Report to Congress:

Annual Update: Identification of Quality Measurement Priorities and Associated Funding for the Consensus-Based Entity and Other Entities

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A Report Required by the Bipartisan Budget Act of 2018

United States Department of Health and Human Services

Centers for Medicare & Medicaid Services

December 2024

Executive Summary

The United States (U.S.) Department of Health and Human Services (HHS), which includes the Centers for Medicare & Medicaid Services (CMS), strives to protect and strengthen equitable access to high quality and affordable healthcare for its beneficiaries across the U.S. CMS, through its value-based purchasing and quality reporting programs, continues to help transform the healthcare system by incentivizing high-quality care and more efficient spending. By establishing and refining national quality standards and quality measurement initiatives, CMS has led efforts to improve healthcare and patient outcomes.

With the support of federal partners and government contractors, CMS is prioritizing the development and use of digital measures and harmonizing measures across public and private payer quality reporting. CMS's focus areas include addressing health inequities, patient-reported outcomes (PRO), and rural health concerns. At the 2023 CMS Quality Conference, CMS finalized the mission, vision, and goals of the CMS National Quality Strategy to support CMS's leadership role in achieving optimal health and well-being for all individuals. One lever central to the CMS National Quality Strategy that unifies Traditional Medicare, Medicare Advantage, Medicaid & Children's Health Insurance Program (CHIP) coverage, Marketplace plans, and Center for Medicare and Medicaid Innovation (CMMI) models and demonstrations is quality measurement. The Meaningful Measures Initiative, active since 2017, remains key to shaping the entire ecosystem of quality measures that drive value-based care. Working as one of many initiatives and activities under the CMS National Quality Strategy, Meaningful Measures 2.0 promotes innovation and modernization of all aspects of quality measurement, addressing a wide variety of settings, and interested parties including healthcare providers, patients, communities, and experts.

As required under section 1890(e) of the Social Security Act (the Act), as added by section 50206(b) of the Bipartisan Budget Act of 2018 (BBA), this report provides the sixth annual update of the coordinated strategy and related funding for using the Consensus-Based Entity (CBE) under contract with HHS. This report primarily describes activities performed by the Battelle Memorial Institute (Battelle), which was awarded the CMS National Consensus Development and Strategic Planning for Health Care Quality Measurement Contract (CBE contract) in February 2023, and other contractors that conduct activities pursuant to the quality and performance measurement provisions of sections 1890 and 1890A of the Act.

The information provided in this report reflects various activities that support the future direction of national quality measurement and includes an annual update regarding the obligated, expended, and projected funding amounts for purposes of carrying out sections 1890 and 1890A of the Act. This report to Congress addresses what has been accomplished with expended funds in the past fiscal year, outlines the work that current and future funding supports and how it will advance CMS's quality goals, and provides an accounting of how funding correlates with the complexities of quality measurement methodologies and systems.

To briefly summarize, funding is used to support tasks in four broad categories of work: (1) Duties of the Consensus-Based Entity, (2) Dissemination of Quality Measures, (3) Program Assessment and Review, and (4) Program Oversight and Design.
Quality measurement development and implementation is by nature multifaceted and challenging. By providing an overview of the tasks, along with the cost estimates for the specific activities and

deliverables, CMS intends to bring transparency and clarity to this complex process that must involve the active participation and engagement of key public and private sector entities, organizations and communities to achieve the quality goals for the nation. Furthermore, cost estimates developed for 2024 and 2025, as specified in section IV, are informed and refined by the experience of previous years to reflect best value for taxpayer dollars.

I. Introduction

I.A. Background

In partnership with numerous entities, including patients and families; clinicians; hospitals and outpatient providers; post-acute care (PAC) and long-term care (LTC) facilities; other federal agencies; state governments; health plan associations; specialty societies; and quality measurement experts, CMS works to ensure that high quality, high value, equitable healthcare and outcomes are accessible to all patients, caregivers, and families. CMS's unique role can shape the implementation of innovative quality measurement activities that target healthcare priorities across the healthcare system. To improve patient care and outcomes and move towards a value-based healthcare system, CMS supports measure development, selection, and implementation across programs. CMS contracts with a CBE, pursuant to section 1890 of the Act, to endorse measures and make recommendations to CMS on measures for use in its programs prior to rulemaking.

The first *Report to Congress: Identification of Quality Measurement Priorities – Strategic Plan, Initiatives, and Activities* (the 2019 report to Congress) documented the CMS quality measurement processes and activities performed pursuant to sections 1890 and 1890A of the Act for the period including 2018 and years prior. CMS continues to advance alignment of measures, identify quality measurement gaps in priority areas, and engages interested parties to root out healthcare inequities.

This report to Congress provides information regarding tasks, activities, and funding details including dollars obligated, expended, and projected to carry out the work required in sections 1890 and 1890A of the Act. It builds upon the previous reports to Congress and provides an annual update to reflect key modifications to existing work and highlights new measurement activities since last year's report.

I.B. Report Organization Corresponding to Requirements of Section 1890(e) of the Act

Section 1890(e)(1) requires this report to Congress to contain a comprehensive plan identifying the quality measurement needs for programs and initiatives overseen by the Secretary, as well as a strategy for how the Secretary plans to use the CBE and any other contractors to perform work associated with sections 1890 and 1890A of the Act, specifically with respect to Medicare programs. CMS submitted the 2019 report to Congress containing the comprehensive plan on March 1, 2019. This is the sixth annual report to Congress, organized as follows, submitted by the Secretary to meet the applicable statutory requirements, and provide transparent disclosure of CMS expenditures, obligations, and planned expenditures.

Section I: Introduction

The Introduction provides the background of continuing activities under sections 1890 and 1890A of the Act.

Section II: Comprehensive Plan

Section II highlights the Meaningful Measures 2.0 Initiative, which aligns with the CMS National Quality Strategy, as a key driver of strategic efforts to reduce the burden of quality measure reporting and as the framework for the comprehensive plan.

For the following sections of this report, the activities performed under sections 1890 and 1890A of the Act are divided into four broad categories:[1]

- Duties of the CBE[2]
- Dissemination of measures[3]
- Program assessment and review[4]
- Program oversight and design[5]

Section III: Funding, Obligations, and Expenditures for Activities Conducted Under Sections 1890 and 1890A of the Act for Fiscal Year (FY) 2023

Section III describes the funding provided under section 1890(d) to carry out sections 1890 and, in part, 1890A of the Act, which include funding for the CBE and other entities to conduct activities under contract with the Secretary. This section describes the amounts obligated and expended during FY 2023 for such activities that are required by sections 1890 and 1890A of the Act.

Section IV: Estimated Expenditures and Anticipated Obligations for Activities Under Sections 1890 and 1890A of the Act for FYs 2024 and 2025

Section IV describes the anticipated obligations and expenditures for FYs 2024 and 2025 as of December 31, 2023, to support the advancement and refinement of the quality measurement activities required under sections 1890 and 1890A of the Act. Cost estimates developed for FYs 2024 and 2025 were based on previous years' experiences and lessons learned, and reflect efforts to reduce overhead, find efficiencies in our contracts and focus on the specific activities and deliverables (as described in Section IV) that would drive us to accomplish the quality goals.

The estimates and tasks anticipated to be accomplished in 2024 and 2025 are subject to the availability of sufficient funds.

Section V: Glossary

The glossary provides clarifications of acronyms and abbreviations.

Appendices:

Appendix A includes links to the statutory language of sections 1890 and 1890A of the Act and the individual prior Reports to Congress.

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

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

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

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

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

Appendix B addresses requirements of section 1890(e)(2)(B), as added by CAA, 2021 and provides detailed information on four categories of activities: Measure Selection Activities; Measure Development Activities; Public Reporting Activities; and Education and Outreach Activities.

II. Comprehensive Plan

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

In 2021, CMS launched Meaningful Measures 2.0 to update the 2017 Meaningful Measures Initiative with a greater emphasis on five interrelated goals to help prioritize and modernize the measures used by CMS Programs. These goals are:

- Using only high-value quality measures impacting key quality domains.
- Aligning measures across value-based programs and across partners, including CMS, federal, and private entities.
- Prioritizing outcome and patient-reported measures.
- Transforming measures to be fully digital and incorporating all-payer data.
- Developing and implementing measures reflecting social drivers/determinants of health (SDOH).

Building on the Meaningful Measures 2.0 goals, in 2023, CMS proposed a new approach, called the Universal Foundation. This building-block approach will streamline quality measures across CMS quality programs for the adult and pediatric populations. Aimed at focusing provider attention, reducing burden, identifying disparities in care, prioritizing development of interoperable, digital quality measures, allowing for cross-comparisons across programs, and helping identify measurement gaps, the work of the Universal Foundation aligns with the CMS National Quality Strategy and supports Meaningful Measures 2.0. The development and implementation of the Preliminary Adult and Pediatric Universal Foundation Measures will promote the best, safest, and most equitable care for individuals as we all work together on these critical quality areas.

As CMS moves forward with the Universal Foundation,[6] we will be working to identify foundational measures in other specific settings and populations to support further measure alignment across CMS programs as applicable. The Universal Foundation will continue to evolve over time, including:

- CMS will develop setting- and population-specific "add-on" measure sets.
- Measures may be replaced or removed when goals are met.
- Measures may be added to assess quality across the care journey.
- CMMI will continue to test new and innovative measures.

[6] https://www.cms.gov/medicare/quality/cms-national-quality-strategy/aligning-quality-measures-across-cms-universal-foundation

As CMS continues refinement of the comprehensive plan and works to ensure the goals and actions align, not just across the agency, but across the entire quality measurement enterprise, CMS will build on the strengths of the Meaningful Measures Initiative and overarching CMS National Quality Strategy. With partnerships across the healthcare industry, CMS will continue to set and raise the bar for a resilient, high-value healthcare system that promotes quality outcomes, safety, equity, and accessibility for all individuals.

III. Funding, Obligations, and Expenditures for Activities Conducted Under Sections 1890 and 1890A of the Act for FY 2023

CMS used FY 2023 funds for the work of the CBE and other entities pursuant to sections 1890 and 1890A of the Act and was able to build on previous activities and continue its commitment and investment to support meaningful, scientifically sound quality measures which are essential to lower the cost and improve quality of healthcare. For example, accomplishments include consensus-based recommendations and strategies to address primary prevention, initial recognition and management, management of acute events, chronic disease, surgery, and behavioral health, advance illness and post-acute care and cost and efficiency. These efforts closely align with key objectives of the CMS National Quality Strategy, including improving healthcare quality on high impact areas such as behavioral health, reducing health disparities, and promoting equitable care, and accelerating interoperability.

Table 1 identifies the appropriated funding for sections 1890 and 1890A of the Act and funds obligated and expended under sections 1890 and 1890A of the Act. The funding dollar amounts throughout this report are rounded to the nearest ten thousands.

Table 1: Funding authority (in millions), funds obligated, and funds expended by public law, as of December 31, 2023

Public Law Amending Section 1890 of the SSA	Appropriation	Sequester	Adjusted Amount	Obligations	Unobligated Amount	Expended Amount
The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. L. 110-275, enacted July 15, 2008)	$50.00	($0.51)	$49.49	$47.37	$2.12*	$47.37
The Patient Protection and Affordable Care Act of 2010 (ACA) (Pub. L. 111-148, Sec. 3014, as amended by section 10304 of the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, enacted March 30, 2010)	$100.00	($2.46)	$97.54	$97.54	$0.00	$97.53
The Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. 113-93, enacted April 1, 2014)	$20.00	$0.00	$20.00	$20.00	$0.00	$20.00
The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114-10, enacted April 16, 2015)	$75.00	($2.07)	$72.93	$72.93	$0.00	$72.86
Bipartisan Budget Act of 2018 (Pub. L. 115-123, enacted February 8, 2018)	$15.00	$0.00	$15.00	$15.00	$0.00	$14.96
Coronavirus Aid, Relief, and Economic Security Act (CARES Act) (Pub. L. 116-136, enacted March 27, 2020)	$20.00	$0.00	$20.00	$20.00	$0.00	$19.02
Consolidated Appropriations Act, 2021 (CAA) (Pub. L. 116-260, enacted December 27, 2020) for FY 2021	$26.00	$0.00	$26.00	$19.12	$6.88	$18.95
CAA, 2021 for FY 2022	$20.00	($0.57)	$19.43	$17.01	$2.42	$16.88
CAA, 2021 for FY 2023	$20.00	($1.14)	$18.86	$16.96	$1.90	$6.73

*These unobligated amounts available for use do not include the $2.12 million unobligated authority related to MIPPA Section 183, which expired in 2013.

Table 2 identifies the total amounts of funding obligated and expended in FY 2023 using funds appropriated to implement sections 1890 and 1890A of the Act. Activities were carried out by the CBE (convening interested parties to provide input on measures), as well as other CMS funded contractors. Table 2 excludes funding for activities performed by the Secretary that are not funded by the appropriations for sections 1890 and 1890A of the Act.[7][8]

Table 2: FY 2023 Funding (in millions) obligated, and expended under sections 1890 and 1890A of the Act, including administrative costs

Funding Section	Obligations	Expended Amount
1890	$7.64	$4.53
1890A	$8.96	$4.16
Administrative	$0.20	$0.11
Total	**$16.80**	**$8.80**

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

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

In February 2023, Battelle was awarded the CBE Contract and selected to oversee the endorsement and maintenance of clinical quality and cost/resource use measures. Under its contract with CMS, the CBE convened interested parties to review new or endorsed quality measures for conceptual importance, scientific acceptability, use or usability, and feasibility. In addition, CMS tasked the CBE to identify measure priorities and measure gaps to support HHS efforts to improve quality of care and health outcomes. The CBE is required to develop and submit an annual report to Congress and the Secretary of HHS containing a description of the quality and efficiency measurement activities during the previous calendar year no later than March 1 of each year. As part of the section 1890A pre-rulemaking process, the CBE convened interested parties that provide input on the selection of quality measures under consideration for use in certain specified quality reporting and value-based purchasing (VBP) programs.

Table 2.1 below describes the funding for FY 2023 for CBE-required and other consensus-based activities under sections 1890 and 1890A of the Act. Those activities included: endorsement and maintenance of quality measures, publication of a required annual report with prescribed activities, including identifying gaps in quality and efficiency measures, and assisting CMS by synthesizing evidence and convening interested parties to make recommendations on priorities for healthcare performance measurement in different settings. These priority setting efforts included continued

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

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

support for the Core Quality Measures Collaborative (CQMC) to align quality measures used by public and private payers across a wide array of specialty areas.

Table 2.1: Total for Duties of the Consensus-Based Entity

Period of Performance	Fiscal Year	Funding Amount
Base Period 02/27/23-02/27/24	**2023**	**$8,963,850**

- Endorsement and Maintenance of Measures:

Most measures used across CMS value-based quality programs have been reviewed and endorsed by the CBE through the endorsement and maintenance process. This review is considered the "standard of approval" for quality measures for the nation. Not only does CMS use endorsed measures for CMS programs, but many other organizations across the country look to CBE endorsement and maintenance as evidence that a measure is scientifically sound, feasible and impactful. Organizations across the nation, such as commercial payers, ratings agencies, specialty societies and Quality Improvement Organizations choose quality measures for a wide variety of programs by assessing measures' endorsement and maintenance status as well as use in CMS programs.

  - The CBE completed the fall 2022 and spring 2023 endorsement and maintenance cycles during the base year of the contract.
  - The CBE convened expert panelists to ensure that measures endorsed by the CBE are updated (or retired if obsolete) as new evidence was developed and remains relevant.
  - The CBE convened topic-specific groups with specialized expertise that reviewed new measures submitted for endorsement to ensure these measures are evidence-based, reliable, valid, verifiable, relevant to enhanced health outcomes, actionable at the caregiver level, feasible to collect and report, and responsive to variations in patient characteristics, such as health status, language capabilities, race or ethnicity, and income level; and is consistent across types of healthcare providers, including hospitals and physicians, thus advancing quality in healthcare for beneficiaries.
  - The process currently has two review cycles per year for each of the topic-specific projects (e.g., primary prevention, cost, and efficiency).

- Pre-rulemaking Measure Review and Measure Set Review

In addition, in FY 2023, the CBE continued to convene key interested parties to evaluate quality and efficiency measures under consideration in specific Medicare payment and public reporting quality programs as the final steps of the pre-rulemaking cycle. The CBE also provides consensus-based recommendations for potential measure removal and replacement under the Measure Set Review process.

- Core Quality Measures Collaborative (CQMC)

The CBE also convenes the CQMC, a group of healthcare leaders working to facilitate cross-payer measure alignment through the development of core sets of measures to assess the quality of

healthcare in the U.S., is a public-private partnership between America's Health Insurance Plans (AHIP) and CMS. The CQMC endeavors to efficiently promote a patient-centered assessment of quality that could be implemented across both commercial and government payers (e.g., CMS, VA).

- In 2023, the CQMC completed over 5 years of work and efforts will continue with the newly awarded CBE, as funding permits. During the base year, the CQMC work focused on light and full maintenance of the core measure sets, performing environmental scans to identify new measures for potential inclusion, workgroup meetings, steering committee meetings and development of a communications plan and strategy to engage stakeholders, public-private partners, including health insurance organizations, primary care and specialty societies, consumer and employer groups, and other quality collaboratives, through convening workgroup meetings.

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

Table 2.2: Total for Dissemination of Quality Measures

Fiscal Year	Funding Amount
2023	**$4,147,077***

*This total funding amount is comprised of two contracts described below (MMS contract ($2,892,550) and the Public Reporting contract ($1,254,527))

- The Measures Management System (MMS)

The MMS is an essential resource for the dissemination of quality measurement across CMS programs and initiatives and is available for interested parties such as federal partners and the public. The MMS supports important efforts to standardize and promote best practices in quality measurement. MMS consists of several tools and resources to assist measure developers in the different stages of the Measure Lifecycle: the CMS Measures Inventory Tool (CMIT), the CMS Measures Under Consideration (MUC) Entry Review Information Tool (MERIT), De Novo Measure Scan (DNMS), Environmental Scan Support Tool (ESST), and the MMS Hub. Collectively, these tools support technical engagement, education and outreach to developers and interested parties, to increase knowledge of quality measurement, CMS quality reporting and VBP programs.

CMS and its partners use the web based CMIT to search and retrieve measure details and to inform future measure development. It is a public repository of information about measures used across CMS programs to inform interested parties, manage the measure portfolio, promote measure alignment, and guide measure development. CMIT contains an ESST for all measure developers to be used as a benchmark against which to compare manually conducted scans, and the measure concepts extracted from the abstract and article text may serve as a useful markup to increase the efficiency of abstract and article review. This provides evidentiary support for the opportunity for improvement. Additionally, CMIT contains the DNMS tool which helps public users efficiently find up-to-date literature about novel measure concepts to support innovation in measure development and maintenance, re-specification, and other scenarios where current, accurate, and relevant evidentiary support specific to quality measurement is needed.

CMS MERIT is a web-based, data collection portal used by measure developers to submit their quality and efficiency measures to CMS for consideration for use in quality programs.

The CMS MMS Hub (The Hub) serves as the trusted source for quality measures and quality measure development and maintenance information. The Hub is comprised of the content previously found in the MMS Blueprint, as well as tools and resources available to developers and interested parties outlining steps and best practices in measure development.

The MMS education and outreach strategy to measure developers and other interested parties includes dissemination and promotion of learning materials, expansive links, and opportunities to actively engage in measure development, informational webinars focused on quality measure development, and a monthly update to over 100,000 subscribers. Webinars focus on key topics that promote the CMS quality priorities and goals. With respect to the pre-rulemaking process, the MMS supports CMS's gathering of measures for inclusion on the MUC list that the Secretary considers for use under Medicare and for review by the public and interested parties convened by the CBE. Together, the activities under the MMS increase standardization, innovation, transparency, and interested parties' engagement in the measure development process across all measure-related activities at CMS.

Period of Performance	Fiscal Year	Funding Amount
Option Year 4 contract modification – 9/30/22-9/29/23 (Mod 6/1/23)	**2023**	**$135,000**
OIT Cloud Cost		**$164,823***
Base Period 11/10/23-11/09/24		**$8,382****
Base Period MMS Task Order – 08/30/23-08/29/24		**$2,584,345**
Total		**$2,892,550**

*OIT Cloud Funds

**SSL Cert Funds

As in prior years, the MMS drove quality measurement by offering a standardized system of resources and tools for developing, implementing, and maintaining the quality measures used in various initiatives and programs both in the public and private sector. The MMS provided support and assistance to entities interested in measure development through education and resources through providing online resources, webinars, and monthly newsletters to over 100,000 subscribers.

The funds for the Option Year 4 contract modification supported the migration of the CMIT platform to a CMS cloud environment, as required by CMS Information Technology policies. The Office of Information Technology (OIT) and Secure Sockets Layer (SSL) Certificate costs cover cloud computing and storage costs, software licensing costs and ensures meeting security-related OIT requirements.

Under the newly awarded MMS contract, the FY23 funds for the Base Period continued to support the:

- updates and enhancements to the web-based MMS Blueprint and MMS Hub to ensure alignment with current measure development trends and best practices and
- alignment and harmonization of quality measures across CMS through the redesigned CMIT to allow users to identify families of measures, measure standards, and variations of measures.

- Public Reporting Coordination

In 2023, CMS continued efforts to maintain the websites for Care Compare and Provider Data Catalog (PDC) and improve the user experience by enabling an intuitive searchable interface, meaningful and streamlined content and public reporting of quality measures. Efforts included overall coordination and convening CMS program and measure leads to support alignment, prioritization, risk assessment and mitigation, scheduling, and timelines for the readiness of enhanced user interfaces.

The table below describes the FY 2023 funding for public reporting coordination activities.

Period of Performance	Fiscal Year	Funding Amount
Option Period 4 03/22/23-03/21/24	**2023**	**$1,254,527**

This work served as part of the eMedicare initiative, which strives to modernize the way beneficiaries and patients get information about Medicare and create new ways to help them make the best healthcare decisions for themselves and their families. Specifically, this contract:

- Oversees the global coordination and transition effort for the Provider Data Catalog (PDC) and Care Compare;
  - Supports ongoing efforts to improve the beneficiary and patient experience for Provider Data Catalog (PDC) and Care Compare.
- Collaborated with subject matter experts and leaders on logistics and planning to enable an intuitive searchable user interface, meaningful and streamlined content and public reporting of quality measures.
- Provided project management for the integrated project team (IPT), including meeting coordination and facilitation; managing work products; and communication management;
- Coordinated alignment and prioritization of tasks and activities across the IPT;
- Supported documented operational processes and procedures for elements including system access, dataset file creation submission, centralized issue tracking, help support and triage, and content identification, display, and management.

(3) Funding, Obligations, and Expenditures Related to Program Assessment and Review

The Secretary must conduct an assessment, beginning not later than March 1, 2012, and at least once every three years thereafter, of the quality and efficiency impact of the use of endorsed

measures described in section 1890(b)(7)(B) of the Act and make that assessment available to the public.[9] To comply with this provision, CMS published National Impact Assessment Reports in 2012, 2015, 2018, and 2021, and prepared for the analyses for the 2024 report in FY 2023.

In FY 2023, the focus of the National Impact Assessment report development work included discussions and gaining feedback from a Technical Expert Panel (TEP) regarding potential methodologies and analyses for quality measures. The TEP comprised of nationally accredited private and public interested parties and a Federal Assessment Steering Committee (FASC), including the Veterans Health Administration (VHA), the Agency for Healthcare Research and Quality (AHRQ), Assistant Secretary for Planning and Evaluation (ASPE), Centers for Disease Control and Prevention (CDC), Defense Health Agency (DHA), Health Resources and Services Administration (HRSA), Indian Health Service (IHS), Assistant Secretary for Technology Policy and Office of the National Coordinator for Health Information Technology (ASTP/ONC), and Substance Abuse and Mental Health Services Administration (SAMHSA). This work on the development of the 2024 Impact Assessment report focused on enhanced health disparity and health equity analysis including conducting focus groups to identify community perspectives on key drivers of disparities. In particular, as in previous reports, the measure analyses in this work during FY 2023 was organized by healthcare priorities identified by the Meaningful Measures 2.0 framework. This supports the statutorily required impact assessment under section 1890A(a)(6) of the Act and evaluation of measure performance at the national level regarding the CMS healthcare quality priorities of Person-Centered Care, Equity, Safety, Affordability and Efficiency, Chronic Conditions, Wellness and Prevention, Seamless Care Coordination, and Behavioral Health.

Additionally, we continued critical work of quality measure data collection and review to inform the analyses of measure trends to understand how the COVID-19 public health emergency (PHE) and associated CMS quality measurement efforts and policy responses affected patients, providers, and healthcare delivery and utilization.

Table 2.3: Total for Program Assessment and Review

Fiscal Year	Funding Amount
2023	**$3,491,782**

- National Impact Assessment

Period of Performance	Fiscal Year	Funding Amount
Option Period 4 07/01/23-06/30/24	**2023**	**$2,652,344**

This work obtains the expert services needed to conduct Impact Assessment work. The statutory mandate at section 1890A(a)(6) requires CMS to assess the quality and efficiency impact of the use of endorsed measures and make the assessment publicly available at least once every three years. The first comprehensive report was published in 2012 followed by subsequent comprehensive reports in 2015, 2018, 2021 and 2024. The recent report published in 2024 focuses on CMS's

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

quality measurement efforts to improve health equity as the agency's response to the COVID-19 pandemic. This includes:

- A comprehensive national evaluation to inform CMS on opportunities to use quality measurement as a lever to improve health equity for CMS's beneficiaries, based on:
  - Focus groups with leaders of community-based organizations serving vulnerable communities on barriers to affordable care and high-quality care, especially those resulting from the pandemic.
  - Recommendations by the TEP and FASC on promising pathways to leverage quality measurement to improve health equity.
  - Disparity analyses of quality measures across each healthcare quality priority area.
  - Discussion related to improving healthcare system resilience for select measure topics and grouped by healthcare quality priority.

- The Quality Measure Index (QMI)

Period of Performance	Fiscal Year	Funding Amount
Option Period 4 07/01/23-06/30/24	**2023**	**$839,438**

This funding supported work to systematically assess and improve standardization of the decision-making processes used by CMS for measure selection (like pre-rulemaking measures under consideration, which is managed by the Measures Management System), implementation, and continued use in CMS quality reporting programs. The funding also supported refinements to the tool and methodology as well as educational trainings and outreach related to the QMI to help ensure program and measure leads improve the utility and understanding of the QMI as part of the measure assessment process.

(4) Program Oversight and Design

Initial year funding was provided to contractual entities to support the Secretary in project management and operations related to quality measurement. These contracts were completed and the last time a contract was awarded using Program Oversight and Design funds was in FY 2012. No contractual activities in this area have been funded or implemented in FY 2023 under section 1890 or 1890A of the Act. Future expenditures in this area are not anticipated.

Table 2.4: Total for Program Oversight and Design

Fiscal Year	Funding Amount
2023	**$0.00**

IV. Estimated Expenditures and Anticipated Obligations for Activities Under Sections 1890 and 1890A of the Act for FYs 2024 and 2025

As the largest payer of healthcare services in the U.S., CMS continues to pursue improvements to the healthcare system through quality reporting programs that use payment incentives, quality improvement activities, and increased transparency through public reporting of performance results.

The sections 1890 and 1890A contracts that CMS anticipates holding in 2024 and 2025 will help to streamline and focus the way CMS approaches quality measurement and the way people receive information to make the best decisions for themselves and their families, particularly to promote equitable healthcare.

Through the efforts of the CBE and the interested parties convened by the CBE, CMS is uniquely informed by key health sector and national quality improvement leaders and is guided by the work (outlined in sections 1890 and 1890A of the Act) to assess measures for endorsement, identify measure gap areas, and recommend best practices that promote rewarding value and outcomes with an increased focus on patients and decreased burden on clinicians. This work supports and informs the measure development process outlined by the MMS and the prioritization guided by the CMS National Quality Strategy and Meaningful Measures Initiative. It also helps to ensure the dissemination of quality measures via our public reporting sites. CMS's work to assess and review the programs through the triennial Impact Assessment report provides the feedback and analytical data needed for continual evaluation of the measurement work in this area and is a tool used by the CBE in their analyses. The expenditures and anticipated obligations for activities previously outlined in these four components create a cyclical process to ensure experts, patients, and clinicians are active participants in guiding, evaluating, and benefitting from CMS's continual efforts to improve healthcare quality and transition to value-based care.

The quality measurement work related to the CBE and other contractors is integral to implementing quality reporting programs, value-based payment programs, public reporting of measures, and adopting high-value measures to inform decision making for patients, clinicians, and healthcare systems. The work authorized by sections 1890 and 1890A of the Act provides the essential infrastructure, trust, scientific validity, and consensus-based review and comment by interested parties that has been the essence of national quality reporting to drive improved health outcomes for all individuals. The Secretary estimates the following obligations and expenditures will be required in the succeeding two-year period (i.e., FY 2024 and FY 2025) to carry out quality measurement activities under the four categories of tasks previously described. Estimates for anticipated obligations are subject to the availability of sufficient funds.

The contracts listed below are anticipated awards using FY 2024 and FY 2025 funding as of December 31, 2023, building from lessons learned and experiences from previous years. These funds are estimated without taking into account the availability of funding and would therefore be the amounts CMS would obligate and expend if funds are available. To note, there are increases due to escalation costs from year to year. As several of our activities have different periods of performance (e.g., more than 12 months), additional work may be performed in these years but will

not be listed in this section because funds were obligated or expended prior to FY 2024 and are described in prior Reports to Congress described in Appendix A. If contracts have been awarded and the cost is already negotiated for option years, this is indicated as 'negotiated' in the tables below. If a contract is new work anticipated to be awarded in FY 2024 or FY 2025, the cost is indicated as 'estimated' in the tables below.

The unobligated amount from FY 2023, as of December 31, 2023, is $11.20 million. This is the carry over amount for FY 2024.

(1) Duties of the Consensus-Based Entity (CBE Contract)

Period of Performance	Fiscal Year	Funding Amount
Option Period 1 02/27/24-02/26/25	**2024**	**$10,351,637 (Estimated)**
Option Period 2 02/27/25-02/26/26	**2025**	**$10,611,164 (Estimated)**

- Endorsement and Maintenance of Quality and Efficiency Measures in CMS Programs

Endorsed measures are considered the standard for healthcare measurement in the U.S. Interested parties that are comprised of various stakeholders including patients, providers, payers, and health quality measurement experts evaluate measures for endorsement. HHS, including CMS and other federal agencies, and many private sector entities use endorsed measures above all others because of the rigor and consensus-based process used to ensure such measures meet standardized, transparent criteria for evidence and testing. It is critical that quality measures are valid and reliable so that CMS can properly evaluate the health of beneficiaries, be accountable to our stakeholders, and improve the quality of healthcare.

It is also critical that the CBE endorsement and maintenance process helps support CMS strategic initiatives and goals to deliver better value and results for patients across the healthcare system and across the entire continuum of care including nursing homes, palliative, and hospice care. The CBE process supports measures that address CMS priorities including systematic improvements in quality and patient safety in hospitals, nursing homes, hospices, home health facilities, and other areas to promote a more coordinated, integrated healthcare system. This five-year contract will continue the statutorily mandated work under section 1890(b)(2) and (3) of the Act for endorsing and maintaining measures in a consensus-based process so that CMS can incorporate feedback and best-in-class measures in its quality and VBP programs.

- Multi-Stakeholder Input on the Selection and Removal of Quality and Efficiency Measure in CMS Programs

During the last Option Period of the contract ending in February 2023, the National Quality Forum – which was the CBE at the time – provided HHS with recommendations on measure utilization and removal across Medicare quality programs from a partnership of interested parties convened by the CBE. This statutorily mandated activity under section 1890A(a) of the Act is part of the Medicare pre-rulemaking process. Additionally, Section 102(c) of Division CC of the Consolidated

Appropriations Act, 2021 (Pub. L. 116-260, enacted December 27, 2020) amended section 1890(b) to add a new paragraph (4) that authorizes the CBE to provide input for measures that could be considered for removal.

The CBE convenes key interested parties to evaluate quality and efficiency measures under consideration in specific Medicare payment and public reporting quality programs as the final steps of the pre-rulemaking cycle. They also review measures actively in those programs and make potential removal and replacement recommendations under the Measure Set Review process.

During nominations for the multi-stakeholder committees, the CBE seats a diverse group of interested parties, including but not limited to representation from patient, family, and caregiver advocacy groups; racial and ethnic minorities; health plans; healthcare providers and practitioners; and experts in rural health or rural healthcare, health disparities, and quality measurement. Additional to committee recommendations, the CBE solicits public comments to further the diversity of perspectives and expertise in reviewing these measures and program so that balance recommendations can be made to HHS.

The process and activities maximize expert insight and perspectives on the quality measurement and quality improvement approaches to support CMS's promotion of better health outcomes for individuals and communities through our Medicare quality reporting and payment programs. Valuable input from national experts across a range of perspectives to help weigh in on the impact these measures will have on various priorities such as health equity, maternal health, nursing home quality and safety, hospice quality and safety, patient-reported outcome performance measures (PRO-PMs), and affordability of care. Gathering interested party feedback on the selection and removal of quality and efficiency measure in CMS Programs gives an opportunity for an additional layer of transparency to Medicare quality reporting and payment programs by having a vehicle across public and private sectors by which to discuss gaps and obtain early feedback on our measure sets and other cross-cutting measurement issues.

Other Activities of the Consensus-Based Entity

Other activities supported by the CBE contract focus on advancing quality through quality measurement and promoting value. The work leverages the unique strengths and expertise of the CBE and its wide network of partners and interested parties to evaluate and make recommendations on specific initiatives which will meaningfully impact quality measurement and performance and promote measure alignment efforts across the public and private sectors.

- Core Quality Measures Collaborative (CQMC)

This task implements section 1890(b)(7) of the Act. The CQMC, a group of healthcare leaders that facilitate cross-payer measure alignment through the development of core sets of measures to assess the quality of healthcare in the U.S., is a public-private partnership between America's Health Insurance Plans (AHIP) and CMS and is convened by the CBE. The CQMC supports nationwide quality measure alignment between Medicare and private payers through the development of core measure sets and in turn, advances the ongoing work to align reporting across programs and health systems. This work supports CMS efforts to reduce burden, creating parsimonious measure sets that reflect national quality priorities and measure alignment.

To date, the CQMC has developed 13 core measure sets to be used in high impact areas. However, based on the cross-cutting nature of the Digital Measures, Cross-Cutting Measures, and the Health Equity Measure sets, the CQMC has decided to sunset the 3 workgroups and incorporate the measures into the existing 10 measure sets listed below:

- Accountable Care Organization (ACO)/Patient Centered Medical Home (PCMH)/Primary Care
- Cardiology
- Gastroenterology
- HIV and Hepatitis C
- Medical Oncology
- Obstetrics and Gynecology
- Orthopedics
- Pediatrics
- Behavioral Health
- Neurology

The CQMC will continue to review new measures through yearly environmental scans to maintain the core sets and work to eliminate measures that are no longer needed, or that have been topped out. Future work will include support of core set implementation and the development of a long-term strategy, as well as additional core set development. Light and full maintenance will be performed yearly for all core sets to ensure the CQMC is using the most up to date measure and removing measures that are no longer needed in the set. The definitions for light and full maintenance, as established by the CQMC, are listed below:

> A full maintenance review is a comprehensive review of the measures currently in the core set and potential measures that could be added to the set. A full review includes reviewing measures for addition, current measures for potential removal, the measure gaps list and discussing implementation guidance.
>
> The goal of the light review process is to allow the core sets to stay remain stable over time to support adoption while allowing a way to make necessary updates in a timely manner. The light maintenance process focuses on measures that should be removed from the set expeditiously (e.g., change in evidence, may be causing unintended consequences) and identify gaps to support the next full review.

Continued efforts will focus on advancing measure sets to be manageable for organizations to adopt and continuing to provide guidance through the CQMC website, while aligning the CQMC measure sets to CMS priorities. The work of the CQMC to develop core measure sets will address widely recognized and long-standing challenges of quality measure reporting and help to align quality measurement across all payers, reducing burden, simplifying reporting, and resulting in a consistent measurement process. This in turn can result in reporting on a broader number of patients, higher reliability of the measures, and improved and more accurate public reporting.

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

- The Measures Management System (MMS) Contract

Period of Performance	Fiscal Year	Funding Amount
OIT Cloud	2024	$165,000 (Estimated)
MMS Task Order – Option Period 1 08/30/24-08/29/25		$2,584,345 (Negotiated)
Total		**$2,749,345**
OIT Cloud	**2025**	$168,795 (Estimated)
MMS Task Order – Option Period 2 08/30/25-08/29/26		$2,542,102 (Negotiated)
Total		**$2,710,897**

NOTE: If contracts have been awarded and the cost is already negotiated for option years, this is indicated as 'negotiated'.

The technical support by the Measures Manager and its tools, resources, and education enables high caliber, meaningful quality measure development and alignment, which is critical for not only CMS and federally contracted work, but for all quality measure development work across the public and private sectors to make data driven decisions. Costs are needed for the Office of Information Technology (OIT) to host MMS tools on the CMS cloud platform. The MMS tools and education are used by the entire healthcare industry. Specific activities include:

- Continued maintenance and improvements to the CMIT (https://cmit.cms.gov/cmit/#/) to capture all quality and efficiency measures across the measure lifecycle. This includes measures from the development phase (measures under development [MUD]), MUC as well as quality and efficiency measures proposed and finalized in federal rules. This facilitates transparency and alignment of CMS program quality measurement for the public-private sector. Additionally, CMIT houses time and resource saving tools. These include the ESST that provides information on measures published in the medical literature through environmental scans. The DNMS helps measure developers conduct early and frequent environmental scans while developing new measures and reduces the time required to conduct information gathering. The DNMS is an advanced feature of the ESST on the controlled-access version of CMIT.
- The CMS MERIT (https://cmsmerit.cms.gov/merit/#/login) is the tool for measure developers to submit their clinical quality and efficiency measures for consideration by CMS and to support the statutorily mandated pre-rulemaking process under section 1890A(a) of the Act. CMS MERIT is also used for facilitating searches of measures from the current and previous years and structuring the workflow for CMS review of measures submitted to MERIT. MERIT is annually updated to maintain currency and efficiency for all users including measure developers and CMS staff.
- Education and outreach to patients, caregivers, clinicians, measure developers, and interested parties to encourage and facilitate their involvement in the measure development

process and support patient-centered quality measurement through monthly communications to over 100,000 subscribers, and The Hub.
- Continued support for measure developers, contracted by CMS and external to CMS, by CMIT, ESST, MERIT, and The Hub, allowing developers to find the measure development and quality-related information more easily. Additionally, for CMS-contracted measure developers and CMS staff, the MMS provides a web-based library that houses many measures related deliverables submitted to CMS across contractors to promote the sharing of best practices, collaboration across contracts and programs, and the streamlining of work, such as environmental scans and business cases.

As CMS evolves its quality footprint, it is critical that the MMS continues to engage and educate healthcare providers and experts, while also documenting best practices and supporting measure developers to ensure consistent and high caliber measures to improve health outcomes for beneficiaries. With the goal and focus of improved health outcomes, the MMS tools, resources, and technical assistance are intended to support improved measure development and alignment processes.

- The Coordination of Quality and Public Reporting Programs and Websites Contract

Period of Performance	Fiscal Years	Funding Amount
Base Period 02/22/24-02/21/25	**2024**	**$1,329,647 (Estimated)**
Option Period 1 02/22/25-02/21/26	**2025**	**$1,343,906 (Estimated)**

For more than 20 years, Medicare's online compare tools have served as the cornerstone for publicizing quality care information for patients, caregivers, consumers, and the healthcare community. CMS has been a driving force behind public quality reporting on facility and clinician performance based on the premise that making this information available to the public will drive improvements to healthcare quality. A priority goal of CMS is to empower patients to select and access the appropriate, high value care from high quality providers.

Work under this five-year contract supported coordination efforts across the previous Compare websites, through the transition to human centered design public reporting and the current standardized website, allowing users to access information through a single point of entry and simplified navigation to find the quality-of-care information they need. In September 2020, CMS launched two new websites, Care Compare and the PDC, replacing former tools to provide a single user-friendly interface. CMS is working to modernize public reporting and how this data collected from providers are publicly reported. CMS aims to use the latest website design and public reporting research to move the public reporting experience out of the past and into the future. As a result, public reporting can be tailored to the specific population, meeting the data needs applicable to their individual situation.

This task order is critical for ensuring that beneficiaries, caregivers, and other users have access to the accurate and detailed information about all Medicare-certified providers, to find and compare services and make informed healthcare decisions.

Total for Dissemination of Quality Measures

Fiscal Year	Funding Amount
FY 2024	**$4,078,992 (Estimated)**
FY 2025	**$4,054,803 (Estimated)**

(3) Program Assessment and Review

- National Impact Assessment of CMS Quality Measures Contract

Period of Performance	Fiscal Year	Funding Amount
Base Period 07/01/24-06/30/25	**2024**	**$1,700,000 (Estimated)**
Option Period 1 07/01/25-06/30/26	**2025**	**$1,800,000 (Estimated)**

The statute requires CMS to publicly release a comprehensive evaluation once every three years; therefore, work begins immediately following the publication of the previous Impact Assessment Report, to develop the content of the next Impact Assessment Report. The most recent Impact Assessment report was published in February 2024.

In 2027, CMS intends to again collect and analyze quality measure data across CMS quality programs and conduct a comprehensive national evaluation to inform CMS on opportunities to use quality measurement as a lever to improve health equity for individuals served by Medicare, Medicaid, and the Marketplace Health Insurance Program. The work would be guided by a Technical Expert Panel of non-federal individuals and a Federal Assessment Steering Committee (FASC) and would track CMS quality programs' measure trends post-COVID-19 PHE to understand the resilience of the healthcare system. CMS will use expert contracting services to conduct the statutorily mandated evaluation of the impact and efficiency of CMS quality measures at the system level and develop the National Impact Assessment Report. The increase in estimated funding amounts for this contract are due to escalation costs from year to year.

(4) Program Oversight and Design

- Future expenditures are not anticipated in this area.

Summary - Estimated Expenditures and Anticipated Obligations for Activities Under Sections 1890 and 1890A for FYs 2024 and 2025

	FY 2024	FY 2025
Consensus-Based Entity Activities		
Total, Consensus-Based Entity Activities	**$10,351,637**	**$10,611,164**
ecretarial Activities Dissemination of Quality Measures		
Measures Management System	$2,749,345	$2,710,897
Coordination of Compare Websites	$1,329,647	$1,343,906
Subtotal, Dissemination of Quality Measures	$4,078,992	$4,054,803
Program Assessment and Review		
National Impact Assessment of Quality Measures	$1,700,000	$1,800,000
Subtotal, Program Assessment and Review	$1,700,000	$1,800,000
Total 1890 and 1890A Activities	$16,130,629.00	$16,465,967.00

The upcoming work in FYs 2024 and 2025 is critical work that is the foundation of improving healthcare quality in this country. CMS looks forward to opportunities to support efforts from both the public and private sectors to leverage quality measurement to improve health outcomes, reduce reporting burden, and enhance cost savings for the American people.

V. Glossary

Acronym/ Abbreviation	Name or Term
ACA	Patient Protection and Affordable Care Act of 2010
AHIP	America's Health Insurance Plans
AHRQ	Agency for Healthcare Research and Quality
ASPE	Office of the Assistant Secretary for Planning and Evaluation
BBA	Bipartisan Budget Act of 2018
CARES Act	Coronavirus Aid, Relief, and Economic Security Act of 2020
CBE	Consensus-Based Entity
CMIT	CMS Measures Inventory Tool
CMS	Centers for Medicare & Medicaid Services
CQMC	Core Quality Measures Collaborative
FASC	Federal Assessment Steering Committee
FY	Fiscal Year
HHS	Department of Health and Human Services
HRSA	Health Resources and Services Administration
IHS	Indian Health Service
IPT	Integrated Project Team
LTC	Long Term Care
MACRA	Medicare Access and CHIP Reauthorization Act of 2015
MIPPA	Medicare Improvements for Patients and Providers Act of 2008
MMS	Measures Management System
MSR	Measure Set Review
MUC	Measures Under Consideration
NQF	National Quality Forum
OIT	Office of Information Technology
ASTP/ONC	Assistant Secretary for Technology Policy Office of the National Coordinator for Health Information Technology
OY	Option Year
PAC	Post-Acute Care
PAMA	Protecting Access to Medicare Act of 2014
PDC	Provider Data Catalog
PRO	Patient-Reported Outcome
PRO-PM	Patient-Reported Outcome-Performance Measure
QMI	Quality Measure Index
SAMHSA	Substance Abuse and Mental Health Services Administration
SDOH	Social Determinants of Health
SSL Cert	Secure Sockets Layer Certificate

Acronym/ Abbreviation	Name or Term
TEP	Technical Expert Panel
VBP	Value-Based Purchasing
VHA	Veterans Health Administration

Appendix A – Sections 1890 and 1890A of the Social Security Act – Links provided below for published Reports to Congress and the Social Security Act:

Reports to Congress Links:

2019 Report – https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Downloads/CMS-RTC-Quality-Measurement-March-1-2019_508.pdf

2020 Report – https://www.cms.gov/files/document/2020-report-congress-identification-quality-measurement-priorities-strategic-plan-initiatives-and.pdf

2021 Report – https://www.cms.gov/files/document/2021-report-congress-identification-quality-measurement-priorities-strategic-plan-initiatives.pdf 2021 Report – https://www.cms.gov/files/document/2021-report-congress-identification-quality-measurement-priorities-strategic-plan-initiatives.pdf

2022 Report – https://www.cms.gov/files/document/annual-1890-rtc-2022-final.pdf

2023 Report - https://www.cms.gov/files/document/fy20231890rtcfinalpdf.pdf

Sections 1890 and 1890A of the Social Security Act:

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

https://www.ssa.gov/OP_Home/ssact/title18/1890A.htm

Appendix B – Addressing Additional Requirements in Section 1890(e)(2)(B) of the Social Security Act, as added by the Consolidated Appropriations Act, 2021

Ensuring Detailed Information on Quality Measurement Activities

Section 1890(e)(2)(B) of the Act, as added by section 102(b)(1)(G) of Division CC of the CAA, 2021, requires CMS, beginning in 2021, to provide in its annual report to Congress detailed information on four categories of quality measurement activities, the specific amounts obligated or expended on each activity, the specific quality measurement activities required, and the future funding needed. Accordingly, this appendix provides below detailed information on the following four categories of activities:

a. Measure Selection Activities
b. Measure Development Activities
c. Public Reporting Activities
d. Education and Outreach Activities

(a) Measure Selection Activities

In this category, we briefly describe the statutory pre-rulemaking process and the endorsement and maintenance activities of the CBE, which are fundamental to the measure selection process.

There is an annual pre-rulemaking process that CMS follows, as defined in section 1890A, to select measures for use in Medicare quality programs. CMS makes several decisions that influence measure selection throughout the process with the goals of filling critical gaps in quality measurement and focusing the high priority areas for quality measurement outlined in the Meaningful Measures Initiative that support improvements in health outcomes. Each year CMS asks measure developers to submit candidate quality measures to CMS for potential selection.

The measure selection process is guided by the Meaningful Measures framework to streamline quality measurement. This framework is intended to drive outcome improvement through public reporting and payment programs, transition CMS to digital measurement, promote person-centered quality measures, and advancing health equity and closing gaps in care.

CMS makes preliminary decisions on which of these measures it is considering for use in its quality programs, and it publishes this selection of measures in its annual Measures under Consideration list (MUC). The MUC list then undergoes public review by a group of interested parties convened by the CBE. After this review, CMS considers the feedback by interested parties, and chooses which measures to propose to add to CMS quality programs through rulemaking.

In addition, endorsement and maintenance of quality measures is a key and important activity that contributes to the ability of CMS to select quality measures for use in CMS programs. Measures that have undergone the rigorous review by the CBE and are ultimately endorsed indicate that these measures have met a gold standard of review. CMS prioritizes the use of endorsed measures in its programs when appropriate.

Finally, the tasks and projects discussed earlier in this report are included in this category of quality measurement because they provide critical information to us, including measure concepts that should be further developed, appropriateness of measures for certain programs, risk adjustment and measure gaps, all of which comprise part of the overall measure selection process.

In FY 2023, CMS obligated approximately $9.06 million from funding available under sections 1890 and 1890A that is considered Measure Selection. This amount includes funding for activities from the CBE contract and the MMS contract. In FY 2024 and 2025, CMS will need an estimated $9.31 million and $9.26 million respectively from the CBE and MMS contracts to continue this level of Measure Selection work.

(b) Measure Development Activities

Appropriations for sections 1890 and 1890A funding source do not provide funding for quality measure development. For an example of measure development, under the Quality Payment Program, an annual report provides a break-down of quality measures being developed for clinicians in this program. In addition to CMS-developed measures, other public and private measure developers outside of CMS develop measures and submit them for consideration to CMS for inclusion in a particular quality program. The most recent 2023 CMS Quality Measurement Development Plan Annual Report, which generally reflects FY 2022 measure development activities to support the Quality Payment Program, can be found here: https://www.cms.gov/Medicare/Quality-Payment-Program/Measure-Development/Measure-development.

(c) Public Reporting Activities

Beginning in FY 2020, CMS modernized public reporting. CMS's eight Compare Sites and Data.Medicare.gov were replaced with two new websites that meet the needs of patients and beneficiaries making quality, price, and volume data accessible and interpretable, and thereby enabling informed, personalized healthcare decision-making. By FY 2023, CMS efforts focused on maintaining the websites for Care Compare and Provider Data Catalog (PDC) and improving the user experience by enabling an intuitive searchable interface, meaningful and streamlined content and public reporting of quality measures. The Coordination of Quality and Public Reporting Programs and Websites contract oversees the global coordination and efforts to support alignment, prioritization, risk assessment and mitigation, and scheduling and timelines for the readiness of the user interfaces. In 2023, the contractor increased communication, coordination and alignment through development, consolidation and dissemination of a comprehensive 2023 calendar year schedule including 75 release and refresh dates across all compare sites settings, a time-based workflow for planning resources around file creation, data validation, and data deployment in the production environments.

CMS also utilizes appropriations for sections 1890 and 1890A of the Act for public reporting of measure information through the Measure Management System (MMS). The MMS supports important efforts to standardize and promote best practices in quality measurement. Developed by the MMS, the web-based CMS Measures Inventory Tool (CMIT) provides the public access to those measures used in CMS programs.[10]

The National Impact Assessment of CMS Quality Measures Report is published every three years and examines results that help to move CMS's goals to improve healthcare through the

[10] https://cmit.cms.gov/CMIT_public/ListMeasures

implementation of quality measures meaningful to both patients and providers. This report includes quality measures used in 26 CMS quality programs.

In FY 2023, CMS continued this work and obligated $7.44 million for public reporting activities. In future years (FY 2024 and 2025), CMS will need an estimated $5.57 million and $5.65 million respectively to continue this level of Public Reporting work. These amounts include funding for activities from the MMS contract, the Coordination of Quality and Public Reporting Programs and Websites contract, and the program assessment and review contract.

(d) Education and Outreach Activities

In FY 2023, CMS continued to increase knowledge and engagement on quality measure and development topics through education and outreach by leveraging tools and outreach venues available through MMS. Given the role MMS plays at supporting standardization of measure development, transparency of quality measures across CMS programs, and promotion of best practices, MMS is in the unique position to provide education to a diverse group of CMS stakeholders, addressing all CMS quality reporting and VBP programs and healthcare settings. Through various quality measurement technical assistance resources and tools, the MMS engages patients, caregivers, measure developers, clinicians, and others. Contractor responsibilities include bimonthly informational webinars, advertising technical expert panels and other engagement opportunities for other CMS contractors and quality programs, distributing monthly newsletter, maintaining a robust website, and developing resources to further engage and educate interested parties in the measure development process.

An important resource, critical to the foundation of the MMS, is the CMS MMS Blueprint, which outlines the conceptual and operational phases and elements of quality measure development. By conveying standards that developers can use to gauge for the readiness of their measures to be endorsed, the Blueprint decreases the CBE Standing Committee's burden of reviewing low-quality measures. Work continues to simplify and streamline the Blueprint and to make it more accessible to specialty societies, patient advocacy groups, researchers, and other private sector entities looking to submit measures into CMS programs or engage with CMS in the measure development process.

The MMS provides education and outreach for patients, families, clinicians, caregivers, providers, hospitalists, measure developers, and others to engage with CMS in the measure development process and understand the impact quality measurement can have. The monthly MMS newsletter is distributed to over 100,000 subscribers across the quality measurement enterprise. The annual public webinars are attended by over 2,500 participants, with another 1,500 viewing the recording.

In FY 2023, CMS obligated $0.1 million under the MMS contract to fund activities to be considered Education and Outreach. In the next two years, FY 2024 and FY 2025, CMS will need an estimated $0.1 million for each fiscal year to continue this level of Education and Outreach work.