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

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Executive Summary

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

With the support of federal partners and government contractors, CMS continues to accelerate interoperability and use of digital measures and increase alignment across public and private payer quality reporting programs and care settings. CMS builds on efforts to address key healthcare quality priorities such as chronic conditions, safety, wellness, nutrition, and person-centered care to create a more resilient healthcare system.

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 seventh annual update of the coordinated strategy and related funding for using the Consensus-Based Entity (CBE) under contract with HHS. This report describes activities performed by the Battelle Memorial Institute (Battelle), which was awarded the 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. Furthermore, cost estimates developed for fiscal years 2025 and 2026 are informed and refined by the experience of previous years to reflect best value for taxpayer dollars.

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.

I. Background

CMS, in collaboration with various interested parties such as patients, clinicians, healthcare facilities, health plan associations, post-acute care (PAC) and long-term care (LTC) facilities, state governments, specialty societiesand quality measurement experts, strives to improve health outcomes for all individuals using levers such as national quality reporting. 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 recommendations on those measures before they are incorporated into Medicare programs via rulemaking.

Since the first *Report to Congress: Identification of Quality Measurement Priorities – Strategic Plan, Initiatives, and Activities* (the 2019 report to Congress), which documented the CMS quality measurement processes and activities performed pursuant to sections 1890 and 1890A of the Act for the period of 2018 and prior, CMS has continued to promote measure alignment, address quality measurement gaps in key priority areas, and collaborate with interested parties.

This report to Congress builds upon the previous reports to Congress, providing annual updates reflecting key modifications to existing work and highlighting new measurement activities since last year's report, including updates on tasks, activities, and funding details such as dollars obligated, expended, and projected to carry out the work required in sections 1890 and 1890A 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.

II. Comprehensive Plan

CMS continues to refine the comprehensive plan required by section 1890(e) of the Act and works to ensure the goals and actions align across the entire quality measurement enterprise. With partnerships across the healthcare industry, CMS continues to raise the bar for a resilient, high-value healthcare 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, which have been slightly modified from last year to reflect current Administration efforts, 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.

CMS introduced the Universal Foundation, an approach which builds on the Meaningful Measures 2.0 goals and streamlines quality measures across CMS quality programs for the adult and pediatric populations.[1] The Universal Foundation aligns with the CMS National Quality Strategy, supports Meaningful Measures 2.0, and is intended to focus provider attention, reduce burden, prioritize development of interoperable, digital quality measures, allow for cross-comparisons across programs, and help identify measurement gaps. In 2024, CMS developed the

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

Hospital, Post-Acute Care, and Maternity Care "add-on" sets to promote the best and safest care for individuals across these critical quality areas.[2]

As CMS advances the Universal Foundation, the Universal Foundation will continue to evolve to support greater alignment across CMS programs. This ongoing evolution may include the following strategies:

- 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 with 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 2024

CMS used FY 2024 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. These measures are essential to lower costs and improve quality of healthcare. For example, accomplishments include the CBE's endorsement and 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, and behavioral health, advanced illness and post-acute care and cost and efficiency.

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

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

Table 1: Funding authority (in millions), funds obligated, and funds expended by public law, as of September 30, 2024

Public Law Amending Section 1890 of the SSA	Appropriation	Sequester	Adjusted Amount	Obligations	Unobligated Amount	Expended Amount
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	$20.00
Consolidated Appropriations Act (CAA), 2021 (Pub. L. 116-260, enacted December 27, 2020) for FY 2021	$26.00	$0.00	$26.00	$21.74	$4.26	$21.32
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	$17.51	$1.35	$16.40
CAA, 2024, Division G, Title I, Subtitle C (Pub. L. 118-42, enacted March 9, 2024)	$9.00	$0.00	$9.00	$7.79	$1.21	$6.34

Table 2 below identifies the total amounts of funding obligated and expended in FY 2024 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 mandatory appropriations for sections 1890 and 1890A of the Act.[3]

Table 2: FY 2024 Funding (in millions) obligated and expended under sections 1890 and 1890A of the Act, including administrative costs, as of September 30, 2024[4]

Funding Section	Obligations	Expended Amount
1890	$7.52	$4.84
1890A	$1.69	$1.09
Total	**$9.21**	**$5.93**

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.

[3] 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.

[4] Administrative costs were not needed in FY 2024.

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

The objective of the CBE contract is to ensure that the healthcare community has access to safe and effective clinical quality and cost/resource use measures that encourage the delivery of high-quality care. Under its contract with CMS, the CBE convened interested parties to review new or currently 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, such as missed opportunities in areas of access to care, preventive care or chronic disease management, 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 provided input on the selection of quality measures under consideration for use in certain specified quality reporting and value-based purchasing programs.

In addition, the CBE (Battelle) created the Partnership for Quality Measurement™ (PQM) to facilitate its CBE activities. The PQM is comprised of interested parties, including but not limited to healthcare 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 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 PQM.

Table 2.1 below describes the funding for FY 2024 for CBE-required and other consensus-based activities under sections 1890 and 1890A of the Act. Those activities include: endorsement and maintenance of quality measures, publication of a required annual report 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 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 02/27/24-02/26/25	**2024**	**$9,211,762**

- <u>Endorsement and Maintenance (E&M) of Measures:</u>

CMS prioritizes use of measures in programs that 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 and is evidence of a measure that 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.

- Within the Option Period 1 (OP1) period of performance (February 27, 2024, through February 26, 2025), the CBE convened five E&M project committees to review and render endorsement decisions on quality and/or cost/resource use measures submitted to the Fall 2023, Spring 2024, and Fall 2024 E&M cycles.
- The CBE convened healthcare 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)

In FY 2024, the CBE continued to convene key interested parties and solicit public comments to evaluate the selection and continued use of quality and efficiency measures in Medicare quality reporting and value-based purchasing programs. The PRMR process gathers feedback if a measure is appropriate for consideration in appropriate Medicare quality programs, whereas the MSR process seeks to optimize the CMS measure portfolio by gathering feedback to review measures for potential removal or continued use in programs.

- Core Quality Measures Collaborative (CQMC)

Convened by the CBE, the CQMC is a group of healthcare leaders working to facilitate cross-payer measure alignment through the development of core measure sets to assess the quality of healthcare 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, Department of Veterans Affairs).

The CQMC seeks to continue its work through ongoing maintenance of the existing core measure sets to reflect the changing measurement landscape, including, but not limited to: changes in clinical practice guidelines, data sources, or risk adjustment. It further seeks to expand into new clinical areas not yet addressed. In addition, the CQMC seeks to identify gaps in measurement and challenges in implementation to advance adoption of the core sets.

The CQMC reviews the core measure sets annually to ensure they reflect the best available measures. Alternating every other year between full and light maintenance review, the CQMC workgroups review potential new measures and review measures in the existing sets and remove measures, if necessary.

- 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.

- A light maintenance review 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. The goal of the light review process is to allow the core sets to remain stable over time, supporting adoption while allowing a way to make necessary updates in a timely manner.

In Option Period 1 (OP1) period of performance (February 27, 2024, through February 26, 2025), the CBE performed full maintenance and light maintenance on the following Core Measure Sets:

Full Maintenance	Light Maintenance
HIV/Hep C	Orthopedics
Cardiology	Pediatrics
Gastroenterology	Accountable Care Organization /Patient Centered Medical Home / Primary Care
Medical Oncology	Behavioral Health
Obstetrician Gynecologist	Neurology

Specifically, in FY 2024 and 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 workgroup meetings.

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

Table 2.2: Total for Secretarial Activities for Dissemination of Quality Measures for FY 2024[5]

Description	Funding Amount
MMS Modification Base Year	$621,281
MMS MUC List Option Period 1	$104,176
Public Reporting Base Year	$811,297
OIT Cloud Cost	$178,213
Software License Cost	$512
Total Secretarial Activities for Dissemination of Quality Measures	**$1,715,479**

[5] These activities are considered Secretarial activities that CMS funds through the appropriation in section 1890(d)(2) of the Act.

- The Measures Management System (MMS)

The MMS consists of several key tools and resources to assist measure developers in the different stages of the Measure Lifecycle including the CMS Measures Under Consideration (MUC) Entry/ Review Information Tool (MERIT).

CMS MERIT is a web-based, data collection portal used by measure stewards or developers to submit their quality and efficiency measures to CMS as part of the pre-rulemaking process described in section 1890A(a) and for consideration for use in quality programs. CMS MERIT initiates the pre-rulemaking process since it is the sole vehicle that obtains the measures that inform the annual MUC list which is assessed by various interested parties, convened by th CBE, who provide input to CMS. A modification to the MMS contract in FY 2024 was required to transition CMS MERIT to the CMS Office of Information Technology's (OIT) Cloud environment from a now decommissioned site. All security protocols were established, enabled and verified to ensure continuity of use for the annual call for measures and pre-rulemaking cycle.

In the exercising of the MMS contract's Option Period, the MMS contractor supported interested parties' engagement in the measure development process and CMS's gathering of measures for inclusion on the MUC List. The Secretary considers this list of measures for use under Medicare and for review by the public and interested parties convened by the CBE.

As noted in the 2024 Report on Unobligated Balances for Appropriations Related to Quality Measurement, CMS gained efficiencies by using a different funding source for the majority of the MMS contract which included support to standardize and promote best practices in quality measurement, and several tools and resources to assist measure developers in the different stages of the Measure Lifecycle: the CMS Measures Inventory Tool (CMIT), De Novo Measure Scan, Environmental Scan Support Tool, and the MMS Hub. Collectively, these support tools for technical engagement, education and outreach to developers and interested parties will no longer use funds designated in section 1890(d)(2) of the Act. Funds designated in section 1890 of the Act will continue to be used for the pre-rulemaking work including MERIT and MUC activities, as described above within the MMS contract.[6]

- Public Reporting Coordination

In FY 2024, 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.

This work serves 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:

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[6] https://www.cms.gov/files/document/2024-report-unobligated-balances-appropriations-relating-quality-measurement.pdf

- Oversees the global coordination and transition effort for the PDC and Care Compare.
- Supports ongoing efforts to improve the stakeholder experience for PDC and Care Compare.
- Collaborates 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.
- Provides project management for the integrated project team, including meeting coordination and facilitation; managing work products; and communication management.
- Coordinates alignment and prioritization of tasks and activities across the integrated project team.
- Supports 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.

As noted in the 2024 Report on Unobligated Balances for Appropriations Related to Quality Measurement, due to efficiencies that CMS gained by using a different funding source for public reporting coordination activities, CMS will not be using funds designated in section 1890(d)(2) of the Act in FY 2025 and beyond.

- Other Costs (OIT 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 Office of Information Technology (OIT) and Secure Sockets Layer (SSL) Certificate costs cover cloud computing and storage, software licensing and ensures meeting security-related OIT requirements.

FY 2024 funds supported the integration with CMS enterprise user authentication service providers, and improvement of MMS Hub tools such as CMS MERIT to support user requirements.

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

Section 1890A(a)(6) 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[7].

In FY 2024, the National Impact Assessment work completed feedback and analyses from a Technical Expert Panel (TEP) regarding methodologies and discussions of quality measures presented in the 2024 National Impact Assessment of CMS Quality Measures report[8]. The TEP comprised of nationally accredited private and public interested parties and a Federal Assessment Steering Committee, including the Veterans Health Administration, the Agency for Healthcare

[7] https://www.cms.gov/medicare/quality/measures/national-impact-assessment

[8] https://www.cms.gov/files/document/2024-national-impact-assessment-report.pdf

Research and Quality, Assistant Secretary for Planning and Evaluation, Centers for Disease Control and Prevention, Defense Health Agency, Health Resources and Services Administration, Indian Health Service, Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology (ASTP/ONC), and Substance Abuse and Mental Health Services Administration. The 2024 report analyzed quality measure results from 2016-2021 across 26 CMS value-based and quality reporting programs, and showed that improvements in measure performance, largely prior to the coronavirus disease 2019 (COVID-19) public health emergency (PHE), were associated with positive impacts for millions of patients and substantial costs avoided. In addition to satisfying the requirements under 1890A(a)(6) of the Act, the report also provided an evaluation of measure performance at the national level regarding the CMS healthcare quality priorities such as Person-Centered Care, Safety, Affordability and Efficiency, Chronic Conditions, and Wellness and Prevention. The report also provides updates on how CMS is optimizing the measure portfolio and reducing burden through broad use of digital data sources and alignment of measures across programs, settings, and federal agencies[9].

It is important to note that in the past, funding from section 1890(d)(2) of the Act was provided for the Quality Measure Index work which is a tool to systematically assess and improve standardization of the decision-making processes used by CMS for measure selection (like pre-rulemaking measures under consideration), implementation, and continued use in CMS quality reporting programs. Due to cost efficiencies, this work is absorbed into a new contract and different funding source.

Table 2.3 Total for Program Assessment and Review

Period of Performance	Fiscal Year	Funding Amount
Base Period 07/01/24-06/30/25	**2024**	**$0**

- National Impact Assessment

Due to transition of a contract that supports the National Impact Assessment work in July 2024, continued activities are not anticipated for this category of work until FY 2025. The new contractor determined that work on the National Impact Assessment report would begin in Option Period 1 which is in FY 2025.

(4) Program Oversight and Design

The last time a contract was awarded in the Program Oversight and Design category was in FY 2012. No activities in this area have been funded or implemented in FY 2024 under section 1890 or 1890A of the Act. Future expenditures in this area are not anticipated.

[9] https://www.cms.gov/files/document/2024-national-impact-assessment-report.pdf

IV. Estimated Expenditures and Anticipated Obligations for Activities Under Sections 1890 and 1890A of the Act for FYs 2025 and 2026

In FY 2025 and 2026 , under the contract(s) with the CBE and other entities that are statutorily required by section 1890 and 1890A, CMS aims 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 equitable healthcare.

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. Guided by the work outlined in sections 1890 and 1890A of the Act, CMS evaluates measures for endorsement, identify measure gap areas, and recommend best practices that emphasize rewarding value and outcomes with a heightened focus on patients and reduced burden on clinicians. 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. This report also serves as a valuable tool for the CBE in their analyses. The expenditures and anticipated obligations associated with the activities previously outlined in these four components create a cyclical process to ensure experts and other interested parties 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 crucial to implementing quality reporting programs, value-based payment programs, public reporting of measures, and adoption of high-value measures that support informed decision-making by patients, clinicians, and healthcare systems. The work authorized by sections 1890 and 1890A of the Act provides the foundational infrastructure, trust, scientific validity, and consensus-based review and feedback by interested parties which are central to national quality reporting efforts aimed at improving health outcomes for all individuals. The following obligations and expenditures are projected to be necessary over the next two-year period (FY 2025 and FY 2026) to carry out quality measurement activities within the four previously outlined task categories. These estimates are contingent upon the availability of sufficient funding.

The contracts listed below are anticipated awards using FY 2025 and FY 2026 funding as of December 31, 2024, 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. If contracts have been awarded and the cost is already negotiated for option periods, this is indicated as 'negotiated' in the tables below. If a contract is new work anticipated to be awarded in FY 2025 or FY 2026, the cost is indicated as 'estimated' in the tables below.

The unobligated amount, for funding sections 1890 and 1890A of the Act, from FY 2024, as of September 30, 2024, is $9.24 million. 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 2 02/27/25-02/26/26	**2025**	**$10,611,164 (Negotiated)**
Option Period 3 02/27/26-02/26/27	**2026**	**$10,925,104 (Negotiated)**

- Endorsement and Maintenance (E&M) of Quality and Efficiency Measures in CMS Programs

CBE-endorsed measures are considered the standard for healthcare measurement in the U.S. As required by section 1890 of the Act, 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 and other federal agencies, and many private sector entities use endorsed measures 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. 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.

In response to the evolving needs and challenges identified during the Fall 2024 and Spring 2025 cycles of the new E&M process, the CBE has developed strategic enhancements aimed at refining the process for the Fall 2025 cycle and beyond. These enhancements focus on improving the submission and communication processes, ensuring proactive engagement and clear role definitions for committee members, and integrating specific policy changes to better evaluate individual measures derived from broader instruments. The CBE believes these enhancements will foster a more dynamic and responsive E&M process, characterized by strategic innovations, enhanced communications, and robust stakeholder engagement. By addressing these areas, the CBE aims to cultivate a more effective, transparent, and inclusive framework for measure endorsement, ultimately contributing to the delivery of higher quality healthcare.

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

Every year, 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 under consideration 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) to add a new paragraph (4) that authorizes the CBE to provide input to CMS on measures that could be considered for removal from programs under the MSR process.

During nominations for the multi-interested party committees, the CBE seats a diverse group of individuals, including but not limited to representation from patient, family, and caregiver advocacy groups; health plans; healthcare providers and practitioners; and experts in rural health or rural healthcare, health disparities, and quality measurement. Additional 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 from national experts across a range of perspectives to help weigh in on the impact these measures will have on various healthcare quality priorities such as safety, chronic conditions, affordability and efficiency, and person-centered 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 promoting value related to quality measurement and improvement. 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)

As a public-private partnership between America's Health Insurance Plans (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 is currently convened by the CBE's (Battelle) Partnership for Quality Measurement (PQM) in its role as the consensus-based entity.

The CQMC continues to focus on 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 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.

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) 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 2 08/30/25-08/29/26	**2025**	**$107,222 (Negotiated)**
Total MMS Task Order – Option Period 3 08/30/26-08/29/27	**2026**	**$110,391 (Negotiated)**

- The Measures Management System (MMS) Contract

The technical support provided by the MMS 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. A portion of the MMS contract supports the pre-rulemaking process required by section 1890A(a) of the Act. Funding is needed for OIT to maintain and update CMS MERIT (https://cmsmerit.cms.gov/merit/#/login), the tool for measure developers to submit their clinical quality and efficiency measures for consideration by CMS, which supports the statutorily mandated pre-rulemaking process under section 1890A(a) of the Act. Specific activities include:

- Ongoing maintenance and improvements to the CMS MERIT application to ensure accuracy for all users, including measure developers and CMS staff.
- Facilitating searches of measures and structuring the workflow for CMS review of measures submitted to CMS MERIT.
- Education and outreach to clinicians, measure developers, and interested parties to encourage and facilitate their involvement in the pre-rulemaking and measure development process, to support the development of the annual MUC List.
- Continued support for measure developers, contracted by CMS and external to CMS, allowing developers to seamlessly submit measures for consideration to CMS.

The pre-rulemaking support tools, resources and education that MMS provides are essential to further engage and educate interested parties and ensure the development of consistent, high-quality measures in CMS programs that enhance health outcomes for beneficiaries.

As previously noted, CMS gained efficiencies by using a different funding source for the majority of the MMS contract. The MMS contract includes several tools to support measure developers in the different stages of the Measure Lifecycle (the CMS Measures Inventory Tool, De Novo Measure Scan, Environmental Scan Support Tool, and the MMS Hub).

(3) Program Assessment and Review

Period of Performance	Fiscal Year	Funding Amount
Option Period 1 07/01/25-06/30/26	**2025**	**$355,434 (Negotiated)***
Option Period 2 07/01/26-06/30/27	**2026**	**$712,424 (Negotiated)**

*In the 2024 Report to Congress titled Annual Update: Identification of Quality Measurement Priorities and Associated Funding for the Consensus-Based Entity and Other Entities, it was estimated that this work would be approximately $1.8M in FY 2025. However, through streamlining work within a new contract using foundational data acquisition, monitoring and analysis activities and contract negotiations, the newly awarded contractor determined this report would cost significantly less than anticipated.

- 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 is anticipated to begin in FY 2025 to meet the triennial requirement.

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 the value of healthcare and close gaps 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 stakeholders and a Federal Assessment Steering Committee and would track CMS quality programs’ measure trends post-COVID-19

PHE to understand the resilience of the healthcare system. By 2027, CMS intends to publish the evaluation of the impact and efficiency of CMS quality measures. 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 2025 and 2026

	FY 2025	FY 2026
Consensus-Based Entity Activities		
Total, Consensus-Based Entity Activities	**$10,611,164**	**$10,925,104**
Secretarial Activities Dissemination of Quality Measures		
Measures Management System	$107,222	$110,391
Coordination of Compare Websites	$0	$0
Subtotal, Dissemination of Quality Measures	**$107,222**	**$110,391**
Program Assessment and Review		
National Impact Assessment of Quality Measures	$355,434	$712,424
Subtotal, Program Assessment and Review	**$355,434**	**$712,424**
Total, Secretarial Activities	**$462,656**	**$822,815**
TOTAL, 1890 and 1890A Activities	**$11,073,820**	**$11,747,919**

The upcoming work in FYs 2025 and 2026 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
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
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
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
PDC	Provider Data Catalog
PHE	Public Health Emergency
PQM	Partnership for Quality Measurement
PRMR	Pre-Rulemaking Measure Review
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

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. 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 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 2024, CMS obligated approximately $9.21 million from funding available under sections 1890 and 1890A of the Act that is considered Measure Selection. This amount includes funding for activities from the CBE contract and the MMS contract. In FY 2025 and 2026, CMS will need an estimated $10.7 million and $11 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, 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

In FY 2024 with approximately $811K, CMS continued efforts to maintain the websites for Care Compare and the 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.

(d) Education and Outreach Activities

In FY 2024, CMS continued to increase knowledge and engagement on quality measurement topics through education and outreach by various leveraging tools. The Measures Management System provides resources and webinars on annual pre-rulemaking activities to disseminate information and support submissions of measure information via CMS MERIT. 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 2024, CMS obligated $0.1 million for activities considered education and outreach across the CBE contract and MMS pre-rulemaking tasks.