Report to Congress:

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

A Report Required by the Bipartisan Budget Act of 2018

United States Department of Health and Human Services
Centers for Medicare & Medicaid Services
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Executive Summary

The United States Department of Health and Human Services (HHS), including the Centers for Medicare & Medicaid Services (CMS), works to protect and strengthen access to high-quality, affordable health care for people across the country. Through its value-based purchasing and quality reporting programs, CMS partners with the health care community to improve quality, value, and health outcomes. CMS leads national efforts to raise care standards by establishing and refining quality measures and supporting initiatives that promote better patient outcomes.

Pursuant to section 1890(e) of the Social Security Act (the Act), as amended by the Bipartisan Budget Act of 2018, the Secretary of HHS must submit an annual report to Congress describing how the contracted Consensus-Based Entity (CBE) (currently Battelle Memorial Institute) and other organizations carried out the quality and performance measurement activities required under sections 1890 and 1890A of the Act. It is also required to include an annual update on the funding CMS has obligated or expended and anticipates will be needed in the succeeding two year period to carry out the statutory requirements and align with CMS's complex quality measurement methods and systems.

CMS uses this funding to support four main areas of work:

1. Duties of the CBE
2. Dissemination of quality measures
3. Program assessment and review
4. Program oversight and design

I. Background

CMS collaborates with patients, clinicians, health care facilities, health plans, post-acute care (PAC) and long-term care (LTC) facilities, state governments, specialty societies, and quality measurement experts to improve health outcomes for all individuals. It uses national quality reporting as one of the key tools to drive these improvements.

CMS actively supports the essential infrastructure, trust, scientific validity, and consensus-based multi-stakeholder review and comment related to the development, selection, and implementation of measures across its programs. Under section 1890 of the Act, CMS engages the CBE through a contract to endorse measures and provide input on those measures before they are incorporated into Medicare programs via rulemaking. Under section 1890A of the Act, CMS implements the pre-rulemaking process where the CBE gathers input from interested parties on the quality measures CMS is considering for various reporting and value-based purchasing programs.

Since CMS published the first report to Congress in 2019, the agency continues to align measures, close gaps in priority areas, and work closely with partners across the health care system. This year's report builds on past reports by explaining the updates CMS made over the last year and highlighting new work.

II. Comprehensive Plan

Section 1890(e)(1) requires that this report to Congress 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 statutorily-mandated work, specifically with respect to Medicare programs.

CMS continues to refine the comprehensive plan and works to ensure the goals and actions align across the entire quality measurement enterprise. With partnerships across the health care industry, CMS continues to raise the bar for a resilient, high-value health care system that promotes quality outcomes, safety, and accessibility for all individuals. CMS's Meaningful Measures 2.0 focuses on 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, the federal government, and private entities.
- Prioritizing outcome and patient-reported measures.
- Transforming measures to be fully digital and incorporating all-payer data.

Since 2023, CMS has used the Universal Foundation, an approach that builds on the Meaningful Measures 2.0 goals, to streamline quality measures across CMS quality programs for the adult and pediatric populations.[1] The Universal Foundation is intended to focus provider attention, reduce burden, prioritize development of digital quality measures, allow for cross-comparisons across programs, and help identify measurement gaps. In 2024, CMS developed the Hospital, Post-Acute Care, and Maternity Care "add-on" sets to promote the best and safest care for individuals across these critical quality areas. In 2025, CMS continued to advance the Universal Foundation and considered several strategies to support greater alignment across CMS programs, including:

- Developing additional setting- and population-specific "add-on" measure sets.
- Replacing or removing measures when goals are met.
- Adding measures to assess quality across the care journey.
- Testing new and innovative measures through the Center for Medicare and Medicaid Innovation.

III. Funding, Obligations, and Expenditures for Activities Conducted Under Sections 1890 and 1890A of the Act for FY 2025

Section 1890(e) requires that this report to Congress include the amount of funding obligated and expended to carry out quality measurement related activities under sections 1890 and 1890A (as well as amounts that remain unobligated) and a description of how the funds have been used. CMS used FY 2025 funds for the work of the CBE and other entities pursuant to sections 1890 and 1890A of the Act to build on previous activities and continue its commitment and investment to support meaningful, scientifically sound quality measures. The CBE's endorsement and

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

maintenance of quality measures, consensus-based recommendations of measures for use and/or removal from CMS Medicare programs, and strategies to address primary prevention, initial recognition and management, management of acute events, chronic disease, surgery, behavioral health, advanced illness, post-acute care, and cost and efficiency are all accomplishments of the CBE.

Table 1 identifies the appropriated funding and funds obligated and expended for activities outlined in sections 1890 and 1890A of the Act.

Table 1: Funding authority (in millions), funds obligated, and funds expended by public law, as of September 30, 2025

Public Law Amending Section 1890 of the SSA	Appropriation	Sequester	Adjusted Amount	Obligations	Unobligated Amount	Expended Amount
Bipartisan Budget Act of 2018, 50206 (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	$20.00
Consolidated Appropriations Act (CAA), 2021 (Pub. L. 116-260, enacted December 27, 2020) for FY 2021	$26.00	$0.00	$26.00	$26.00	$0.00	$21.55
CAA, 2021 for FY 2022	$20.00	($0.57)	$19.43	$19.43	0.00	$16.97
CAA, 2021 for FY 2023	$20.00	($1.14)	$18.86	$18.86	$0.00	$18.73
CAA, 2024, Division G, Title I, Subtitle C (Pub. L. 118-42, enacted March 9, 2024)	$9.00	$0.00	$9.00	$9.00	$0.00	$4.96
American Relief Act, 2025 (Pub L. 118-158, enacted December 21, 2024)	$2.03	$0.00	$2.03	$2.03	$0.00	$0.98
Full-Year Continuing Appropriations and Extensions Act, 2025 (Pub. L. 119-4, enacted March 15, 2025)	$3.00	$0.00	$3.00	$3.00	$0.00	$0.00

Table 2 below identifies the total amounts of funding obligated and expended in FY 2025 using funds appropriated to implement sections 1890 and 1890A of the Act. The CBE and other CMS-funded contractors conducted the activities funded by the mandatory appropriations for sections 1890 and 1890A of the Act. Table 2 excludes funding for activities performed by the Secretary.[2]

[2] Section 1890(b)(5)(B), and (e) describes activities performed by the Secretary. The funding used for these activities are not included in Table 2.

Table 2: FY 2025 Funding (in millions) obligated and expended under sections 1890 and 1890A of the Act, including administrative costs, as of September 30, 2025[3]

Funding Section	Obligations	Expended Amount
1890	$11.86	$7.27
1890A	$2.40	$1.54
Total	**$14.26**	**$8.81**

The sections below provide additional detail on the activities funded by sections 1890 and 1890A of the Act followed by a table showing the corresponding funding amounts. These activities are categorized by the 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.

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

The CBE contract aims to ensure that the health care community can use safe, effective, and reliable quality measures. Under this contract, the CBE brings together patients, clinicians, health plans, facilities, researchers, and other experts to review new and existing quality measures to make sure they are important, scientifically sound, useful, and feasible to implement. In the contract, CMS also asks the CBE to identify priority areas and gaps in measurement, such as access to care, prevention, and chronic disease management, and to support HHS efforts to improve care and health outcomes.

Under section 1890(b)(5), each year by March 1, the CBE must submit an annual report to Congress and the Secretary of HHS that outlines the quality measurement work completed in the previous calendar year. As part of the pre-rulemaking process required by section 1890A, the CBE gathers input from interested parties on the quality measures CMS is considering for various reporting and value-based purchasing programs.

The CBE also develops consensus-based recommendations to help CMS advance a coordinated national strategy for quality measurement and improvement. In addition, the CBE works on creating a prevention and wellness measurement framework to strengthen prevention-focused quality measurement across care settings.

In addition, the CBE created the Partnership for Quality Measurement™ (PQM) to facilitate its CBE activities. The PQM is comprised of interested parties, including but not limited to health care providers (e.g., clinicians, health plans, health systems), patients and caregivers, measure experts (e.g., developers, stewards, researchers), and health information technology specialists. Membership in the PQM is free, and to participate in any of the CBE's committees (e.g., Endorsement and Maintenance, Pre-Rulemaking Measure Review, Measure Set Review, etc.), individuals and organizations must be members of the PQM. To support these measure review processes, the CBE focused on enhancing training for CBE committees, developing an artificial intelligence (AI) tool, and developing digital measure review criteria.

Activities in this category of work, described in more detail below, include endorsement and maintenance of quality measures, pre-rulemaking review of quality measures and measure set

[3] We note that the CBE contract in FY 2025 was from February 27, 2025, to February 26, 2026.

review for removal of measures, the publication of a required annual report, and convening of the Core Quality Measures Collaborative (CQMC) to align quality measures used by public and private payers across a wide array of specialty areas.

Endorsement and Maintenance (E&M) of Measures

CMS prioritizes use of measures reviewed and endorsed by the CBE through the Endorsement and Maintenance process. This review process is the "gold standard' for quality measures for the nation and demonstrates 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.

Across two E&M cycles in FY 2025 (Fall 2024 and Spring 2025), measure developers and stewards submitted 92 measures; the E&M committees reviewed 59. Of those measures, 21 were endorsed; 33 were conditionally endorsed; and five were not endorsed, or endorsement was removed. The CBE convened health care experts to ensure that measures endorsed by the CBE are updated (or retired if obsolete) with consideration of new, relevant evidence. 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. The process currently has two review cycles per year for each of the topic-specific projects (e.g., primary prevention, cost and efficiency, etc.).

Pre-rulemaking Measure Review (PRMR) and Measure Set Review (MSR)

The CBE facilitates two processes: PRMR and MSR, established in sections 1890A(a) and 1890A(c) of the Act, respectively. The CBE provides HHS with meaningful recommendations on quality measures either being considered for use or for measures being considered for removal and or continued use in CMS quality and value-based reporting programs. The CBE convenes interested parties most impacted by quality measurement for both PRMR and MSR. These interested parties include patients, caregivers, and advocacy groups; population health and rural health experts; purchaser/health plan representatives, and health service researchers; clinicians and clinician associations; representatives from facilities and institutions; and measure developers/stewards.

The PRMR process is conducted annually once the Measures Under Consideration (MUC) List is published on or before December 1 each year. The CBE convenes recommendation committee groups for each care setting, including Hospital, Clinician, and PAC/LTC. Each measure is reviewed for appropriateness to the program and target population. The input received consists of public comments and committee recommendations and is provided to HHS as part of the year-long pre-rulemaking process for CMS quality and value-based programs. In the 2025 PRMR cycle, the recommendation committees reviewed and provided input on 24 quality measures from the MUC List, which were considered for 17 CMS quality programs.

The MSR process seeks input from the public and a recommendation group for the potential removal or continued use of measures in a CMS quality program to optimize the CMS measure portfolio. MSR evaluates measures to avoid redundancy and ensure that high-value measures address the right aspects of patient care to improve outcomes. For the 2025 MSR cycle, the

recommendation group reviewed and provided input on 21 measures for use in six CMS quality programs.

Annual Report

Each year, as required by section 1890(b)(5) of the Act, the CBE drafts and publishes a report to Congress and the Secretary. The report includes: 1) an itemization of financial information for the previous FY ending September 30, including annual revenues of the entity, annual expenses of the entity, and a breakdown of the amount awarded per contracted task order and the specific projects funded in each task order assigned to the entity, and 2) any updates or modifications to internal policies and procedures of the entity as they relate to the duties of the CBE including specifically identifying any modifications to the disclosure of interests and conflicts of interests for committees, work groups, task forces, and advisory panels of the entity, and information on external stakeholder participation in the duties of the entity. No later than six months after receiving the report, the Secretary publishes the report in the Federal Register and provides comments, if any, on the report.

Core Quality Measures Collaborative (CQMC)

Convened by the CBE, the CQMC is a group of health care leaders working to facilitate cross-payer measure alignment through the development of core measure sets to assess the quality of health care in the U.S. The CQMC is a public-private partnership between America's Health Insurance Plans (AHIP) and CMS, to promote a patient-centered assessment of quality that could be efficiently implemented across both commercial and government payers (e.g., CMS and the Department of Veterans Affairs).

The CQMC continued ongoing maintenance of the existing core measure sets to reflect the changing measurement landscape, including changes in clinical practice guidelines, data sources, or risk adjustment. In addition, the CQMC identified gaps in measurement and challenges in implementation to advance adoption of the core sets. Over the past year, the CBE facilitated the review of 173 measures across seven CQMC work groups. In FY 2025 to support the maintenance of CQMC core sets, the work focused on performing environmental scans to identify new measures for potential inclusion, holding steering committee meetings to discuss feedback, and development of a communications plan and strategy to engage stakeholders through convening work group meetings.

In addition to the routine maintenance of the core sets, the CBE collaborated with AHIP and health services providers to draft a CQMC Implementation Guide/Tool Kit to outline processes and provide links to tools that aid in implementing core sets. The CBE received recommendations from the CQMC Steering Committee, the Full Collaborative and the core set work groups to complete the Implementation Guide/Tool Kit.

Table 2.1 below describes the funding for FY 2025 for CBE-required and other consensus-based activities under sections 1890 and 1890A of the Act.

Table 2.1: Total for Duties of the Consensus-Based Entity in FY 2025

Period of Performance	Funding Amount
Base Period 02/27/25-02/26/26	**$13,703,925**

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

Section 1890A(b) of the Act requires the Secretary to establish a process for disseminating quality measures. CMS also uses MMS tools, including MERIT, to support pre-rulemaking activities under section 1890A(a). CMS, along with contractors, developed several tools, resources, and education to enable high caliber, meaningful quality measure development and alignment.

The Measures Management System (MMS)

The MMS consists of several key tools and resources to assist measure developers and other interested parties in the different stages of the Measure Lifecycle, including: the CMS MUC Entry/ Review Information Tool (MERIT), the CMS Measures Inventory Tool (CMIT), the De Novo Measure Scan, the Environmental Scan Support Tool, and the MMS Hub. CMS MERIT is a web-based data collection tool used by CMS, measure stewards, and developers to submit quality and efficiency measures, for consideration and potential use in CMS quality programs. As the sole submission tool for quality and efficiency measures that inform the annual MUC List, CMS MERIT serves as the entry point for the pre-rulemaking process described in section 1890A(a) of the Act. The MUC List is subsequently reviewed by various interested parties convened by the CBE, who provide input and recommendations to CMS. The MMS contractor also supported the quality measurement community with education and engagement opportunities through information sessions and webinars to support measure development.

As noted in the *2025 Report on Unobligated Balances for Appropriations Related to Quality Measurement,*[4] CMS achieved operational efficiencies by utilizing an alternative funding source for MMS activities not specifically mandated under sections 1890 and 1890A of the Act. Funds designated in section 1890 of the Act will continue to support pre-rulemaking activities, including MERIT and MUC activities, as described above and performed under the MMS contract.

Other Costs (Information Technology and Licensing)

The funds for the Base Year MMS contract modification supported the migration of the MMS platform (containing web applications such as CMS MERIT) to the CMS Cloud, as required by CMS Information Technology policies. The CMS Office of Information Technology (OIT) and Secure Sockets Layer Certificate costs cover cloud computing and storage, software licensing, and ensure meeting security-related OIT requirements. FY 2025 funds supported the integration with CMS enterprise user authentication service providers and the improvement of MMS Hub tools, such as CMS MERIT, to support user requirements.

Table 2.2 below describes the total FY 2025 funding for the pre-rulemaking activities as part of the MMS contract and other costs as described above. These are statutorily mandated activities the Secretary performs and that CMS funds through the appropriation in section 1890(d)(2) of the Act.

[4] https://www.cms.gov/files/document/2025-report-unobligated-balances-appropriations-related-quality-measurement.pdf

Table 2.2: Total Dissemination of Quality Measures in FY 2025

Description	Funding Amount
Total Secretarial Activities for Dissemination of Quality Measures (MUC List)	**$206,306**

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

National Impact Assessment of CMS Quality Measures

Section 1890A(a)(6) of the Act requires the Secretary to 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. To satisfy this provision, CMS published National Impact Assessment Reports in 2012, 2015, 2018, 2021, and 2024.[5]

In FY 2025, CMS began preparing the 2027 National Impact Assessment of CMS Quality Measures, which is targeted for publication by March 2027. CMS drafted the report outline and methodology and recruited a Technical Expert Panel (TEP) to help guide the analyses and structure of the report. The TEP includes experts from public and private organizations, along with a federal steering committee that includes agencies such as the Agency for Healthcare Research and Quality, the Centers for Disease Control and Prevention, the Health Resources and Services Administration, and the Indian Health Service.

The 2027 report will assess how CMS quality measures have performed since the 2024 report and across CMS's value-based and quality reporting programs. It will estimate how many patients were affected by these measures and the costs that were avoided. The report will also examine priority areas such as patient safety, chronic conditions, prevention and wellness, rural health, closing gaps in care, reducing burden, and recovery from the public health emergency.

CMS will use the findings to identify opportunities to strengthen quality measurement and improve health outcomes for people served by Medicare, Medicaid, and Marketplace programs.[6]

Table 2.3 Total for Program Assessment and Review in FY 2025

Period of Performance	Funding Amount
Base Period 06/01/25-05/31/26	**$355,431**

[5] Previous reports can be found at: https://www.cms.gov/medicare/quality/measures/national-impact-assessment.

[6] The cost estimates for fiscal years (FYs) 2026 and 2027 contained in this report reflect what CMS learned from previous years to ensure the best value for taxpayers.

(4) Program Oversight and Design

There have been no expenditures in this area since 2019.

Pursuant to Section 3b of Executive Order (EO) 14222 – *Implementing the President's "Department of Government Efficiency" Cost Efficiency Initiative*, HHS conducted a comprehensive assessment of all existing covered contracts for reducing contract costs.

IV. Estimated Expenditures and Anticipated Obligations for Activities Under Sections 1890 and 1890A of the Act for FYs 2026 and 2027

In FYs 2026 and 2027, under the contract(s) with the CBE and other entities to perform statutorily required tasks in sections 1890 and 1890A of the Act, CMS will continue efforts to streamline and enhance CMS's approach to quality measurement while improving how people access information to make informed decisions for themselves and their families, with a particular focus on advancing health care outcomes and closing gaps in care.

With the efforts of the CBE and the interested parties brought together by the CBE, CMS benefits from insights of key health sector and national quality improvement leaders. CMS evaluates measures for endorsement, identifies measure gap areas, and recommends high-value measures for use in CMS quality programs to improve outcomes while reducing burden on clinicians and maintaining a patient-centered focus. CMS's efforts to assess and review programs through the triennial Impact Assessment report provides the feedback and analytical data necessary for ongoing evaluation of the measurement activities. Collectively, these activities ensure experts and other interested parties are active participants in guiding, evaluating, and benefiting from CMS's continual efforts to improve health care quality and advance the transition to value-based care.

The quality measurement work accomplished by the CBE and other contractors is crucial to implementing quality reporting programs, value-based payment programs, public reporting of quality measure data, and adoption of high-value measures that support informed decision-making by patients, clinicians, and health care systems. This statutorily-mandated work provides the foundational infrastructure, scientific rigor, and consensus-based review processes that are central to national quality reporting efforts aimed at improving health outcomes for all individuals.

CMS expects to use the projected funds in FY 2026 and FY 2027 to continue its quality-measurement work across the four task areas described earlier. These cost estimates are based on what CMS has learned from previous years.

The projections reflect CMS's priorities for the next two years, including advancing digital quality measures, refining and implementing the prevention and wellness framework, testing an AI tool to support measure review, and gathering expert recommendations to guide a national quality measurement strategy.

The amounts shown are estimates and may change if funding levels differ from expectations. If CMS already negotiated contract costs for future option years, those appear as "negotiated" in the tables. Costs for new work or contract modifications expected in FY 2026 or FY 2027 appear as "estimated."

The unobligated amount from FY 2024, as of September 30, 2025, is $2.14M. This is the carry over amount for FY 2025.

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

Period of Performance	Fiscal Year	Funding Amount
Option Period 3 02/27/26-02/26/27	**2026**	**$14,359,064 (Estimated)**
CBE Hybrid Cloud AI Tool	**2026**	**$44,842 (Estimated)***
Option Period 4 02/27/27-02/26/28	**2027**	**$14,777,911 (Estimated)**
CBE Hybrid Cloud AI Tool	**2027**	**$30,900 (Estimated)***

*The CBE Hybrid Cloud AI Tool is separated from the CBE contract funding amount because it is not part of the CBE contract. It is a separate CMS OIT cost. The 2026 estimated amount covers one and a half years.

E&M of Measures

CBE-endorsed measures are considered the standard for health care measurement in the U.S. Pursuant to statute, the CBE convenes various interested parties that are comprised of stakeholders including patients, providers, payers, and health quality measurement experts to evaluate measures for endorsement. HHS, including CMS, other federal agencies, and many private sector entities use endorsed measures because of the rigor and consensus-based process that ensures 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 health care.

It is also critical that the CBE E&M process helps support CMS strategic initiatives and goals to deliver better value and results for patients across the health care system and across the entire continuum of 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 health care system. HHS's five-year contract with the CBE includes 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 value-based purchasing programs.

PRMR and MSR

Annually, the CBE provides HHS with recommendations from experts as part of a statutorily-required pre-rulemaking process outlined in section 1890A(a) of the Act. The CBE convenes multi-interested parties to evaluate quality and efficiency measures submitted by CMS and external measure developers to be considered for specific Medicare quality and payment programs as the

final steps of the pre-rulemaking cycle. Additionally, the Consolidated Appropriations Act, 2021, amended section 1890(b) of the Act to authorize the CBE to provide input to CMS on quality and efficiency measures that could be considered for removal from Medicare quality and payment programs under the MSR process.

During selection of the multi-interested party committees, the CBE focuses nominations on a diverse group of individuals, including but not limited to representation from patient, family, and caregiver advocacy groups; health plans; health care providers and practitioners; and experts in rural health and quality measurement. In addition to committee input, the CBE solicits public comments to further the diversity of perspectives and expertise in reviewing these measures so that balanced 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 is provided across a range of perspectives to help weigh in on the impact these measures will have on various health care quality priorities such as safety, nutrition, chronic conditions, prevention (primary, secondary & tertiary), well-being, and person-centered care. Gathering interested party feedback on the selection and removal of quality and efficiency measures 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 CMS's measure sets and other cross-cutting measurement issues.

Other Activities of the CBE

Other activities supported by the CBE contract focus on promoting value related to quality measurement and improvement. The CBE intends to lead several initiatives supporting federal priorities in prevention & wellness, digital measurement and AI. 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. CBE activities include development of a five-year strategic framework to guide meaningful and science-based recommendations to CMS; development of a structured framework to assess readiness and reliability of digital measures; testing the use of AI to reduce burden in measure evaluation processes; and enhancement of education and decision-making tools for CBE committee members to support measure evaluation processes.

CQMC

As a public-private partnership between AHIP and CMS, the CQMC members consist of over 70 member organizations, such as health insurance organizations, primary care and specialty societies, consumer and employer groups, and other quality collaboratives. The CQMC continues to focus on maintaining the 10 developed Core Measure Sets to be used in high-impact areas.

- Accountable Care Organization/Patient-Centered Medical Home/Primary Care
- Cardiology
- Gastroenterology

- HIV and Hepatitis C
- Medical Oncology
- Obstetrics and Gynecology
- Orthopedics
- Pediatrics
- Behavioral Health
- Neurology

The CQMC continues to review new measures through yearly environmental scans and focuses on advancing measure sets to be manageable for organizations' adoption in alignment with CMS priorities. Future work will include support of core set implementation and the development of a long-term strategy. The CQMC will perform annual maintenance for all 10 core sets to ensure it is using the most up-to-date measures and removing measures that are no longer needed in each core set. The CQMC addresses widely-recognized and long-standing challenges in quality measure reporting and aligns/simplifies/improves consistency in quality measurement, thereby reducing burden across all payers.

(2) Secretarial Activities for Dissemination of Quality Measures under Section 1890A(b) of the Act

Period of Performance	Fiscal Year	Funding Amount
Total MMS Task Order – Option Period 3 08/30/26-08/29/27	**2026**	**$310,391 (Estimated)**
Total MMS Task Order – Option Period 4 08/30/27-08/29/28	**2027**	**$313,060 (Estimated)**

The MMS Contract

The technical support provided by the MMS tools, resources, and educational offerings enables the development and alignment of high-quality, meaningful quality measures. This support is critical not only for CMS and federally contracted work, but for quality measure development efforts across the public and private sectors that rely on data-driven decision making. CMS MERIT, the web-based portal used by measure developers to submit their clinical quality and efficiency measures for CMS consideration, is supported through a portion of the MMS contract and facilitates the pre-rulemaking process required under section 1890A(a) of the Act. Funding is needed for CMS's OIT to maintain and enhance CMS MERIT.[7] Specific activities include:

- Ongoing maintenance and enhancement of the CMS MERIT application to ensure accuracy, reliability, and useability for all users, including measure developers and CMS staff.
- Enabling efficient search functionality and structured workflows to support CMS review of measures submitted through CMS MERIT.
- Conducting education and outreach to clinicians, measure developers, and other interested parties to encourage and facilitate participation in the pre-rulemaking and measure development processes, including support for the development of the annual MUC List.

[7] https://cmsmerit.cms.gov/merit/#/login

This work also requires ensuring that all MUC-related materials meet federal Section 508 accessibility standards. Because these documents are extensive and technically complex, contractor support is necessary to complete accessibility remediation efficiently and ensure equitable access for all users.

- Providing continued technical support to measure developers, both CMS-contracted and external to CMS, to enable seamless submission of measures for CMS consideration.

The pre-rulemaking support tools, resources, and educational activities provided through the MMS are essential to engaging and educating interested parties and ensuring the development of consistent, high-quality measures across CMS programs to improve health outcomes for beneficiaries.

(3) Program Assessment and Review

Period of Performance	Fiscal Year	Funding Amount
Option Period 2 07/01/26-06/30/27	**2026**	**$712,408 (Negotiated)**
Option Period 3 07/01/27-06/30/28	**2027**	**$0 (Negotiated)**

National Impact Assessment of CMS Quality Measures

The statute requires publication of a national evaluation of CMS quality measures once every three years. The most recent Impact Assessment report was published in February 2024 and work began in FY 2025 to meet the triennial requirement.

CMS intends to continue with the development of a comprehensive national evaluation of impact of quality measures across CMS quality programs. In FY 2026, the data analyses and methodologies will be finalized. The work will be guided by a TEP of non-federal stakeholders and a Federal Assessment Steering Committee and will track CMS quality programs' measure trends since the publication of the last report in 2024. The increase in estimated funding amounts for this contract is due to escalation costs from year to year. CMS does not currently include funding estimates for FY 2027 because the next 2030 triennial report preparation is anticipated for the following year.

(4) Program Oversight and Design

Future expenditures are not anticipated in this area.

Pursuant to Section 3b of Executive Order (EO) 14222 – *Implementing the President's "Department of Government Efficiency" Cost Efficiency Initiative*, HHS conducted a comprehensive assessment of all existing covered contracts for reducing contract costs.

Estimated Expenditures and Anticipated Obligations for Activities Under Sections 1890 and 1890A for FYs 2026 and 2027	FY 2026	FY 2027
CBE Activities	$14,359,064	$14,777,911
CBE Hybrid Cloud AI Tool*	$44,842**	$30,900
Total, Consensus-Based Entity Activities	**$14,403,906**	**$14,808,811**
Secretarial Activities Dissemination of Quality Measures		
Measures Management System	$310,391	$313,060
Coordination of Compare Websites	$0	$0
Subtotal, Dissemination of Quality Measures	**$310,391**	**$313,060**
Program Assessment and Review		
National Impact Assessment of Quality Measures	$712,408	$0
Subtotal, Program Assessment and Review	**$712,408**	**$0**
Total, Secretarial Activities	**$1,022,799**	**$313,060**
TOTAL, 1890 and 1890A Activities	**$15,426,705**	**$15,121,871**

* The CBE Hybrid Cloud AI Tool is separated from the CBE contract funding amount because it is not part of the CBE contract. It is a separate OIT cost.
**This estimated amount covers one and a half years.

The work completed in FY 2026 and upcoming in FY 2027 is critical work that is the foundation of improving health care 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
AHIP	America's Health Insurance Plans
AI	Artificial Intelligence
BBA	Bipartisan Budget Act of 2018
CAA	Consolidated Appropriations Act
CARES Act	Coronavirus Aid, Relief, and Economic Security Act of 2020
CBE	Consensus-Based Entity
CMIT	Centers for Medicare & Medicaid Services Measures Inventory Tool
CMS	Centers for Medicare & Medicaid Services
CQMC	Core Quality Measures Collaborative
E&M	Endorsement and Maintenance
FY	Fiscal Year
HEP C	Hepatitis C Virus
HHS	Department of Health and Human Services
HIV	Human Immunodeficiency Virus
LTC	Long-Term Care
MERIT	Measures Under Consideration (MUC) Entry/Review Information Tool
MMS	Measures Management System
MSR	Measure Set Review
MUC	Measures Under Consideration
OIT	Office of Information Technology
OP	Option Period
PAC	Post-Acute Care
PQM	Partnership for Quality Measurement
PRMR	Pre-Rulemaking Measure Review
SSL	Secure Sockets Layer
TEP	Technical Expert Panel
VA	Department of Veterans Affairs

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

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

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

2024 Report - https://www.cms.gov/files/document/2024-report-congress-identification-quality-measurement-priorities-strategic-plan-initiatives-and.pdf

2025 Report - https://www.cms.gov/files/document/cms-rtc-1890-1890a-quality-measurement.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 include in its annual report to Congress detailed information on four categories of quality measurement activities, including the specific amounts obligated or expended for each activity, the specific quality measurement activities required, and the projected future funding needs. This appendix provides 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

The four categories outlined above encompass all quality measurement activities required under section 1890(e)(2)(B). Certain activities may support more than one category but are reported within the category most closely aligned with the statutory frameworks.

(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. Pursuant to section 1890A of the Act, CMS follows an annual pre-rulemaking process 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 on high-priority areas for quality measurement as outlined in the Meaningful Measures Initiative. The Meaningful Measures Framework promotes outcome measures as well as digital quality measures in an effort to decrease burden on measured entities while promoting person-centered quality measures. Each year CMS asks measure developers to submit candidate quality measures to CMS for potential consideration.

CMS makes preliminary decisions on which measures it is considering for use in its quality programs, and publishes this selection of measures in its annual MUC List. 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 add to CMS quality programs through proposed rulemaking.

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

In FY 2025, CMS obligated approximately $11.2M from funding available under sections 1890 and 1890A of the Act for measure selection. This amount includes funding for activities from the

CBE contract and the MMS contract. In FY 2026 and 2027, CMS will need an estimated $13.2M and $13.5M respectively for the CBE and MMS contracts to continue this level of measure selection work.

(b) Measure Development Activities

Appropriations for sections 1890 and 1890A funding sources do not provide funding for quality measure development. Examples of measures that have been developed for potential consideration in CMS quality programs are publicly accessible in the annual MUC List.[8] In addition to CMS-developed measures, private entities (including external measure stewards or developers) submit measures for consideration to CMS for inclusion in a particular quality program.

(c) Public Reporting

As noted in the *2025 Report to Congress: Identification of Quality Measurement Priorities and Associated Funding for the Consensus- Based Entity and Other Entities*, due to efficiencies that CMS gained by using a different funding source, CMS did not use funds designated in section 1890(d)(2) of the Act in FY 2025 and beyond for public reporting coordination activities. However, activities that maintained support include the development and publication of the triennial National Impact Assessment report, which is anticipated for March 2027. In FY 2025, CMS obligated approximately $355.4K from funding available under sections 1890 and 1890A of the Act that is considered public reporting. In FY 2026, CMS will need an estimated $712.4K; however, no funds needs are anticipated for FY 2027.

(d) Education and Outreach Activities

In FY 2025, CMS continued to increase knowledge and engagement with the quality measurement community with support from the MMS web-based tools, such as CMS MERIT and the MMS Hub, that help provide technical guidance on measure development, pre-rulemaking activities, and quality measure maintenance of CMS quality measures and priorities. There are also education and outreach activities supported by the CBE contract to support technical experts as they participate in consensus meetings to provide CMS recommendations for measures to be considered, maintained, or removed in quality reporting and value-based purchasing programs. In FY 2025, CMS obligated $0.3M for activities considered education and outreach across the CBE contract and MMS pre-rulemaking tasks. CMS anticipates similar funding needs for FY 2026 and FY 2027.

[8] https://mmshub.cms.gov/measure-lifecycle/measure-implementation/pre-rulemaking/lists-and-reports/overview