January 2009. Specifically in our July 2010 report, we highlighted that NQF reported costs and fixed fees totaling approximately $6.5 million for the first contract year—January 14, 2009, to January 13, 2010. In addition, NQF had reported about $22.4 million in costs and fixed fees from January 14, 2010, through August 31, 2011—our reporting period that covers the second and part of the third contract years. See GAO-10-737.

[60]From January 14, 2011, through August 31, 2011, NQF reported about $4 million in costs and fixed fees for PPACA-required activities. HHS officials told us that they plan to obligate $10 million of the PPACA funding for health care quality measurement each fiscal year from 2011 through 2014. Therefore, at least $40 million in PPACA funding is expected to be available to NQF under the contract. HHS officials said that because PPACA does not specify the proportion of the $100 million for NQF's and HHS's health care quality measurement work for NQF, they determined that $10 million per year was a reasonable amount.

HHS Has Used or Planned to Use 164 of the 344 Measures That NQF Has Endorsed, Maintained, or Retooled under the Contract

According to HHS officials, HHS has used or planned to use[61] about one-half (164) of the 344 health care quality measures it has received from NQF through various endorsement, maintenance, and retooling projects under the contract, as of August 31, 2011.[62] For example, of the 164 measures used or planned for use, 44 were used in CMS's Medicare and Medicaid EHR Incentive Program after being retooled—that is, converted to an electronic format that is compatible with EHRs—under the NQF contract.[63] Although these 44 retooled measures were used in the EHR Incentive Program, HHS officials stated that NQF and HHS detected coding and other errors in the versions of the 44 retooled measures that were published in the program's final rule in July 2010 that required NQF to make corrections to them after publication of the final rule. NQF did not submit the revised versions of the 44 retooled measures published in the final rule to HHS until December 2010. HHS officials stated that because the final rule had already been published prior to receiving the final

[61]For the purpose of this report, we defined a measure as used if the measure was identified by HHS and included in an HHS program or initiative as of August 31, 2011, and indicated as such by a final rule or other HHS documentation. We defined a measure as planned for use if the measure was identified by HHS for potential use in an HHS program or initiative as of August 31, 2011, and indicated as such by a proposed rule or other HHS documentation.

[62]Measures that are endorsed, maintained, and retooled under the NQF contract are counted separately, even if they are the same measure. Therefore, the 344 measures HHS has received from NQF do not represent 344 distinct measures. For example, a measure that had been maintained under the contract and later retooled would be counted as two separate measures. Therefore, the measure would appear twice in our count of the total number of measures received from NQF—once as a maintained measure and then separately as a measure that was retooled. Similarly, the measure would also be counted as two separate measures for purposes of determining the number used or planned for use. If both versions of the measure were used or planned for use in HHS programs or initiatives, then it would also appear twice in our count of measures used or planned for use.

[63]See 75 Fed. Reg. 44,314 (July 28, 2010). The Medicare and Medicaid EHR Incentive programs will provide incentive payments to eligible Medicare and Medicaid professionals and hospitals that adopt and use health information technology, and reduce payments for those Medicare professionals or hospitals that do not. The Medicare and Medicaid EHR programs are divided into three stages. Stage I, which is underway, focuses on establishing the functionalities in certified EHR technology that will allow for continuous quality improvement and ease of information exchange. Stages II and III will potentially become more stringent as the capabilities of health information technology infrastructure increase. In 2011, part of the requirement for Stage I of the Medicare EHR Program is that eligible professionals attest that they have met the program's reporting requirements, which includes that they report on a certain number of measures that were retooled by NQF.

formatted measures, CMS listed general guidance on its website to address the errors. HHS officials told us that these 44 measures are being used but have not yet been tested to assess the feasibility of implementing them in the electronic format.[64] Until the testing is complete, HHS runs the risk that some of these measures may not work as intended when implemented in electronic format for performance measurement. As a result, the agency does not have reasonable assurance that the retooled versions of the measures will correctly capture information from EHRs. In addition to the 44 retooled measures used in the EHR Incentive Program, HHS also has used or planned to use 120 measures that it received from endorsement and maintenance projects under the NQF contract for various HHS programs and initiatives. (See table 2 for details on specific programs in which HHS has used or planned to use health care quality measures received from NQF under the contract.)

[64]HHS officials said that the 44 measures are not included as part of the scope of work under the two contracts under which feasibility testing of the retooled measures will be performed.

Table 2: Status of Measures Used or Planned for Use under the NQF Contract, as of August 31, 2011

Projects	Total measures received from NQF under the contract	Measures used or planned for use by HHS	Description of HHS programs and initiatives for which NQF measures are being used or planned for use
Promote the development and use of electronic health records			
Measure retooling	113	44	Forty-four measures have been used in Stage I of the Electronic Health Records (EHR) Incentive Program.[a]
Total retooled measures	**113**	**44**	
Endorse health care quality measures			
Patient outcomes	38	6	Six measures are planned for use in various programs including the Hospital Inpatient Quality Reporting Program.[b]
Patient safety	1	0	No measures used or planned for use.
Nursing homes	21	17	Seventeen measures are planned for use in various programs including Nursing Home Compare.[c]
Child health quality	41	8	Eight measures have been used in CMS Medicaid Programs as part of CMS's Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) Initial Core Set of Children's Health Care Quality Measures.[d]
Total endorsed measures	**101**	**31**	
Maintain previously endorsed health care quality measures[e]			
3-Year maintenance review cycle[f]			
Diabetes	13	10	Twenty-three measures have been used or are planned for use in various programs and initiatives including the Physician Quality Reporting System[g] and the Hospital Outpatient Quality Reporting Program.[h]
Mental health	11	3	
Musculoskeletal conditions	17	10	
Other maintenance review processes			
Ad hoc review	3	2	Two measures have been used or are planned for use in various programs, including the EHR Incentive Program and the Hospital Inpatient Quality Reporting Program.
Time-limited review	80	63	Sixty-three measures have been used or are planned for use in various programs and initiatives, including the EHR Incentive Program and the Physician Quality Reporting System.
Total maintained measures	**124**	**88**	

Projects	Total measures received from NQF under the contract	Measures used or planned for use by HHS	Description of HHS programs and initiatives for which NQF measures are being used or planned for use
Other health care quality measurement activity			
Imaging efficiency measures	6	1	One measure is planned for use in the Hospital Outpatient Quality Reporting Program.
Total measures from other quality measurement activity	**6**	**1**	
Total measures	**344**	**164**	

Source: GAO analysis of final rules, proposed rules, and other HHS documentation.

Note: Measures that are endorsed, maintained, and retooled under the NQF contract are counted separately, even if they are the same measure. Therefore, the 344 measures HHS has received from NQF do not represent 344 distinct measures. For example, a measure that had been maintained under the contract and later retooled would be counted as two separate measures. Therefore, the measure would appear twice in our count of the total number of measures received from NQF—once as a maintained measure and then separately as a measure that was retooled. Similarly, the measure would also be counted as two separate measures for purposes of determining the number used or planned for use. If both versions of the measure were used or planned for use in HHS programs or initiatives, then it would also appear twice in our count of measures used or planned for use.

[a]The EHR Incentive Program provides incentive payments to eligible Medicare and Medicaid providers that adopt and use health information technology (IT) and reduces payments for those Medicare professionals or hospitals that do not.

[b]The Hospital Inpatient Quality Reporting program provides hospitals a financial incentive to report the quality of their services as well as provides CMS data to help consumers make more informed decisions about their health care.

[c]Nursing Home Compare is a tool of the Nursing Home Quality Initiative that allows consumers, providers, states, and researchers to compare information on health quality measures among various nursing homes.

[d]CMS's CHIPRA Initial Core Set of Children's Health Care Quality Measures identifies an initial core set of child health quality measures for voluntary use by state Medicaid and Children's Health Insurance Program (CHIP) programs to evaluate the quality of care and health outcomes in children enrolled in Medicaid and CHIP programs.

[e]NQF can also maintain measures through its (1) annual updates, (2) ad hoc requests, and (3) time-limited endorsement review processes. NQF officials told us that as of August 2011, 83 measures have been maintained using these processes, including 80 under time-limited review and 3 under ad hoc request.

[f]NQF officials told us the review of the diabetes, mental health, and musculoskeletal measures were maintained under its previous 3-year maintenance review process because the project began in September 2009, which is prior to the updated process that took effect in August 2010.

[g]The Physician Quality Reporting System provides an incentive payment to eligible professionals who select among 240 measures to report.

[h]CMS's Hospital Outpatient Quality Reporting is a pay-for-performance program for outpatient hospital services.

HHS officials told us that they expect to evaluate if and how they could use all of the remaining 180 of the 344 quality measures that were endorsed, maintained, or retooled under the NQF contract that are not currently in use or planned for use in HHS programs or initiatives. According to HHS officials, any measure developer can submit a measure to be considered for NQF endorsement. Therefore, all the measures

received under the contract may not be applicable to a particular HHS health care quality program or initiative. HHS officials told us that they will review the remaining 180 measures to determine if they are applicable to their health care quality programs or initiatives. The officials expect that many of these measures will be used in HHS programs or initiatives required by PPACA. For example, HHS officials told us that they will consider implementation of most of the retooled measures in future stages of the EHR Incentive Program. In addition, PPACA directed HHS to establish a hospital value-based purchasing program, as well as to make plans or begin pilot programs for value-based purchasing in other settings of care. The hospital value-based purchasing program will use various quality measures and depend on the information collected on them to determine payments to providers. PPACA also required the development of no less than 10 provider-level outcome measures for hospitals and physicians by March 2012. Further, PPACA directed HHS to identify quality measures that could be used to evaluate hospice programs and publish these measures by October 1, 2012. HHS officials told us that they are in the process of determining whether or to what extent the remaining 180 measures HHS has received under the NQF contract can be used to address the new measurement needs and priorities established by PPACA. HHS officials told us that they prefer to use NQF-endorsed measures to meet HHS's measurement needs because these quality measures are nationally recognized standards and in some cases HHS is required to use them.[65]

[65]See, e.g., Pub. L. No. 111-148, § 3004(a), 124 Stat. 119, 368 (2010) (codified as amended at 42 U.S.C. § 1395ww(m)(5)) (directing HHS to publish measures for long-term care hospitals and requiring the department to consider measures endorsed by NQF). For specific areas for which NQF has not endorsed feasible and practical measures, HHS may specify measures that have not been endorsed by NQF as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization.

HHS Does Not Have a Comprehensive Plan for Determining How It Will Use NQF's Work under the Contract to Implement PPACA Requirements Related to Quality Measurement

Although HHS has taken steps to determine how it can use the measures received under the contract with NQF, the agency does not have a comprehensive plan for determining how it will use the remainder of the work conducted under NQF's contract to implement PPACA requirements, including plans for additional quality measures that need to be endorsed during the remaining contract years. HHS officials told us that HHS determines on an annual basis which activities—including work on quality measures—NQF is to perform under the contract through the interagency workgroup. The workgroup is comprised of representatives from various HHS agencies and allows them to provide input on their needs, including quality measures that need endorsement from NQF, for their respective programs. However, HHS officials told us that each HHS program assesses its quality measurement needs separately and provides varying levels of detail about its needs. Therefore, it is unclear the extent to which all programs consistently incorporate PPACA's quality measurement requirements and deadlines into these assessments. The NPP's September 2011 report noted the importance of greater alignment of national quality measurement efforts, including the establishment of a comprehensive measurement strategy that identifies core measure sets, among other things. In addition, the report noted that all federal programs should work toward the establishment of a common platform for measurement and reporting. Without a comprehensive plan that delineates HHS's quality measurement needs, and given that each program assesses its quality measurement needs separately, the interagency workgroup may not be able to systematically ensure that all of HHS's quality measurement needs that implement PPACA requirements align with the selection and prioritization of activities for NQF to complete under the contract.

While HHS has begun various efforts to assess its quality measurement needs, the lack of a plan that comprehensively determines the impact of PPACA on its needs could affect the agency's progress on its quality measurement efforts as well as how it selects and prioritizes NQF's contract activities. Officials told us that prior to PPACA's enactment, CMS maintained a 5-year plan that listed its measurement needs based on agency priorities and the priorities established by the NPP for some of its

programs.[66] However, officials told us that they have not updated this list to reflect the requirements related to quality measurement and time frames established by PPACA. In March 2011, HHS published the National Quality Strategy as required by PPACA, which included six priority areas of focus. The report was required by PPACA to include agency-specific plans, goals, benchmarks, and standardized quality metrics for each priority area, but did not do so. HHS officials stated that this document describes HHS's initial plan for these elements and that they may be included in future versions of the strategy. In June 2011, HHS officials told us that they plan to convene a Quality Measurement Task Force within CMS with a goal to comprehensively align, coordinate, and approve the development, maintenance, and implementation of health care quality measures for use in various CMS programs. As of August 2011, the task force was in an early stage of development, and therefore it is too early to determine whether it will accomplish its goal. Although these various HHS efforts are key steps toward helping the agency meet its quality measurement needs, they are not guided by a comprehensive plan that synthesizes key priority areas identified in various sources, such as those reported by the NPP or in the National Quality Strategy, for which measures may be needed. Without such a plan, HHS may be limited in its efforts to prioritize which specific measures it needs to develop and have endorsed by NQF for its health care quality programs and initiatives established by PPACA. As a result, HHS may be unable to ensure that the agency receives the quality measures needed to meet PPACA requirements and specified time frames related to quality measurement.

Conclusions

Health care quality measures are increasingly important to HHS as it uses and will continue to use them in its existing and forthcoming programs and initiatives to evaluate health care delivery. For example, HHS's value-based purchasing programs are pay-for-performance programs that will

[66]The NPP identified six priorities in a November 2008 report: (1) patient and family engagement, (2) population health, (3) patient safety, (4) care coordination, (5) palliative and end-of-life care, and (6) elimination of overuse. In its October 2010 report to HHS, the NPP identified two additional priority areas: equitable access to ensure that all patients have access to affordable, timely, and high-quality care; and infrastructure supports, such as health information technology (IT), to address underlying system changes necessary to attain the goals of the other priority areas. See National Priorities Partnership, *Input To The Secretary Of Health And Human Services On Priorities For The 2011 National Quality Strategy* (Washington, D.C.: 2010).

require providers to collect and report information on health care quality measures and adjust payment levels based on providers' performance against the measures. PPACA has increased HHS's quality measurement needs, and the time frames specified in the law have also increased the urgency of obtaining endorsed quality measures—which are nationally recognized standards and in some cases are required by statute—to meet these needs. Given that NQF is the entity in the United States with lead responsibility for endorsing health care quality measures, NQF's endorsement activities under the contract are of key importance to help meet HHS's quality measurement needs.

However, NQF's endorsement process takes time. For more than half of the projects, including all five projects in the endorsement activity, NQF did not meet or did not expect to meet the initial time frames approved by HHS. In addition, projects under three of the contract activities have exceeded initial cost estimates, which resulted in HHS's modification of NQF's scope of work in some instances to help ensure that NQF's costs did not exceed the funding allocated for the contract activities. While HHS received information in monthly progress reports to help monitor NQF's performance under the contract, the agency did not use all of the monitoring tools required under the contract to help address issues related to time lines and cost estimates. These monitoring tools included an annual performance evaluation that could help HHS officials consider potential issues related to NQF's time frames and cost estimates when planning work for the next year and a financial graph to be included in NQF's monthly progress reports. The graph would have compared reported costs to initial cost estimates, which is something that monthly progress reports do not do. Although HHS officials reported that they recently began in August 2011 to enforce the contractual requirement for NQF to submit the graph, they have not implemented the required annual performance evaluation. By not taking advantage of these tools, HHS runs the risk of not having detailed and timely information that could help identify instances in which NQF might be at risk of not meeting time frames or exceeding estimated costs. Identifying such instances could provide an opportunity for HHS to make any appropriate changes to NQF's scope of work, including setting priorities to ensure that HHS receives the quality measures it needs in a timely manner.

With the time remaining under the contract, HHS has an opportunity to ensure that the work performed under NQF's contract better meets the agency's needs for its programs and initiatives. However, HHS has not developed a plan that comprehensively identifies its quality measurement needs for its programs and initiatives in light of PPACA's requirements or

determines how it will use the work conducted during the remaining years of the NQF contract to help it meet these needs. In addition, critical tasks may need to be completed outside of the NQF contract. For example, HHS requested that NQF retool 113 measures under the contract and used 44 of the 113 measures that included errors in its EHR Incentive Program. As of November 2011, feasibility testing related to implementation of the retooled measures had not been completed, and HHS expected to perform this work outside of the NQF contract. Until the testing is completed, HHS runs the risk that some of the retooled measures may not work as intended when implemented in electronic format for performance measurement, which is a concern because use of these measures is an important component of HHS's long-term goal for providers to use health information technology (IT) to exchange information and improve the quality of care.

Without a comprehensive plan, HHS lacks assurance that its selection of the work to be performed by NQF—and the approximately $55.2 million that the agency expects to spend for remaining work under the NQF contract—will be prioritized in the most effective way possible. Given that PPACA includes time frames for the implementation of quality measurement programs, NQF's pace in completing some of the work under the contract—particularly the endorsement activity—raises concerns. If the endorsement projects continue to require extended completion times, HHS runs the risk of not having all the endorsed measures it needs for implementing its programs and initiatives. Should this occur, HHS may need to select nonendorsed measures for its programs and initiatives that have not undergone an objective and transparent review by NQF.

Recommendations for Executive Action

To help ensure that HHS receives the quality measures it needs to effectively implement its quality measurement programs and initiatives within required time frames, we recommend that the Secretary of HHS take the following three actions:

- use monitoring tools required under the NQF contract to obtain detailed and timely information on NQF's performance and use that information to inform any appropriate changes to time frames, projects, and cost estimates for the remaining contract years;
- ensure that testing of the electronic versions of the measures retooled by NQF that are being used or are planned for use in the Medicare and Medicaid EHR Incentive programs is completed in a timely

manner to help identify potential errors and address issues of implementation; and

- develop a comprehensive plan that identifies the quality measurement needs of HHS programs and initiatives, including PPACA requirements, and provides a strategy for using the work NQF performs under the contract to help meet these needs.

Agency and Other External Comments and Our Evaluation

We provided a draft of this report to HHS and NQF for review and comment. HHS neither agreed nor disagreed with our recommendations and provided general comments. NQF concurred with many of the findings in the report and provided clarification and additional context on the findings and recommendations. HHS and NQF's letters conveying their comments are reproduced in appendixes V and VI, respectively. In addition to the overall comments discussed below, we received technical comments from HHS and NQF, which we incorporated into our report as appropriate.

HHS Comments

HHS's comments included separate general comments from CMS and ASPE that provided context on aspects of our findings and recommendations. CMS's comments stated that the draft report suggests that CMS must use all of the measures endorsed by NQF, and noted that not all NQF-endorsed measures are suitable for HHS quality reporting and public reporting programs. Although our draft report did not state that CMS must use all of the measures endorsed by NQF, we modified it to note specifically, among other things, that all measures received under the contract may not be applicable to a particular HHS health care quality program or initiative. CMS also stated that the report suggests that CMS has not developed measurement plans for various provisions of PPACA related to quality reporting, public reporting, and value-based purchasing programs. CMS provided additional context for current planning efforts to address these requirements, including its Quality Measurement Task Force. The draft report acknowledged this and other CMS planning efforts to address the health care quality requirements contained in PPACA and noted that, as of August 2011, this initiative was just beginning. Further, while various efforts are underway and CMS's comments state that it has documented how quality measures will be used to address all relevant provisions of PPACA, CMS has not provided documentation of comprehensive plans to address PPACA requirements that include alignment across programs, detailed time frames to meet PPACA deadlines, or how it will use the NQF contract to help ensure that it receives the endorsed measures it needs to meet these requirements.

ASPE's comments noted, with respect to our first recommendation, that HHS used all except two of the monitoring tools called for in the contract. As noted in the draft report, HHS began receiving the monthly financial graph—one of the two monitoring tools—from NQF in August 2011. Also, ASPE noted its plans to update its performance evaluation system with NQF performance information for the first 2 contract years—the period January 14, 2009, through January 13, 2011—and to complete a final performance evaluation at the end of the contract in January 2013, which is the end of the fourth contract year. It did not indicate any plans to conduct the annual performance evaluation for the third contract year—January 14, 2011, through January 13, 2012—which would be consistent with the contract's requirements. With respect to our second recommendation, ASPE provided technical comments and also told us that CMS issued a contract solicitation to test the retooled measures, but CMS did not receive any bids. Instead, ASPE noted in its comments that two of CMS's current contractors will conduct feasibility testing on 69 of the 113 retooled measures that are planned for use in HHS's EHR Incentive programs. CMS does not plan to issue a solicitation for a new contract to test the feasibility of the remaining 44 retooled measures, which are currently being used in HHS's EHR Incentive Program. We noted these comments in the report. Regarding our third recommendation, ASPE stated that the measures that are not currently in "use" are being evaluated by HHS and that any conclusions that they will not be used are not accurate. Our draft report provided information on which measures were used or planned for use as of August 2011, and indicated that the remaining measures may be used in the future. Specifically, the report noted that HHS officials expect that many of these measures will be used in HHS programs or initiatives, and that HHS officials told us that they will review all the measures received under the contract to determine if they are applicable to their health care quality programs or initiatives. ASPE's comments also noted that our draft report did not include information on all NQF-endorsed measures used by the various agencies within HHS. As noted in the draft report, we relied on HHS to identify programs and initiatives across HHS that use or plan to use these health care quality measures and recognize that those included in our report may not represent a comprehensive list of all health care quality programs and initiatives. As we recommended in our report, having a comprehensive plan could help HHS identify programs or initiatives that use or plan to use health care quality measures, including those endorsed by NQF.

NQF Comments

NQF's comments state that it is providing its services to HHS under a cost reimbursement contract, which is used in circumstances where aspects of performance, such as time frames, cost estimates, and scope of work, cannot be reasonably estimated, and therefore, should not be expected. As noted in the draft report, the contract type used for this work is used for efforts such as research, design, or study efforts where costs and technical uncertainties exist and it is desirable to retain as much flexibility as possible in order to accommodate change. However, the draft report also noted that this type of contract provides only a minimum incentive to the contractor to control costs. Given the risk associated with this type of contract, the fact that NQF has not met expected time frames on about half of its projects as of August 2011, and that NQF exceeded its initial cost estimates for some of its projects under its contract activities, it is especially important that HHS obtain detailed and timely information on NQF's performance and use that information to inform any appropriate changes to time frames, projects, and cost estimates for the remaining contract years, as noted in our recommendations. NQF's comments also state that time frames and costs for the work performed under the contract were initial estimates based on an early understanding of the work, that HHS and NQF understood that there would likely be changes to them as a result of the complexity and novelty of the work, and that they have worked collaboratively throughout the contract period to address these and other factors. As noted in the draft report, the final work plans, the technical proposal, and other documents that we reviewed included initial time frames for all projects and costs for the work performed during the contract year that were approved by HHS in collaboration with NQF. The draft report also notes several examples of reasons why the time frames and costs were modified over time. Contributing factors include the high volume of measures submitted, changes to the scope of work, and the novelty and complexity of the work.

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 website 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. 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 VII.

Linda T. Kohn
Director, Health Care

List of Committees

The Honorable Max Baucus
Chairman
The Honorable Orrin G. Hatch
Ranking Member
Committee on Finance
United States Senate

The Honorable Tom Harkin
Chairman
The Honorable Michael B. Enzi
Ranking Member
Committee on Health, Education, Labor, and Pensions
United States Senate

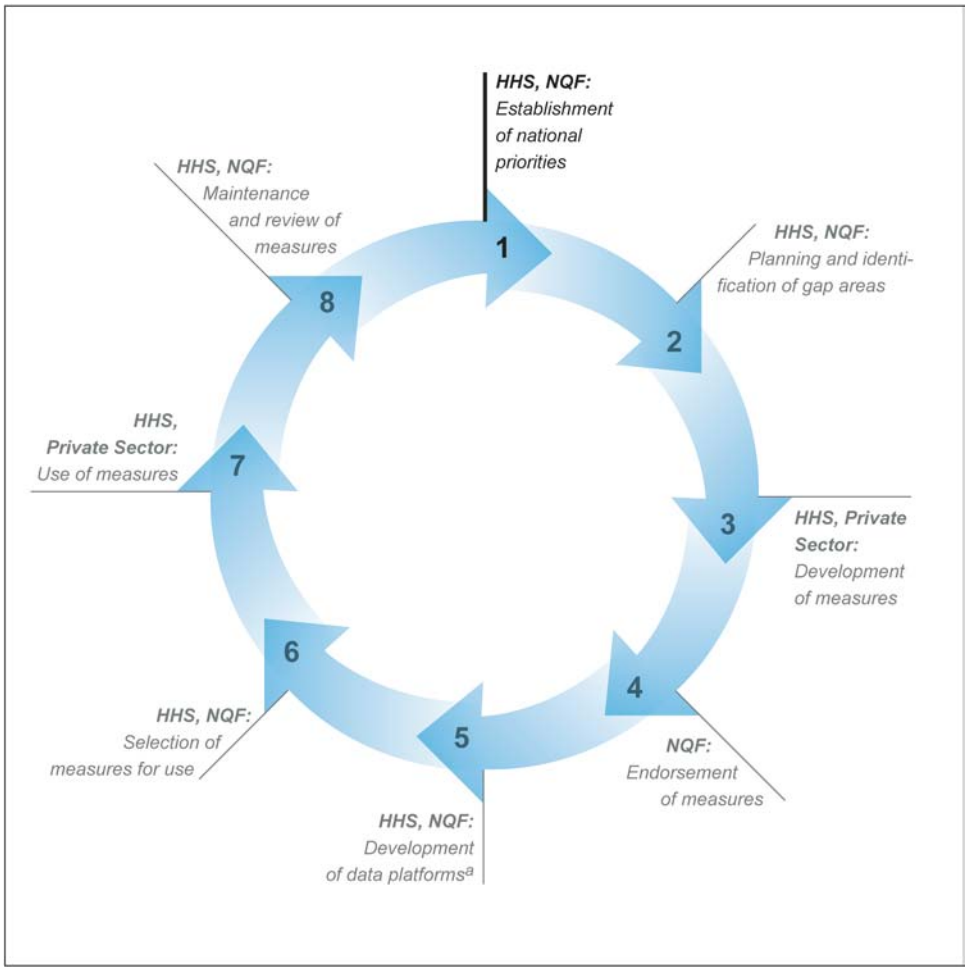
The Honorable Fred Upton
Chairman
The Honorable Henry A. Waxman
Ranking Member
Committee on Energy and Commerce
House of Representatives

The Honorable David Camp
Chairman
The Honorable Sander M. Levin
Ranking Member
Committee on Ways and Means
House of Representatives

Appendix I: Health Care Quality Measurement Framework

Figure 5 illustrates a health care quality measurement framework of the various stages that a quality measure will go through, as described by the Department of Health and Human Services (HHS) and National Quality Forum (NQF) officials and others. These stages include measure development, endorsement, selection, and use, among others. This framework also shows examples of which entities, including HHS and NQF, are involved in each of the stages.

Figure 5: Health Care Quality Measurement Framework



Source: GAO analysis of NQF, HHS, and Congressional Research Service data.

[a]NQF officials told us that the development of data platforms allows measure developers to create quality measures directly in an electronic format as well as retool—that is, convert measures from a paper-based format to an electronic format. For example, NQF's work to create a measure authoring tool provides measure developers with a tool to create standardized electronic measures that help capture information in electronic health records. NQF officials told us development of data platforms, such as through the use of the measure authoring tool, is increasingly important as NQF will begin to require that measure developers include electronic specifications in quality measures beginning in May 2012.

HHS's Role in Planning and Identifying Gap Areas

As an example of actions taken during the second stage of this quality measurement framework, HHS officials described two different processes used for planning and identifying gap areas.

The Centers for Medicare & Medicaid Services (CMS) Office of Clinical Standards and Quality[1] has developed a standardized approach to identify quality measures that it uses in its health quality initiatives and programs using CMS's Measures Management System.[2] The Measures Management System requires the convening of a technical expert panel in the initial planning stage.[3] Once convened, the technical expert panel is expected to work with measure developers who will gather information that will help the panel determine whether measures need to be developed for a program or initiative. During this stage, measure developers may conduct environmental scans or literature reviews, to determine the existence of measures that could be used for a program or initiative. If a measure does not exist, then the developer will work with CMS to develop the needed measures for the program or initiative, including measure testing. Upon development of the measures, the technical expert panel will evaluate them based on (1) importance to making significant gains in health care quality and improving health outcomes, (2) scientific acceptability of the measure properties including tests of reliability and validity, (3) usability, and (4) feasibility. Measures recommended by the panel are generally submitted for NQF endorsement.

In contrast, CMS's Center for Medicaid, Children's Health Insurance Program (CHIP), and Survey & Certification Office—the CMS center which implements CHIP—uses a measure identification process that relies on existing measures rather than development of new measures, according to officials. This office worked with a technical advisory group,

[1]CMS is an agency within HHS.

[2]The Measures Management System is used by divisions within CMS and provides guidance to CMS-contracted measure developers on the development and maintenance of measures. It was developed to help CMS manage an ever-increasing demand for quality measures to use in its various public reporting and quality programs as well as in value-based purchasing initiatives.

[3]The technical expert panel consists of a group of recognized experts in relevant fields including clinicians, statisticians, quality improvement experts, methodologists, and pertinent measure developers who are recruited to provide input on the measure under development by the contract.

the Subcommittee on Children's Healthcare Quality Measures for Medicaid and CHIP, to recommend an initial core set of measures for the CHIP. With assistance from CMS, the subcommittee evaluated measures based on importance, validity, and feasibility. CMS officials told us that they considered existing NQF-endorsed and non-NQF-endorsed measures based on the measurement needs of the program, and relied on measure testing conducted by the measure developers. Officials stated that they have also relied on the subcommittee to evaluate candidate measures for Medicaid child health programs. Officials said that they are not required to submit measures that will be used for Medicaid programs for NQF endorsement.

Appendix II: How GAO Categorized NQF's 16 Tasks under the Contract into Nine Contract Activities

From January 14, 2010, through August 31, 2011, the National Quality Forum's (NQF) contract with the Department of Health and Human Services (HHS) included 16 tasks that NQF is required to perform. For purposes of our work, we categorized these tasks into nine contract activities. Specifically, in certain cases, we grouped activities that covered related areas of work into a single contract activity. For example, we consolidated the six administrative activities NQF is required to perform into a single contract activity. (See table 3 that shows how we consolidated these contract activities.)

NQF was required to perform specific projects under the nine contract activities we identified. For example, under the endorsement contract activity, NQF was required to complete an endorsement project related to patient outcome measures. For purposes of our work, we identified and reviewed 63 projects NQF is required to perform under the nine contract activities, as shown in appendix III.

Table 3: GAO's Categorization of the NQF Contract's 16 Tasks into Nine Activities

NQF contract's 16 tasks[a]	Nine contract activities categorized by GAO
1. Opening meeting between HHS and NQF	1. Administrative activity[b]
2. Development of the annual work plan	
3. Quality assurance (development of an internal evaluation plan and monthly call to discuss the plan)	
4. Weekly conference calls	
5. Monthly progress reports	
6. Develop public website for project documents[c]	
7. Formulation of national strategy and priorities for health care quality measures, as specified by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)	2. Recommendations on a National Strategy and Priorities for Quality Measurement (MIPPA)
8. Implementation of a consensus process for endorsement of health care quality measures (MIPPA)	3. Endorsement of Health Care Quality Measures (MIPPA)
9. Implementation of a consensus process for maintenance of previously endorsed health care quality measures (MIPPA)	4. Maintenance of Endorsed Quality Measures (MIPPA)
10. Promotion of electronic health records (MIPPA)	5. Promotion of the Development and Use of Electronic Health Records (MIPPA)
11. Submission of annual report to Congress and the Secretary of Health and Human Services (MIPPA) 12. Additional Requirements for Annual Report—Measure Gaps and Inadequacies and Input of the Multistakeholder Groups, as specified by the Patient Protection and Affordable Care Act (PPACA)	6. Annual Report to Congress and the Secretary of HHS (MIPPA and PPACA)
13. Focused Measure Development, Harmonization, and Endorsement Efforts to Fill Critical Gaps in Performance Measurement (not specified by MIPPA or PPACA)	7. Other Health Care Quality Measurement Activity Not Identified in MIPPA or PPACA
14. Provision of Input on Priorities for the National Strategy for Quality Improvement in Healthcare (PPACA) 15. Input to the Annual National Quality Strategy (PPACA)	8. Multistakeholder Input into HHS's National Strategy for Quality Improvement in Health Care (as required by PPACA)
16. Selection of Quality Measures for Use in Payment Programs and Value-Based Purchasing Programs under PPACA, Other Private/Public Payers, and Other Programs (PPACA)	9. Multistakeholder Input on the Selection of Quality Measures for use in Payment Programs and Value-Based Purchasing Programs Under PPACA, Other Private/Public Payers, and Other Programs (as required by PPACA)

Source: GAO analysis of MIPPA, PPACA, the NQF contract, the 2010 and 2011 final MIPPA work plans, and the 2011 PPACA technical proposal.

[a]The numbering of the 16 tasks, or contract activities, does not reflect the numbering used under the NQF contract with HHS.

[b]A number of activities NQF performs under the HHS contract are administrative and are not directly related to NQF's work on health care quality measurement. Rather, these activities focus on project planning and contract management efforts.

[c]Development of a public website was part of the 2010 final annual work plan but this work was canceled in 2011.

Appendix III: Status of NQF's Nine Contract Activities and the Projects under Each Activity GAO Identified

The tables below provide a status update on the projects that the National Quality Forum (NQF) is required to complete under the nine contract activities we identified (see app. II). The contract activities and the projects under the activities NQF is expected to perform are determined on an annual basis by the Department of Health and Human Services (HHS) and NQF. As a result, the number of projects under the contract activities varies by contract year. For our reporting period—January 2010 through August 2011—we determined that NQF was required to conduct work on 63 projects under the contract activities we reviewed. To determine initial time frames for each project, we calculated the approximate time between expected start and end dates established in NQF's 2009, 2010, and 2011 final annual Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) work plans, the 2011 Patient Protection and Affordable Care Act (PPACA) technical proposal, and other NQF documents. Actual time frames were determined by calculating the approximate time between the actual start date and the actual date of completion. For projects that were not yet complete as of August 2011, we included an expected time frame based on the approximate difference between the actual start date and the expected date of completion. NQF and HHS officials stated that any changes to the initial time frames were approved by HHS.

Table 4: Status of Projects under NQF's Contract Activity to Provide Recommendations on a National Strategy and Priorities for Quality Measurement, as of August 31, 2011

Projects under contract activity to provide recommendations on a national strategy and priorities for quality measurement (MIPPA)	Description of project	Status	Expected time frame (estimated months)	Actual time frame (estimated months)
Formulate national strategies and priorities	Report that prioritizes 20 high-impact Medicare conditions and associated measure gaps.	●	14	15
Evaluation of the uses of NQF-endorsed measures	Report that investigates the use of NQF-endorsed measures.	⊙	9	*exp*. 18
Measurement development and endorsement agenda	Report that sets a national measure development and endorsement agenda.	●	10	10
Measurement framework for multiple chronic conditions	Report that presents an analysis of measures being used to assess quality of care for people with multiple chronic conditions.	⊙	14	*exp*. 13[a]
Advice to the Office of the National Coordinator on meaningful use of measures	Report that analyzes measures targeted for use in the Medicare Electronic Health Record Incentive Program, specifically examining how health information technology (IT) tools can improve the efficiency, quality, and safety of health care delivery.	●	2	2

Source: GAO analysis of NQF's contract with HHS, the 2010 and 2011 final MIPPA annual work plans, and NQF's monthly progress and Internal Evaluation Plan (IEP) reports from January 2010 to August 2011.

Note: Status is defined by the following symbols.

● = Completed ⊙ = In progress *exp*. = expected time frame

[a]The initial time line for this work was June 2010 through August 2011, which is approximately 14 months. However, due to delays in approving the subcontractor NQF engaged to perform the work, the project was not started on time. As a result, the modified time line for the project is April 2011 through May 2012, which represents a delay of approximately 9 months.

Table 5: Status of Projects under NQF's Contract Activity to Endorse Health Care Quality Measures, as of August 31, 2011

Projects under NQF's contract activity to endorse health care quality measures (MIPPA)[a]	Description of project	Status	Expected time frame (estimated months)	Actual time frame (estimated months)
Patient outcomes	Endorsement of health care outcome measures related to 20 high-impact Medicare conditions identified by the Centers for Medicare & Medicaid Services (CMS), and mental health, and child health conditions.	●	14	13-19[b]
Patient safety	Endorsement of patient safety measures and other projects related to patient safety, including a framework for public reporting of patient safety information, endorsement of serious reportable events (SRE), and collaboration with state-based reporting agencies.	⊙	17	23, *exp*. 27[c]
Nursing homes	Endorsement of performance measures for chronic and postacute care nursing facilities.	●	10	17
Evaluation of Consensus Development Process	A comprehensive analysis of NQF's endorsement process by Mathematica Policy Research, Inc., to identify areas of improvement related to timeliness and effectiveness.	●	9[d]	18
Child health quality	Endorsement of measures that could be used in public reporting for certain conditions or cross-cutting areas applicable to the Medicaid population.	⊙	11	*exp*. 16[e]

Source: GAO analysis of NQF's contract with HHS, the 2010 and 2011 final MIPPA annual work plans, and NQF's monthly progress and IEP reports from January 2010 to August 2011.

Note: Status is defined by the following symbols.

● = Completed ⊙ = In progress *exp*. = expected time frame

[a]HHS officials told us that they consider an NQF measure endorsed when the board ratifies the measures. However, NQF is required to submit a final report to HHS following ratification to complete the project. For purposes of our report, we consider the project completed when the board endorses the measures.

[b]The patient outcomes project was conducted in three phases. Phases I and II were initially expected to be completed in 13 months; however, the project was completed in 19 months. NQF officials told us a high volume of measures contributed to the delays. Phase II was initially expected to take 15 months but it took 17 months.

[c]As of August 2011, NQF endorsed one patient safety measure under phase II of the endorsement project and expects to complete this phase in September 2011 following the review of an additional patient safety measure. Phase I is expected to be completed by December 2011.

[d]In the 2009 final work plan, this project was expected to be completed between October 2009 and July 2010, or approximately 9 months. NQF officials stated the delays in completing this work were a result of additional time needed for data collection efforts, among other things.

[e]In August 2011, NQF announced endorsement of 41 out of 44 child health quality measures under the child health quality endorsement project. The remaining 3 measures are still under consideration and are scheduled to be reviewed for endorsement in September 2011.

Table 6: Status of Projects under NQF's Contract Activity to Maintain Previously Endorsed Health Care Quality Measures, as of August 31, 2011

Projects under NQF's contract activity to maintain health care quality measures (MIPPA)[a]	Description of project	Status	Expected time frame (estimated months)	Actual time frame (estimated months)
Updated 3-year endorsement maintenance cycle review process projects (6 projects)	Six maintenance projects using NQF's process that reviews previously endorsed measures across 22 topic areas every 3 years using three measure maintenance cycles.[b] The projects relate to the following conditions: • Cardiovascular • Surgical • Cancer • Pulmonary/critical care • Perinatal • Renal care	⊙	Various[c]	*All ongoing*
3-Year maintenance cycle review prior to updated process (3 projects)	Three maintenance projects conducted under the old NQF maintenance review process related to the following conditions: • Diabetes • Mental health • Musculoskeletal conditions	●	No specific time frame[d]	20
Time-limited endorsement review	Maintenance review of measures that have been granted a time-limited endorsement—measures that require additional testing to be conducted by measure developers within 12 months of endorsement.	⊙	No specific time frame[e]	No specific time frame
Annual measure maintenance update	Review of measures submitted by measure developers to determine whether the measure has undergone any change.	⊙	Various[f]	Ongoing
Ad hoc review	Review of measures that were initiated during the contract year by request and based on justifiable evidence to substantiate the review.	●	n/a	n/a[g]

Source: GAO analysis of NQF's contract with HHS, the 2010 and 2011 final MIPPA annual work plans, and NQF's monthly progress and IEP reports from January 2010 to August 2011.

Note: Status is defined by the following symbols.

● = Completed ⊙ = In progress n/a = no time frame was established

[a]In addition to the 3-Year Maintenance Review cycles, NQF can also maintain measures through (1) annual updates, (2) ad hoc requests, and (3) time-limited endorsement reviews. As of August 2011, NQF has maintained 3 measures under ad hoc requests and 80 measures under time-limited endorsement reviews. NQF officials told us they also began annual updates for 59 measures during our reporting period.

[b]NQF has developed three cycles of review—cycles A, B, and C. Cycle A focuses on measures related to cardiovascular; surgery; prevention; endocrine; GU/GYN; mental health; and musculoskeletal disorders. Cycle B focuses on measures related to cancer; pulmonary/critical care; palliative and end-of-life care; Perinatal; renal; safety; disparities; and care coordination. Cycle C will focus on health care infrastructure; head/eye/ear/nose/throat conditions; infectious disease; neurology; patient experience and engagement; functional status; and gastrointestinal. NQF is expected to complete Cycle A by the end of 2010, Cycle B by the end of 2011, and Cycle C by the end of 2012. As of August 2011, the cardiovascular and surgery measures from Cycle A are still under review.

[c]As of August 2011, NQF was conducting six maintenance projects under its updated 3-year review cycle. The initial and estimated time frames for these projects vary by project. For example, review for phases I and II of the cardiovascular measures is expected to take 15 months and review for phase I of the surgical measures is expected to take 13 months and phase 2 is expected to take 16 months. NQF also initiated the review of renal measures in May 2011 and was initially expected to take 7 months; however, the time line has been extended to 8 months. As of November 2011, NQF has issued a call for measures for Perinatal measures and expects to issue a call for cancer and pulmonary/critical care measures in November 2011 and January 2012, respectively.

[d]NQF officials stated that no estimated time frame for completion was established for these three projects. Although officials stated they anticipated the length of the review to be similar to other NQF projects, they encountered delays that extended the time frame, such as a high volume of measures under review.

[e]NQF officials provided us with a time line for completing time-limited reviews that included an initial start date of January 2011 but did not provide specific expected dates of completion.

[f]NQF officials told us that the annual reviews did not begin until 2011 and are conducted in cycles.

[g]NQF officials told us that there is no time line established for ad hoc reviews because requests for ad hoc reviews will be considered by NQF on a case-by-case basis and can be made at any time.

Table 7: Status of Projects under NQF's Contract Activity to Promote the Development and Use of Electronic Health Records, as of August 31, 2011

Project under NQF's contract activity to promote the development and use of electronic health records (MIPPA)	Description of project	Status	Expected time frame (estimated months)	Actual time frame (estimated months)
Measure authoring tool	Development of a software tool that measure developers will use to create standardized eMeasures.	⊙	15	*exp*. 28
Clinical decision support	Report that provides a framework for Clinical Decision Support rules and key elements for health IT systems to help ensure compatibility and functionality with the Quality Data Model.	●	14	17
eMeasure creation and testing	Establish a uniform standard for electronic measures.	●	13	13
Quality data model	Maintenance and revision of a health IT model that allows data from electronic health records to be collected and used in quality measurement.	⊙	28	*exp*. 28[a]
Health information technology (IT) utilization expert panel	Expert panel convened to examine the information needed to measure effective health IT use.	●	12	14
Initial measure retooling	"Retooling"—that is, converting 113 NQF-endorsed health care quality measures from paper-based format to an eMeasure format.	●	19	22
Update of retooled measures	Publish a list of updated versions of the initial 113 measures under the contract that describes any changes made to the measures, including those identified during public comment and by a review panel.	⊙	10	*exp*. 10
eMeasure syntactical review panel	Expert panel that conducts a thorough review of the retooled measures to help ensure that a measure's intent remains intact for continued NQF endorsement.	⊙	9	15, *exp*. 19[b]

Source: GAO analysis of NQF's contract with HHS, the 2010 and 2011 final MIPPA annual work plans, and NQF's monthly progress and IEP reports from January 2010 to August 2011.

Note: Status is defined by the following symbols.

● = Completed ⊙ = In progress *exp*. = expected time frame

[a]NQF officials told us they anticipate a number of versions will be published annually under the contract to allow for ongoing review and updates. NQF expects to publish an updated version for public use in January 2012.

[b]In June 2011, the review panel completed its review of the 113 retooled measures and expects to publish a report that synthesizes comments on and updates to the measures by October 2011. NQF officials told us that a request by HHS to expand the scope of this work extended the time line by 3 months.

Table 8: Status of Projects under NQF's Contract Activity to Submit an Annual Report to Congress and the Secretary of HHS, as of August 31, 2011

Project under NQF's contract activity to submit an annual report to Congress and the Secretary of HHS (MIPPA and PPACA)	Description of project	Status	Expected time frame (estimated months)	Actual time frame (estimated months)
Report due March 1, 2010	Summary of NQF's progress on activities under the contract during the first contract year (2009).	●	12	12
Report due March 1, 2011	Summary of NQF's progress on activities under the contract during the second contract year (2010).	●	13	12
Report due March 1, 2012	Summary of NQF's progress on activities under the contract, including a report on gaps in endorsed and nonendorsed health care quality measures and a summary of activities conducted by multistakeholder groups during the third contract year (2011).	⊙	13	*exp*. 12

Source: GAO analysis of NQF's contract with HHS, the 2010 and 2011 final MIPPA annual work plans, and NQF's monthly progress and IEP reports from January 2010 to August 2011.

Note: Status is defined by the following symbols.

● = Completed ⊙ = In progress *exp*. = expected time frame

Table 9: Status of Projects under NQF's Contract Activity to Provide Multistakeholder Input into HHS's National Strategy for Quality Improvement in Healthcare, as of August 31, 2011

Project under NQF's contract activity to provide multistakeholder input to HHS's National Quality Strategy (PPACA)	Description of project	Status	Expected time frame (estimated months)	Actual time frame (estimated months)
Recommendations on HHS's National Strategy for Quality Improvement in Healthcare (2010)	Multistakeholder input on national priorities related to improvement in population health and in delivery of health care services that HHS will consider when developing the National Quality Strategy issued in 2011.	●	1	1
Provision of input on priorities for HHS's annual National Quality Strategy	Multistakeholder input on a plan for measuring and improving health and health care with a focus on the six priorities identified in HHS's National Quality Strategy.	⊙	5	*exp*. 6
Provision of input on Partnership for Patients[a]	Quarterly webinars, facilitated by the National Priorities Partnership (NPP), for purposes of gathering input issues related to HHS's Partnership for Patients initiative.	⊙	7	*exp*. 5
Care coordination	A two-phase project that will include an endorsement project related to prioritized gap areas related to care coordination, such as transitions across settings and providers; and (2) two reports that will address issues related to care coordination measures, such as readiness of health information technology systems.	⊙	Phase 1: 6 Phase 2: 13	Phase 1: *exp*. 10 Phase 2: *exp*. 15
Palliative and end-of-life care	Endorsement project for individual and composite measures or cross-cutting measures related to palliative and end-of life care.	⊙	9	*exp*.. 9
Patient safety	Initiative that includes (a) an endorsement project for patient safety complications measures; (b) work related to SRE codification; and (c) development of an integrated strategy for high-profile areas in patient safety.	⊙	(a) 9 or 10, to be determined[b] (b) 7 (c) 6	(a) *exp*.9 (b) *exp*. 8 (c) *exp*. 6
Population health	Endorsement project for (a) preventive services and population health measures and (b) a report that provides information related to key topic areas related to population health, including applicable NQF evaluation criteria.	⊙	(a) 9 (b) 5	(a) *exp*. 9 (b) *exp*. 6
Patient reported outcomes	Two reports—one that addresses issues related to use of patient reported outcomes measures, including methodological issues, and another that discusses information needed to prepare measures for the endorsement process.	⊙	9	*exp*. 9

Source: GAO analysis of NQF's contract with HHS, the 2011 PPACA technical proposal, and NQF's monthly progress and IEP reports from January 2010 to August 2011.

Note: Status is defined by the following symbols.

● = Completed ⊙ = In progress *exp.* = expected time frame

[a]In April 2011, HHS launched the Partnership for Patients, which is a national partnership with the goal to save 60,000 lives by improving patient safety through reduction in preventable injuries, complications, and hospital readmissions over the next 3 years.

[b]NQF officials told us that they expect the time lines for the endorsement project to be extended because the project will be conducted in phases to accommodate additional measures. However, as of August 2011, NQF officials told us they are still finalizing the scope of work for this project, including determining if there will be any impact on the overall time line.

Table 10: Status of Projects under NQF's Contract Activity to Provide Multistakeholder Input on Selection of Quality Measures, as of August 31, 2011

Project under NQF's contract activity to provide multistakeholder input on selection of quality measures (PPACA)	Description of project	Status	Expected time frame (estimated months)	Actual time frame (estimated months)
Multistakeholder prerulemaking input	Multistakeholder input provided annually by the Measure Applications Partnership (MAP) to HHS on the selection of measures to be implemented through the federal rulemaking process for various programs.[a]	⊙	11	*exp*. 11
Measures for use in improvement of quality reporting programs	Multistakeholder input provided to HHS by the MAP to help develop a coordination strategy for performance measurement and identify health care quality measures for use in four quality reporting programs: (a) physicians, (b) postacute care programs under Medicare, (c) PPS-exempt cancer hospitals, and (d) hospice care.	⊙	(a) 7 (b) 11 (c) 15 (d) 15	(a) *exp*. 7 (b) *exp*. 11 (c) *exp*. 15 (d) *exp*. 15
Measures for dual eligible beneficiaries	Multistakeholder input provided to HHS by the MAP on a measurement strategy and potential new health care quality measures that address quality issues identified for dual eligible beneficiaries, such as multiple chronic conditions.	⊙	15	*exp*. 15
Measurement strategy for readmissions and healthcare-acquired conditions (HAC)	Multistakeholder input provided to HHS by the MAP on a coordination strategy for readmission and HAC measurement across public and private payers.	⊙	18	*exp*. 17

Source: GAO analysis of NQF's contract with HHS, the 2011 PPACA technical proposal, and NQF's monthly progress and IEP reports from January 2010 to August 2011.

Note: Status is defined by the following symbols.

⊙ = In progress *exp*. = expected time frame

[a]The MAP will provide input on measures beginning February 1, 2012, based on a list of measures published on December 1 of each year by the Secretary of HHS. The 11 programs included in this prerulemaking input are: hospice, hospital inpatient, hospital outpatient, physicians' offices, cancer hospitals, end-stage renal disease (ESRD) facilities, inpatient rehabilitation facilities, long-term care hospitals, CMS hospital value-based purchasing, psychiatric hospitals, and home health care.

Table 11: Status of Projects under NQF's Other Health Care Quality Measurement Activity Not Identified in MIPPA or PPACA, as of August 31, 2011

Project under NQF's other health care quality measurement contract activity	Description of project	Status	Expected time frame (estimated months)	Actual time frame (estimated months)
Imaging efficiency measures	Endorsement project for imaging efficiency measures because Medicare spends approximately $14 billion annually on outpatient imaging studies.	●	8	15-18[a]
Resource-use measures	Endorsement project for measures to help assess the cost of health care services provided.	⊙	12-14[b]	*exp*.11-14
Resource-use white paper	White paper on resource-use measures that will inform a 2011 endorsement project on this topic.	⊙	9	*exp*. 22
Geographic-level efficiency measurement white paper	White paper on geographic-level efficiency measures that are used for quality measure reporting at the geographic and population level.	- -	canceled (June 2010)	
Harmonization	Report that provides operational guidance related to harmonization to be used in future NQF consensus development projects.	●	9	9[c]
ICD-10 conversion[d]	Report that examines implications of the transition from an HHS code set that is used to classify health care on NQF's measure maintenance process and provides recommendations to assist measure developers and NQF during the transition.	●	11	15
Measure development[e]	Maintenance of subcontracts with eight measure developers to allow for development of critical measures as needed.	○	n/a	
Regionalized emergency medical care services	Identification of existing quality measures and gap areas related to measurement of regionalized emergency care services to inform creation of a framework to guide measure development in this area.	⊙	14	*exp*. 18

Source: GAO analysis of NQF's contract with HHS, the 2010 and 2011 final MIPPA annual work plans, and NQF's monthly progress and IEP reports from January 2010 to August 2011.

Note: Status is defined by the following symbols.

● = Completed ⊙ = In progress ○ = Not started - - = Canceled *exp*. = expected time frame

n/a = no time frame was established

[a]The imaging efficiency measures endorsement project was initially expected to endorse measures by July 2010; however, due to measure harmonization efforts, NQF divided the endorsement review in two phases. The first six measures were endorsed in February 2011. In May 2011, NQF issued a second report announcing endorsement of another measure.

[b]The resource use endorsement project will be conducted in two cycles—cycle 1 is expected to be completed in 11 months and cycle 2 is expected to be completed in 14 months.

[c]The initial time line for completing this project was February 2010 through November 2010; however, the actual time line for completion was from March 2010 through December 2010, which delayed delivery of the report by 1 month.

[d]HHS uses the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code sets to classify health care. In 2013, HHS will transition to the Tenth Revision, or ICD-10-CM/PCS. The ICD-10 update activity aims to help HHS prepare for this transition by examining the impact of the change on measure development and submitting measures for NQF endorsement.

[e]HHS officials stated that HHS has never implemented this project and likely will not do so through the remainder of the contract period.

Table 12: Status of Projects under NQF's Administrative Contract Activity

Project under NQF's administrative contract activity	Description of project	Status	Expected time frame (estimated months)	Actual time frame (estimated months)
Opening meeting with HHS	Meeting between NQF and HHS officials at the beginning of the contract year to review activities to be performed during for the year.	●	*This is a single event held annually*.	
2010 annual work plan	Development of a draft and final work plan that outlines specific activities to be performed during the 2010 contract year.	●	3	4
2011 annual work plan	Development of a draft and final work plan that outlines specific activities to be performed during the 2011 contract year related to NQF's activities funded by MIPPA.	●	5	6
Quality assurance and monthly Internal Evaluation Plan (IEP) reports	Monthly report compiled by NQF that includes process and outcome measures to help monitor NQF's progress under the contract.	●	All completed in reporting period, *ongoing annually*	
Weekly conference call with HHS	Weekly conference call with HHS and NQF to go over projects under each activity.	●	Not all held in reporting period,[a] *ongoing annually*	
Monthly progress report	Monthly report compiled by NQF that includes a summary for each activity and the status of project planning, implementation, management, quality assurance, and evaluation that has occurred during the previous month's contract period.	●	All completed in reporting period, *ongoing annually*[b]	
Public website	Overhaul and maintenance of NQF's website to allow measure developers, members, and the public easier access to relevant documents.	- -	canceled (February 2011)	

Source: GAO analysis of NQF's contract with HHS, the 2010 and 2011 final MIPPA annual work plans, and NQF's monthly progress and IEP reports from January 2010 to August 2011.

Note: Status is defined by the following symbols.

● = Completed - - = Canceled

[a]NQF officials told us that this meeting did not occur each week, as scheduled, because in some instances those involved determined it was unnecessary.

[b]From January 2010 to June 2010, NQF was required to submit its monthly progress reports by the 1st of every month; however, it did not submit these reports until the 15th of the month. In June 2010, HHS modified the due date to the 15th, beginning in July 2010. Since that time, all reports have been submitted on time.

Appendix IV: Summary of Projects to Review the National Quality Forum's Endorsement Process

As part of a project under its contract with the Department of Health and Human Services (HHS), NQF was required to review its endorsement process. To complete this project, the National Quality Forum (NQF) subcontracted with Mathematica Policy Research, Inc. (Mathematica), to conduct a review of NQF's endorsement process, as requested by HHS. HHS officials stated that, given the importance of the endorsement process as part of the health care quality measurement framework, they requested that an objective and thorough review of NQF's endorsement process that focused on timeliness, efficiency, and effectiveness should be conducted. For example, they stated that they were interested in whether there were any efficiencies that could be implemented to shorten the process while maintaining an objective review of the health care quality measures that were evaluated under the process. Mathematica initiated its review of NQF's endorsement process in October 2009 and completed the work in December 2010.

In December 2010, Mathematica submitted a final report to NQF and recommended eight areas where improvements could be made and inefficiencies could be addressed in the endorsement process. In the final report, Mathematica noted that the current process is lengthy and the timeliness of the endorsement projects varies substantially. The report further noted that the length of the endorsement process affects the availability of endorsed measures for end users, such as HHS. To help reduce the time required to complete projects, Mathematica recommended that NQF create a schedule for its endorsement process for measure developers and develop feasible time lines that include clear goals for each endorsement project.

As of May 2011, NQF officials stated that NQF has taken steps or plans to take steps in its future projects to address the eight areas for improvement Mathematica identified. For example, as of May 2011, NQF has solicited measures earlier based on a tentative annual project schedule to reduce the time lines of its endorsement process and reduced the period for voting by NQF member organizations from 30 to 15 days. NQF officials stated that they believe their efforts to implement the recommendations will shorten the time lines for the endorsement projects by 3 to 4 months without compromising the integrity of the endorsement process and measures to be evaluated under the process. HHS officials stated Mathematica's recommendations were valuable because much of the work under the NQF contract needs to be completed in an accelerated time line to help fill critical measurement gaps associated with HHS's health care quality programs and initiatives. They noted that it is too soon to tell the effects of these changes on the

endorsement process, but they plan to monitor implementation of the changes in NQF's 2011 endorsement projects under the contract. In addition, as of September 2011, HHS approved a new project under the contract to identify how the endorsement process can best align with HHS's time frame for needed measures. As part of this project, NQF is expected to work with a consulting group to identify key performance metrics and define milestones and time lines to help streamline its endorsement process.

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

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

DEC 16 2011

Dear Ms. Kohn:

Attached are comments on the U.S. Government Accountability Office's (GAO) draft report entitled, "HEALTH CARE QUALITY MEASUREMENT: HHS Should Address Contractor Performance and Plan for Needed Measures" (GAO 12-136).

The Department appreciates the opportunity to review this report before its publication.

Sincerely,

Jim R. Esquea
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 MEASUREMENT: HHS SHOULD ADDRESS CONTRACTOR PERFORMANCE AND PLAN FOR NEEDED MEASURES" (GAO-12-136)

The Department appreciates the opportunity to review and comment on this draft report.

Centers for Medicare & Medicaid Services (CMS) Response

The draft report suggests that CMS must use all of the measures endorsed by NQF in the various maintenance and Consensus Development Process projects. However, CMS, when considering NQF endorsed measures for implementation, must also consider program requirements, administrative burden, suitability for program implementation, and the resources for data collection. During an NQF open Call for Measures, any measure developer can submit a measure for endorsement. Each developer has their purpose for development and plans for implementation, which may or may not involve HHS quality reporting and public reporting programs. The NQF MAP process will help identify measures that are suitable and pertinent for CMS quality reporting and public reporting programs.

The report also suggests CMS has not developed measure development plans for the various Affordable Care Act (ACA) sections involving quality reporting, public reporting, and value-based purchasing programs. We would like to note that the CMS Quality Measures Task Force has identified measure priorities, current measures implemented, and measures under consideration for future implementation for 23 quality programs. The measures will be reviewed and analyzed by the NQF Measure Applications Partnership (MAP) for multi-stakeholder input (Affordable Care Act section 3014). These measures will be considered for selection in the 2012 Federal Rulemaking process and may be used for future program implementation. During the 2012 Federal Rulemaking process, measures for programs may be finalized for future years and payment determinations.

CMS has analyzed program and measurement needs and has developed plans for each of the ACA sections involving quality reporting and public reporting. For instance, ACA has established 5 new quality reporting programs for Inpatient Rehabilitation Facilities (IRFs), Long-Term Care Hospitals (LTCHs), Hospices, PPS-exempt Cancer Hospitals, and Psychiatric Hospitals. We would like to clarify where we are with these 5 programs: Three of these programs (IRF, LTCH, and Hospice) finalized the first set of measures for the 2014 payment year through the Federal Rulemaking process. Measures have been identified for future program implementation for PPS-exempt Cancer Hospitals and Psychiatric Hospitals, which will be proposed through the Federal Rulemaking process in 2012. CMS continues to track the progress of ACA measure development and implementation activities.

Finally, CMS has undertaken the following processes to identify the initial core set and address measurement development needs within Medicaid and the Children's Health Insurance Program (CHIP):

1

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "HEALTH CARE QUALITY MEASUREMENT: HHS SHOULD ADDRESS CONTRACTOR PERFORMANCE AND PLAN FOR NEEDED MEASURES" (GAO-12-136)

The Children's Health Insurance Reauthorization Act of 2009 (CHIPRA, P.L. 111-3) directed the Secretary of HHS to identify an initial core set of health care quality measures for children in Medicaid/CHIP based on measures currently in use. In 2009, under delegated authority of the Secretary, CMS began collaborating with the Agency for Healthcare Research and Quality (AHRQ) to identify the initial core set. In order to include a wide range of national expertise in identifying measurement priority areas and the initial core set of measures, AHRQ established a Subcommittee of its National Advisory Council (SNAC). The Subcommittee reviewed and evaluated measures from nationally recognized sources, including measures endorsed by the National Quality Forum (NQF). A key priority used in selecting the initial core set measures was whether or not the measure was relevant to the Medicaid/CHIP population. While NQF endorsement signifies that measures have been deemed as meeting certain criteria for scientific soundness, validity and reliability, requiring NQF endorsement would have eliminated inclusion of measures in the initial core set that are relevant for assessing important aspects of care for the Medicaid/CHIP population. In addition to working with AHRQ's Subcommittee of health care experts, CMS also held a listening session to provide State Medicaid and CHIP programs the opportunity to comment on the draft initial core set of quality measures. Additionally, a Federal Quality Work Group comprised of representatives from various Federal agencies reviewed the measures.

Supplementing the initial core measures is the development of the CHIPRA Pediatric Quality Measures Program (PQMP). Working in partnership, AHRQ and CMS awarded grants to seven Centers of Excellence in Pediatric Quality Measures in March 2011, which comprise the PQMP. These Centers of Excellence are charged with refining the initial core set of measures to make them more broadly applicable across types of payers and developing additional quality measures that address dimensions of care, where standardized measures do not currently exist.

Section 2701 of the Affordable Care Act requires the development of a core set of health quality measures for adults eligible for benefits under Medicaid. The statute parallels the requirement under section 1139A of the Act to identify and publish a recommended initial core set of quality measures for children in Medicaid and the Children's Health Insurance Program. CMS used a similar process to identify the initial set of health care quality measures for Medicaid-eligible adults and partnered with AHRQ to collaborate on the identification of the initial core set of health care quality measures for adults. Working through its National Advisory Council for Healthcare Research and Quality which provides advice and recommendations to the Director of AHRQ and to the Secretary of HHS on priorities for a national health services research agenda, AHRQ created a Subcommittee in the fall of 2010 to evaluate candidate measures for the initial core set. The Subcommittee consisted of State Medicaid representatives, health care quality experts, and representatives of health professional organizations and associations, and was charged with considering the health care quality needs of adults (ages 18 and older) enrolled in Medicaid in its recommendation for an initial core set of measures to HHS. The draft list of 51 measures were posted for public comment through a **Federal Register** (75 FR 82397) notice from December 30, 2010 to March 1, 2011.

2

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "HEALTH CARE QUALITY MEASUREMENT: HHS SHOULD ADDRESS CONTRACTOR PERFORMANCE AND PLAN FOR NEEDED MEASURES" (GAO-12-136)

In August 2011, CMS and AHRQ reconvened the Subcommittee to the National Advisory Council to review the public comments, identify measures that ensured comprehensive representation of variables affecting Medicaid-eligible adults, and consider ways to decrease the number of measures in the set. Five criteria were used to evaluate measures: importance; scientific evidence supporting the measure; scientific soundness of the measure; current use in and alignment with existing Federal programs; and feasibility of State reporting.

The initial core set of quality measures for voluntary annual reporting by States, to be published by January 1, 2012, was determined based on recommendations from the AHRQ Subcommittee to the National Advisory Council for Healthcare Research and Quality, as well as public comments, before being finalized by the Secretary. These core set measures will support HHS and its State partners in developing a quality-driven, evidence-based, national system for measuring the quality of health care provided to Medicaid-eligible adults.

Office of the Assistant Secretary for Evaluation and Planning (ASPE) Response

The National Quality Forum (NQF) contract was established to meet two broad objects outlined in the Medicare Improvement for Patients and Providers Act (MIPPA) and expanded by the Patient Protection and Affordable Care Act (ACA). The first was to establish and implement a process to endorse measures of health care performance as a national quality standard for HHS programs. This objective is typical of other work conducted under Federal contract. The second was to develop and implement this process under a contract with a 'consensus-based' entity with expertise in joining public and private stakeholders in decision-making, and to build a consensus to address the current disparate quality improvement efforts across the Nation. This nationwide public-private effort is designed to address national health care priorities and ultimately be the best strategy for quality improvement in Federally-sponsored programs. The implications of the second, less typical objective, is key to understanding the management flexibility required of this contract.

Among the innovative advances toward improving health care under the contract, NQF created the National Priorities Partnership of 48 leading organizations which provided input on national priorities for improvement in population health and delivery of health care services. NQF also undertook a harmonization project to address duplication and overlapping of measures which result from separate quality initiatives that focus on different settings and patient populations; it convened a stakeholder Steering Committee to develop and publish operational guidance for achieving global harmonization in all settings within future NQF consensus development projects. The final report, *Guidance for Measure Harmonization*, was completed in January 2011. A pragmatic and utilitarian example of the multi-stakeholder consensus process undertaken by the NQF is the selection of quality measures for payment programs and value-based purchasing. The challenges of addressing the complex, innovative and ultimately practical projects, required by law, are being successfully met through the multiple perspectives that have been facilitated by the flexible management of the contract.

3

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "HEALTH CARE QUALITY MEASUREMENT: HHS SHOULD ADDRESS CONTRACTOR PERFORMANCE AND PLAN FOR NEEDED MEASURES" (GAO-12-136)

The first issue for which GAO makes a recommendation is: "HHS did not use all monitoring tools required under the NQF contract." With two exceptions, HHS used all of the monitoring tools called for in the contract, and developed an additional tool as well. These tools include: an Internal Evaluation Plan (IEP) and monthly IEP calls between NQF and the Project Officer; weekly conference calls to review current activities; and monthly progress reports. In addition, NQF produced the Annual Reports to Congress, HHS conducted the Secretarial review of the Report and both were published in the Federal Register as required by law within the mandated timeframes. Finally, beginning January 2010, ASPE produced a monthly Gantt chart which depicts the progress of each of the more than 60 tasks required by MIPPA and ACA against its identified timeline. As GAO notes, HHS did not use two of the required monitoring tools: a financial graph and the annual performance evaluation. As acknowledged in the Report, HHS began receiving the monthly financial graph in August 2011. The financial graph plots the actual vs. planned direct costs on each of the active projects.

Effective October 1, 2010, the National Institutes of Health (NIH) Contractor Performance System (CPS) was replaced with the Department of Defense's Contractor Performance Assessment Reporting System (CPARS) for documenting the evaluation of contractor performance. CMS experienced issues transitioning from the NIH system to the CPARS system. CMS is currently able to access the CPARS system and plans to update the CPARS system with the NQF performance information for the period January 14, 2009 through January 13, 2011. CMS continually monitors contractor performance through the receipt and review of monthly deliverables including monthly status reports. A final performance evaluation will be completed in the CPARS system at the end of the contract in January 2013.

The final recommendation is to develop a comprehensive plan for HHS quality measure needs. In the GAO report, 'use' of quality measures and 'plans for use' of quality measures are defined as either being published as a final rule or in a notice of proposed rule-making (NPRM) or other HHS documentation. The measures that are not yet in "use" are being evaluated by HHS, so any conclusions that they will not be used are not accurate. For example, not all HHS Operating Divisions were involved in the GAO's study; thus, their use or plan for use of endorsed quality measures were not included in this report. However, IHS, HRSA, and SAMHSA all include NQF-endorsed measures in their quality measurement programs. GAO raised a related issue: whether or not quality measures comprehensively address the measurement needs of the Patient Provider and Affordable Care Act (ACA). CMS reports that it has documented how quality measures will be used to address all relevant sections of ACA.

4

Appendix VI: Comments from the National Quality Forum

NATIONAL
QUALITY FORUM

1030 15TH STREET, NW, SUITE 800
WASHINGTON, DC 20005
202.783.1300 MAIN 202.783.3434 FAX

December 9, 2011

Linda T. Kohn, Ph.D.
Director, Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Dr. Kohn:

The National Quality Forum (NQF) appreciates the opportunity to formally comment on the report, *Health Care Quality Measurement: HHS Should Address Contractor Performance and Plan for Needed Measures (GAO-12-136).* Improving the quality and value of our nation's health care is vitally important. NQF is committed to encouraging quality through performance measurement and accountability.

We concur with many of the findings in GAO's report. However, we wish to clarify and provide context on the findings and recommendations regarding the pace of NQF's endorsement activity and cost and timeline adjustments in the health information technology (HIT) work. The novelty and complexity of the work and the consensus-based environment in which NQF operates – and which the legislation requires for much of the work – all affect timing and cost.

The report indicates that the performance of particular tasks exceeded their initial schedule and cost estimates. As you know, NQF is providing its services to HHS under a cost reimbursement contract. Authority to use such a contract vehicle is closely regulated. The Federal Acquisition Regulation ("FAR"), at FAR 16.301-2, specifies that such a contract vehicle is to be used only when:

1. Circumstances do not allow the agency to define its requirements sufficiently to allow for a fixed price contract; or

2. Uncertainties involved in contract performance do not permit costs to be estimated with sufficient accuracy to use any type of fixed price contract.

It is, of course, self-evident that if neither the scope of work nor uncertainties regarding contract performance can be reasonably estimated, then fixed, immovable schedules should not

be expected. The deadlines in these schedules were set based upon an early understanding of the work. Both HHS and NQF understood that there would likely be changes to the work and the deadlines. These factors, while identified generally in your report, are so critical to understanding the historical performance of the HHS contract that we wish to provide specific examples of the diligent efforts expended by HHS, NQF, and others to minimize the impact of these factors.

Specific factors that led to uncertainty regarding the timeline and cost of performance under the HHS contract included:

1. No one previously had attempted to reach cross-industry consensus on, endorse, and implement harmonized healthcare quality measures to the degree sought under the HHS contract. There was no prior model to look to for reliably estimating time and cost.

2. Reaching consensus required coordination among diverse stakeholders, each of which has unique, reasonable needs and expectations that were not always consistent with the needs and expectations of other stakeholders. All were represented by experienced, knowledgeable, often highly opinionated individuals who represented their positions effectively. These differences had to be resolved through a consensus process. Sometimes this was comparatively easy. Many times not.

3. Ground rules for the contract work sometimes changed mid-effort based on the latest legislative or administrative policy requirements or recommendations.

4. No pre-existing commercial software program could be adapted to implement the health information technology requirements of the contract. New software had to be designed, developed, and tested.

The potential existence of all of these issues was identified at the time of contract award but the extent of their impact could not be reasonably estimated. In the paragraphs that follow, we provide some specific examples of the issues faced and how HHS, NQF, and others addressed the issues and reduced their impact to a minimal level.

With respect to endorsement activities, a scientifically rigorous, consensus-based process is a major part of NQF's value to HHS. Both the technical and collaborative nature of that process can adversely affect timelines. However, those same characteristics are necessary to yield a high quality result that is useful to HHS.

NQF evaluates measures presented by third parties for NQF endorsement against technical criteria for:

- importance to measure and report;
- scientific acceptability;
- feasibility to implement; and
- usability of measure results.

This endorsement process includes review by technical experts, public comment, review and voting by multiple NQF committees, and ultimately a decision by NQF's Board of Directors to endorse a measure. The process is intended to identify strong measures that advance health care quality, but deadlines may require adjustment due to:

- the volume of measures submitted (e.g., NQF received 75 measures for consideration in the Child Health Quality Project, approximately twice the number of measures typically received in a call for measures);
- the need for additional information from measure developers (e.g., developers were asked to address differences in two competing diabetes composite measures in the Patient Outcomes Project, a process that took several months);
- HHS-requested project delays for coordination of federally funded measure development (e.g., additional time for federal contractors to submit measures in the Nursing Home Project); and
- the need to harmonize similar measures.

Harmonization of measures is a critical and time-consuming part of the endorsement process and accounted for modifications to timelines in three of the five endorsement projects reviewed by GAO. Harmonizing measures involves standardizing specifications or definitions for measures that have the same focus. For example, in the Patient Safety Measures Project, the Centers for Disease Control and Prevention and the American College of Surgeons submitted surgical site infection measures that differed in terms of inclusions of specific procedures and risk adjustment approaches. After consultation with HHS, NQF provided the measure developers with the opportunity to harmonize their measures into a single surgical site infection measure. Other measures in the project moved forward on schedule but the project end date was moved out to provide the necessary time for NQF to evaluate the newly harmonized measure. The use of related measures with different specifications by various public and private sector payment and public reporting programs is a source of immense frustration and burden for providers and can also be confusing to clinicians, consumers and other end users of the performance results. Measure harmonization is one of the most important and value-added benefits of the NQF endorsement process to HHS and the provider community.

NQF's endorsement work proceeded in parallel with the work of the National Priorities Partnership (NPP) and the Measure Applications Partnership (MAP), both convened by NQF. The work of NPP and MAP, as well as HHS internal planning initiatives, informed NQF's endorsement activities and changes to the work and the schedule for endorsement resulted, such as the addition of a hospital readmissions project to the 2011 work plan to meet legislative mandates. HHS and NQF worked together to adjust the timelines where priorities shifted and the scope of work was refined. These adjustments are a byproduct of a collaborative process – both the collaboration between HHS and NQF and the collaboration among stakeholders.

NQF's work in the health information technology (HIT) arena on measure retooling and the Measure Authoring Tool led to similar challenges. This work was not just new to NQF. Measure retooling and the Measure Authoring Tool were brand new, untested concepts for everyone. NQF, HHS, and measure developers learned as they moved through each step of the work, and each step informed and modified subsequent steps. To our knowledge, no one has comprehensively retooled existing measures prior to this effort.

NQF provided critical technical assistance and coordination to measure developers whose measures were scheduled for retooling. NQF does not develop performance measures or directly retool measures for use with electronic health records. The retooling work under the HHS contract was performed by 18 measure developers who own the intellectual property in the measures. NQF was deeply enmeshed in supporting the efforts of these developers by reviewing the electronic measure specifications, identifying errors and inconsistencies, and working directly with developers to correctly retool the measures.

The number of measures that required retooling rose from 10 to 113 in six months, a dramatic expansion of NQF's scope of work. In addition, the measures HHS identified for retooling shifted several times throughout the process. This unavoidably led to higher costs than originally planned and revised timelines for completing the work.

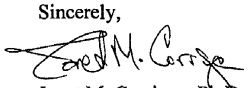
The Measure Authoring Tool is a new software concept designed to produce an electronic version of a performance measure for any developer who uses it. Given the complexity and the novelty of this project, the intent was to create versions of the Tool that would evolve by building on prior versions of the Tool. As with any piece of software, the Tool is not static and requires constant refinement and updates to be able to support HHS' rapidly evolving measurement needs. HHS and NQF could not have anticipated the difficulty of this project and all of the resources required to move forward, which resulted in increased cost and adjustments to timelines.

Finally, we note that the GAO report states that HHS lacks a comprehensive plan for using the work NQF has produced under the contract. We believe that HHS is rightly adjusting

its plan based upon a constant review of the work product, ever-changing national needs, and knowledge resulting from an effective collaboration between HHS and NQF. We are unaware of a more effective way to approach such a massive and important undertaking. The work is innovative and, therefore, unpredictable, but HHS and NQF have made, and will continue to make, steady progress toward improving America's health care.

We appreciate the opportunity to review and comment on this report. If you have any questions, please do not hesitate to contact me at (202) 783-1300.

Sincerely,



Janet M. Corrigan, Ph.D.
President and Chief Executive Officer

Appendix VII: GAO Contact and Staff Acknowledgments

GAO Contact

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

Staff Acknowledgments

In addition to the contact named above, Will Simerl, Assistant Director; La Sherri Bush; Krister Friday; Amy Leone; Carla Lewis; John Lopez; Elizabeth Martinez; Lisa Motley; Teresa Tucker; Carla Willis; and William T. Woods made key contributions to this report.