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 (U.S.) Department of Health and Human Services (HHS), which includes the Centers for Medicare & Medicaid Services (CMS), focuses on advancing high quality, safe and equitable care for its beneficiaries across the U.S. CMS promotes transparent quality performance information, accountability and improvements across the health care system through its value-based purchasing and quality reporting programs. Through establishing and refining national quality standards and quality measurement initiatives, CMS has led efforts to improve health care and patient outcomes.

CMS continues to evaluate how the recent public health emergency (PHE) impacted the health and safety of Americans and CMS has had many insights and lessons learned from its response to the effects of Coronavirus (COVID-19) pandemic on healthcare. For example, CMS maintained policies around expanded care and use of telehealth services, as well as other flexibilities to ensure resources are at the disposal of healthcare providers across states, tribes, and localities.

The COVID-19 pandemic highlighted inequities across this nation. As a result, CMS is making health equity a key priority. CMS contracted with the consensus-based entity (CBE) to perform work related to addressing the health inequities identified during the ongoing COVID-19 pandemic. With a disparities lens, areas of measure framework development funded by CMS included the impact of telehealth on rural health care system readiness; maternal morbidity and mortality; functional and social risk adjustment; and collaboration with non-healthcare sectors to address polysubstance use among opioid users with behavioral health conditions. Additionally, endorsed measures were aligned and refined with health equity in mind.

With the support of federal partners and government contractors, CMS is prioritizing the development and use of digital measures and harmonizing measures across public and private payer quality reporting. CMS is focusing efforts in addressing health inequities, patient-reported outcomes (PRO), and rural health concerns. In 2022, the agency launched the CMS National Quality Strategy to advance a more equitable, safe, and outcomes-based health care system for all individuals. The CMS National Quality Strategy builds upon the Meaningful Measures Initiative, which remains a critical approach to promoting high value quality measurement across health care settings and providers.

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 fifth annual update of the coordinated strategy and related funding for using the CBE under contract with HHS. This report describes activities performed by the National Quality Forum (NQF), who was the CBE from 2010-2023[1], 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 task orders and 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

[1] Battelle Memorial Institute is the CBE from March 2023 through March 2028.

expended funds in the past fiscal year, outlines the work that current and future funding supports and how it will advance CMS's quality goals, and provides an accounting of how funding correlates with the complexities of quality measurement methodologies and systems.

To briefly summarize, funding is used to support tasks in four broad categories of work: (1) Duties of the Consensus-Based Entity, (2) Dissemination of Quality Measures, (3) Program Assessment and Review, and (4) Program Oversight and Design. For example, in Category 1, with 2022 expended funds, the CBE convened interested parties under the NQF's Measure Applications Partnership (MAP) to provide input to the Secretary on measures under consideration for use in Medicare value-based quality reporting programs. Section III and Appendix B describe in more detail 2022 expended funds.

Section IV discusses in detail the costs associated with specific quality measurement activities and deliverables in order to accomplish the quality goals as set out in this executive summary.

Quality measurement development and implementation is by nature multifaceted and challenging. By providing the details of the task orders, along with the cost estimates for the specific activities and deliverables, CMS intends to bring transparency and clarity to this complex process that must involve the active participation and engagement of key private sector stakeholders to achieve the quality goals for the nation. Furthermore, cost estimates developed for 2023 and 2024, as specified in section IV, are informed and refined by the experience of previous years in order to reflect best value for taxpayer dollars.

I. Introduction

I.A. Background

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

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

This Report to Congress provides information regarding task orders, activities, and funding details including dollars obligated, expended and projected to carry out the work required in

sections 1890 and 1890A of the Act. It builds upon the previous Reports to Congress and provides an annual update to reflect key modifications to existing work and highlights new measurement activities since last year's report.

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

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

Section I: Introduction

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

Section II: Comprehensive Plan

Section II of the 2019 Report to Congress highlighted the Meaningful Measures Initiative as a key driver of strategic efforts to reduce the burden of quality measure reporting and as the framework for the comprehensive plan. The Meaningful Measures 2.0 Initiative, which aligns with the CMS National Quality Strategy, is the key driver of strategic efforts for the comprehensive plan.

For the following sections of this Report, the activities performed under sections 1890 and 1890A of the Act are divided into four broad categories:[2]

- Duties of the CBE[3]
- Dissemination of measures[4]
- Program assessment and review[5]
- Program oversight and design[6]

Section III: Funding, Obligations, and Expenditures for Activities Conducted Under Sections 1890 and 1890A of the Act

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

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

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

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

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

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

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

Section IV describes the anticipated obligations and expenditures for Fiscal Year (FY) 2023 through 2024 to support the advancement and refinement of the quality measurement activities required under sections 1890 and 1890A of the Act. Cost estimates developed for 2023 and 2024 were developed directly from the experiences and lessons learned from work in 2022 and reflect efforts to reduce overhead and focus on the specific activities and deliverables (as described in Section IV) that would drive us to accomplish the quality goals.

The estimates and tasks anticipated to be accomplished in 2023 and 2024 are subject to the availability of sufficient funds.

Section V: Glossary

This Report includes a glossary of acronyms and abbreviations.

Appendices

Appendix A includes links to the statutory language of sections 1890 and 1890A of the Act and the individual prior Reports to Congress. Appendix B contains details of task orders and activities under sections 1890 and 1890A of the Act for actions awarded using FY 2022 funding under section 1890(d).

II. Comprehensive Plan

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

In 2017, CMS launched the Meaningful Measures Initiative, updated in 2021 as Meaningful Measures 2.0, to improve health outcomes for patients and beneficiaries by focusing on streamlining quality measurement and reducing burden to measures entities. CMS continues to use the Meaningful Measures framework to eliminate redundant, low-impact measures--along with prioritizing outcome measures that drive value-based care. In 2022, CMS launched the National Quality Strategy[7] which is a unified, person-centric approach to drive improvements in health care quality by leveraging a number of approaches including quality measurement; public reporting; value-based payment programs and models; establishing and enforcing health and safety standards; and providing quality improvement technical assistance. Specifically related to quality measurement, the CMS National Quality Strategy expands upon Meaningful Measures with a significant focus on the alignment of quality activities, including alignment of measures across all CMS programs and with federal partners. CMS received broad input from across the agency and from external entities on these strategic initiatives and has developed a coordinated

[7] Schreiber, M, Richards, A., Moody-William, J., and Fleisher, L. "The CMS National Quality Strategy: A Person-Centered Approach to Improving Quality." (June 2022) https://www.cms.gov/blog/cms-national-quality-strategy-person-centered-approach-improving-quality.

and aligned approach to closely track, prioritize, develop and allocate resources for quality measures.

The eight goals of the CMS National Quality Strategy embrace an action-oriented approach to improving outcomes, equity, safety, patient engagement, resilience, interoperability and scientific innovation. One of the key eight goals of the CMS National Quality Strategy is Alignment; specifically, to align and coordinate across programs and care settings. CMS developed its "universal foundation"[8] of the key quality measures to be aligned across all programs (to the degree feasible) in order to reduce inconsistency and promote a focus on important quality issues.

Unfortunately, known challenges in quality measurement continue to exist, such as burden on measured entities, challenges associated with electronic health record (EHR) data for quality measurement, usefulness of measures for patients and caregivers, and the measurement of disparities in social determinants of health to inform equity improvement. Recognizing the continuation of these known challenges in quality measurement, CMS has committed to continuing its efforts to improve the landscape of quality measurement, including the selection of high priority measures, reporting of those measures, associated provider burden, and transparency.

CMS continues to use the following five interrelated goals of the Meaningful Measures 2.0 to ensure the use of impactful quality measures to improve health outcomes and to support the delivery of value:

- Using only high-value quality measures that impact key quality domains.
- Aligning measures across value-based programs.
- Prioritizing outcome and patient-reported measures.
- Transforming measures to be fully digital and incorporating all-payer data.
- Developing and implementing measures that reflect social and economic determinants.

The goals outlined require work across the agency, and in some instances across the entire federal government, with support and input needed from private partners and interested parties. CMS plans to continue gathering feedback on these goals to:

- Align measures across CMS, federal programs, and private payers to reduce the number of unique measures, thereby reducing the burden to CMS and measured entities associated with those measures.
- Accelerate ongoing efforts to streamline and modernize programs, reducing burden, and promoting strategically important focus areas.
- Use data and information as essential aspects of a healthy, robust healthcare infrastructure to allow for payment and management of accountable, value-based care and development of learning health organizations.
- Empower patients through transparency of data and public reporting, so patients can make the best-informed decisions about their healthcare.
- Commit to a person-centered approach in quality measure and value-based incentives programs to ensure that quality and safety measures address healthcare equity.

[8] Douglas B. Jacobs et al. "Aligning Quality Measures across CMS: The Universal Foundation." The New England Journal of Medicine 388, no. 9 (February 1, 2023): 776–79. https://www.nejm.org/doi/full/10.1056/NEJMp2215539.

It is through these goals and objectives that CMS will be able to use impactful quality measures to improve health outcomes and deliver value by empowering patients to make informed care decisions while reducing burden to measured entities, which starts with how the measures in CMS programs are developed, implemented, and evaluated.

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

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

With FY 2022 expended funds and the work of the CBE and other entities pursuant to sections 1890 and 1890A of the Act, CMS built on previous activities and continues its commitment and investment to support meaningful, scientifically sound quality measures which are essential to lower the cost and improve quality of healthcare. For example, accomplishments include consensus-based recommendations and strategies to address rural health challenges, care communication and coordination issues using electronic health record data, and opioid-related outcomes for those with co-occurring behavioral health conditions. These efforts closely align with key objectives of the CMS National Quality Strategy, including improving health care quality on high impact areas such as behavioral health, reducing health disparities and promoting equitable care, and accelerating interoperability.

Table 1 identifies the authorized funding for sections 1890 and 1890A of the Act and funds obligated and expended under 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, 2023

Public Law Amending Section 1890 of the SSA	Authority	Sequester	Adjusted Authority	Obligations	Unobligated Authority	Expended Amount	Unexpended Balances
The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. L. 110-275, Sec.183)	$50.00	($0.51)	$49.49	$47.37	$2.12	$47.37	$0.00
The Patient Protection and Affordable Care Act of 2010 (ACA) (Pub. L. 111-148, Sec. 3014, as amended by section 10304 of the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152)	$100.00	($2.46)	$97.54	$97.54	$0.00	$97.52	$0.02
The Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. 113-93, Sec. 109)	$20.00	$0.00	$20.00	$20.00	$0.00	$20.00	$0.00
The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114-10, Sec. 207)	$75.00	($2.07)	$72.93	$72.93	$0.00	$72.74	$0.19
Bipartisan Budget Act of 2018 (Pub. L. 115-123, Sec. 50206)	$15.00	$0.00	$15.00	$15.00	$0.00	$14.96	$0.04
Coronavirus Aid, Relief, and Economic Security Act (CARES Act) (Pub. L. 116-136, Sec. 3802)	$20.00	$0.00	$20.00	$20.00	$0.00	$18.96	$1.04
Consolidated Appropriations Act of 2021 (CAA) (Pub. L. 116-260, Sec. 102)* - FY21	$26.00	$0.00	$26.00	$19.12	$6.88	$18.69	$0.42
Consolidated Appropriations Act of 2021 (CAA) (Pub. L. 116-260, Sec. 102)* - FY22	$20.00	($0.57)	$19.43	$17.01	$2.42	$12.39	$4.61
Consolidated Appropriations Act of 2021 (CAA) (Pub. L. 116-260, Sec. 102)* - FY23	$20.00	($1.14)	$18.86	$17.51	$1.35	$0.19	$17.32
Grand Total	**$346.0**	**($6.75)**	**$339.25**	**$326.48**	**$10.65****	**$302.82**	**$23.64**

*Currently, the CAA is the only funding source available for these activities as the others listed have been exhausted. All three years of CAA funding have been combined as it is considered one source of funding by the CMS Office of Financial Management (OFM).

**The anticipated unobligated authority as of 09/30/2023 is $10.65 million, which is the amount carried over for FY 2024. These amounts do not include the $2.12 million unobligated authority related to MIPPA Section 183, which expired in 2013.

Table 2 below identifies the total amounts of funding obligated, expended, and unexpended in FY 2022 using funds appropriated to implement sections 1890 and 1890A of the Act. Activities

not performed by the Secretary[9] under section 1890A of the Act were carried out by the CBE (convening interested parties to provide input on measures through the MAP), as well as other CMS funded contractors. Table 2 excludes activities conducted by the CBE that are not funded by the appropriations for sections 1890 and1890A of the Act. Appendix B provides additional details on the activities, including the task orders, for which these funds were obligated or expended.

Table 2: FY 2022 Funding (in millions) obligated, expended, and unexpended under sections 1890 and 1890A of the Act, including administrative costs*

Funding Section	Obligations	Expended Amount	Unexpended Balances
1890	$5.21	$2.26	$2.95
1890A	$11.62	$3.87	$7.75
Administrative	$0.27	$0.03	$0.24
Grand Total	**$17.10**	**$6.16**	**$10.94**

* Numbers have been rounded to the nearest 10,000.

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

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

In 2022, NQF was the CBE which HHS contracted with to perform duties and tasks under sections 1890 and 1890A of the Act. Under the contract with HHS, the CBE convened interested parties to review new or endorsed quality measures for conceptual importance, scientific acceptability, use or usability, and feasibility. In addition, CMS tasked the CBE to identify measure priorities and measure gaps to support HHS efforts to improve quality of care and health outcomes. The CBE is required to develop and submit an annual Report to Congress and the Secretary of HHS containing a description of the quality and efficiency measurement activities during the previous calendar year no later than March 1 of each year. In addition, as part of the section 1890A pre-rulemaking process, the CBE convened interested parties that provide input on the selection of quality measures under consideration for use in certain specified quality reporting and value-based purchasing (VBP) programs.

Table 3 below describes the funding for FY 2022 for activities performed by the CBE under sections 1890 and 1890A of the Act. Those activities included: endorsement and maintenance of quality measures, publication of a required annual report with prescribed activities, including identifying gaps in quality and efficiency measures, and assisting CMS by synthesizing evidence and convening interested parties to make recommendations on priorities for health care 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; developing best practices for

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

testing and developing risk adjustment models; and developing technical guidance for measure developers on selecting patient-reported outcome measures (PROMs) that may be used for digital patient-reported outcome performance measures **(**PRO-PMs). Other priority setting efforts included identifying all-payer measures and measure concepts that could address opioid-related overdose and mortality among polysubstance users with co-occurring behavioral health conditions; eliciting expert input to define and establish comprehensive terms to encompass the roles in measure development of patients, caregivers and Patient Advisors; recommended best practices for addressing challenges associated with leveraging EHR-sourced data to improve care communication and coordination. The duties of the CBE performed by NQF under section 1890A of the Act included convening interested parties through the MAP that provided input on measure selection for use in various quality programs. For further details of the purpose of each task order, please refer to Appendix B.

Table 3: Funding (in millions) for FY 2022 for activities performed by the CBE under sections 1890 and 1890A of the Act*

Section and Fiscal Year	Obligations	Expended Amount	Unexpended Balances
Section 1890			
2022	$5.21	$2.29	$3.19
Section 1890A			
2022	$2.44	$0.81	$1.63
Grand Total	**$7.92**	**$3.10**	**$4.82**

* Numbers have been rounded to the nearest 10,000.

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

The Measures Management System (MMS)

The MMS is an essential resource for the dissemination of quality measurement programs and initiatives across CMS and is also available for federal partners, interested parties, and the public. The MMS supports important efforts to standardize and promote best practices in quality measurement, in addition to providing innovative tools to help address quality measurement challenges. One of the most important resources on the MMS is the Blueprint, which outlines the conceptual and operational phases and elements of quality measure development. By conveying standards that developers can use to gauge for the readiness of their measures to be endorsed, the Blueprint decreases the CBE Standing Committee's burden of reviewing low-quality measures. The MMS provides technical support for developers and education and outreach to stakeholders to increase engagement and knowledge of quality measurement, CMS quality reporting and VBP programs, the pre-rulemaking process, and the web-based CMS Measures Inventory Tool (CMIT).[10]

CMS and its partners use the CMIT to search and retrieve measure details and to inform future measure development. It is a public repository of information about measures used across CMS programs to inform stakeholders, manage the measure portfolio, promote measure alignment, and guide measure development. CMIT contains an environmental scan support tool for all

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

measure developers to be used as a benchmark against which to compare manually conducted scans, and the measure concepts extracted from the abstract and article text may serve as a useful markup to increase the efficiency of abstract and article review. This provides evidentiary support for the opportunity for improvement. Additionally, CMIT contains the De Novo Measure Scan (DNMS) tool which helps public users efficiently find up-to-date literature about novel measure concepts to support innovation in measure development and maintenance, re-specification, and other scenarios where current, accurate, and relevant evidentiary support specific to quality measurement is needed.

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

Public Reporting Coordination

In 2022, 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 convening CMS program and measure leads to coordinate and support alignment, prioritization, risk assessment and mitigation, scheduling and timelines for the readiness of the new user interfaces. This contract oversees the global coordination and transition effort namely the Alignment of Quality and Public Reporting Programs and Websites. In 2022, the contractor increased communication, coordination and alignment through development, consolidation and dissemination of a comprehensive 2022 calendar year schedule including 75 release and refresh dates across all compare sites settings, a time-based workflow for planning resources around file creation, data validation and data deployment in the production environments.

Table 4 below describes the FY 2022 funding for activities under section 1890A of the Act related to the dissemination of quality measures, which included the MMS, as well as coordination, testing, and alignment for the dissemination of quality measures via the two public reporting websites.

Table 4: Funding (in millions) provided in FY 2022 for activities under section 1890A(b) of the Act related to dissemination of quality measures*

Fiscal Year	Obligations	Expended Amount	Unexpended Balances
2022	$5.58	$ 1.67	$ 3.91

*Numbers have been rounded to the nearest 10,000.

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

The Secretary must conduct an assessment, beginning not later than March 1, 2012, and at least once every three years thereafter, of the quality and efficiency impact of the use of endorsed measures described in section 1890(b)(7)(B) of the Act and make that assessment available to the public.[11] To comply with this provision, CMS published National Impact Assessment Reports in 2012, 2015, 2018, and 2021.

In FY 2022, we continued critical work for the development of the upcoming 2024 Impact Assessment Report including quality measure data collection and review for 26 CMS quality reporting programs to inform the analyses and draft of the report. Since the data period for the 2024 report spans from 2019 through 2022, one area that the 2024 report will focus on examining measure trends to understand how the COVID-19 public health emergency (PHE) and associated CMS quality measurement efforts and policy responses affected patients, providers, and health care delivery and utilization. In addition, work in FY 2022 for the development of the 2024 Impact Assessment report focused on identifying a subset of quality measures for which data were available to conduct disparities analysis. To assess progress in advancing health equity, trend data were examined by selected social drivers of health and summarized across CMS health care priorities to demonstrate where disparities are prevalent.

As in previous reports, health care priorities identified by the Meaningful Measures 2.0 framework organize the measure analyses of the 2024 Impact Assessment report. This supports the statutorily required impact assessment under section 1890A(a)(6) of the Act and evaluation of measure performance at the national level regarding the CMS health care quality priorities of Person-Centered Care, Equity, Safety, Affordability and Efficiency, Chronic Conditions, Wellness and Prevention, Seamless Care Coordination, and Behavioral Health. CMS's efforts were supported by a Technical Expert Panel (TEP) comprised of nationally accredited private and public interested parties and a Federal Assessment Steering Committee (FASC), including the Veterans Health Administration (VHA), the, Agency for Healthcare Research and Quality (AHRQ), Assistant Secretary for Planning and Evaluation (ASPE), Centers for Disease Control and Prevention (CDC), Defense Health Agency (DHA), Health Resources and Services Administration (HRSA), Indian Health Service (IHS), Office of the National Coordinator for Health Information Technology (ONC), and Substance Abuse and Mental Health Services Administration (SAMHSA).

Table 5 below describes the funding that CMS used for the required assessment of the quality and efficiency impact of the use of endorsed measures.

Table 5: Funding (in millions) in FY 2022 related to activities under section 1890A of the Act for program assessment and review*

Fiscal Year	Obligations	Expended Amount	Unexpended Balances
2022	$ 3.61	$ 1.39	$ 2.21

* Numbers have been rounded to the nearest 10,000.

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

(4) Program Oversight and Design

Initial year funding was provided to contractual entities to support the Secretary in project management and operations related to quality measurement. These contracts were completed and the last time a contract was awarded using Program Oversight and Design funds was in FY 2012. No contractual activities in this area have been funded or implemented in FY 2022 under section 1890 or 1890A of the Act. Future expenditures in this area are not anticipated.

Table 6: Funding (in millions) for FY 2022 for activities under section 1890A of the Act related to program oversight and design*

Fiscal Year	Obligations	Expended Amount	Unexpended Balances
2022	$ 0.00	$ 0.00	$ 0.00

* Numbers have been rounded to the nearest 10,000.

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

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

The sections 1890 and 1890A contracts that CMS anticipates holding in 2023 and 2024 will help to streamline and focus the way CMS approaches quality measurement and the way people receive information to make the best decisions for themselves and their families, particularly to promote equitable health care.

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

The quality measurement work related to the CBE and other contractors is integral to implementing quality reporting programs, value-based payment programs, public reporting of

measures, and adopting high-value measures to inform decision making for patients, clinicians, and healthcare systems. The work authorized by sections 1890 and 1890A of the Act provides the essential infrastructure, trust, scientific validity, and consensus-based review and comment by interested parties that has been the essence of national quality reporting to drive improved health outcomes for all individuals. The Secretary estimates the following obligations and expenditures will be required in the succeeding two-year period (i.e., FY 2023 and FY 2024) to carry out quality measurement activities under the four categories of tasks previously described. Estimates for anticipated obligations are subject to the availability of sufficient funds.

The contracts listed below are anticipated awards using FY 2023 and FY 2024 funding, building from lessons learned and experiences from previous years. As several of our activities have different periods of performance (e.g., more than 12 months), additional work may be performed in these years but will not be listed in this section because funds were obligated or expended prior to FY 2023 and are described in prior Reports to Congress described in Appendix A. If contracts have been awarded and the cost is already negotiated for option years, this is indicated as 'negotiated' in the tables below. If a contract is new work anticipated to be awarded in FY 2023 or FY 2024, the cost is indicated as 'estimated' in the tables below.

(1) Duties of the Consensus-Based Entity

Period of Performance	Funding Amount	Fiscal Year
Base Period 02/27/23-02/26/24	**$10,369,290**	**2023**
Option Period 1 02/27/24-02/26/25	**$10,351,637**	**2024**

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

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

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

This five-year contract provides HHS with recommendations on measure utilization and removal across Medicare quality programs from a partnership of interested parties convened by the CBE. This statutorily mandated activity under section 1890A(a) of the Act is part of the Medicare pre-rulemaking process. Additionally, Section 102(c) of Division CC of the Consolidated Appropriations Act, 2021 amended section 1890(b) to add a new paragraph (4) that authorizes the CBE to provide input for measures that could be considered for removal.

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

At a minimum, input from interested parties includes representation from patient, family, and caregiver advocacy groups; racial and ethnic minorities; health plans; health care providers and practitioners; and experts in rural health or rural health care, health disparities, and quality measurement. Public comments are also critical to the process and incorporated into the interested parties' meetings and the recommendations to HHS.

The process and activities are designed to leverage 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. The discussions and recommendations provide CMS with valuable input from national experts to address various priorities such as health equity, maternal health, nursing home quality and safety, hospice quality and safety, PRO-PMs, and affordability of care. The work provides an additional level of transparency to Medicare quality reporting and payment programs by having a vehicle across public and private sectors by which to discuss gaps and obtain early feedback on our measure sets and other cross-cutting measurement issues.

Other Activities of the Consensus-Based Entity

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

- Core Quality Measures Collaborative (CQMC)

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

This task order supports Agency efforts to reduce burden, creating parsimonious measure sets that reflect priorities related to equity and digital measurement.

To date, CQMC has developed 13 core measure sets to be used in high impact areas, with the inclusion of the newest core set developed for Health Equity:

- ACO/PCMH/Primary Care
- Cardiology
- Gastroenterology
- HIV and Hepatitis C
- Medical Oncology
- Obstetrics and Gynecology
- Orthopedics
- Pediatrics
- Behavioral Health
- Neurology
- Digital Measures
- Cross-Cutting Measures
- Health Equity

The CQMC will continue to focus on core set maintenance and continue to review new measures for addition 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. One way to help organizations navigate the CQMC is through the various guides that have been developed and maintained, such as, the updated Implementation Guide, The Health Equity Report, The Digital Measures Report, The Measure Model Alignment Report and the continuous updates and maintenance to the core measure sets.

Continued efforts will focus on advancing measure sets to be manageable for organizations to adopt and continuing to provide guidance through the CQMC website. 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.

- <u>Building a Roadmap from Patient-Reported Outcome Measures to Patient-Reported Outcome-Performance Measures</u>

This task order implements section 1890(b)(7) of the Act. Incorporating the voice of the patient through patient-reported outcomes (PRO) is a priority of CMS. However, currently there is a lack of detailed technical guidance that measure developers can use to develop high impact outcome measures based on patient-reported data. Feedback from CMS staff who oversee measure development contracts has pointed to the need for expert input on how best to address the challenges of collecting data on PROs.

This work began in FY 2020 and continued through FY 2022. This task order informed CMS's efforts in all aspects of developing and implementing patient-reported outcome performance measures (PRO-PMs) through the completion of a technical guide. In particular, it filled knowledge gaps in selecting high quality PROMs for developing high impact PRO-PMs, collecting outcomes data from patients with minimal burden, maximizing response rates to PROMs to increase representativeness, leveraging EHRs for data collection, storage, and measure calculation, all of which will increase return on investment for CMS. The final technical guidance report that was published in November 2022 provides a compilation of resources and tools for measure development, endorsement, and interoperability. The report provides a roadmap for the development of digital measures and frames the guidance through the lens of patient-reported performance measurement.

- Leveraging Quality Measurement to Improve Rural Health

The need for quality measurement in rural healthcare persists. Rural providers continue to confront challenges in reporting quality measures, especially as it relates to access to data, reporting infrastructure, and small denominators (lower case volumes) leading to statistical methodology challenges. The CBE implemented the 15-month base period of this task order in FY 2020. With this work, the CBE maintains a focus on timely quality measurement issues to support CMS's priority for strengthening care provided in rural settings, applying a rural lens to CMS's measure development work and measure selection for program use.

  - In FY 2022, the Rural Health Workgroup reviewed the rural relevant core set developed in 2018 to ensure that the measures remain feasible for rural providers to report with minimal effort and to identify measures not in the core set for potential inclusion, evaluating whether they address high priority rural health issues and are feasible for rural providers to report. Consistent with the standard approach of the CQMC, as well as quality measurement programs, a frequent review of measure sets is necessary to ensure that new, emerging clinical findings, latest scientific evidence, and critical measure specification updates are addressed in each core set. In recent years, issues such as the opioid crisis, maternal morbidity, chronic co-morbidities have afflicted the general population and are found to be even more acute among the rural population. The major deliverables included an environmental scan of measures, some of which may not be CBE-endorsed, that can be considered for potential addition to the core set, and a final report of recommendations.

The CBE's final reports informed CMS's measure development and pre-rulemaking by selecting measures that are feasible and minimally burdensome for rural health care providers.

Total for Duties of the Consensus-Based Entity

Funding Amount	Fiscal Year
$10,369,290	**2023**
$10,351,637	**2024**

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

- The Measures Management System (MMS)

Period of Performance	Funding Amount	Fiscal Year
SSL Certificates - Base Period 11/10/23-11/09/24	**$8,400*** **	**2023 (Negotiated)**
MMS Task Order - Base Period 09/30/23-09/29/24	**$3,084,345**	
Total	**$3,092,745**	
SSL Certificates – Option Period 1 11/10/24-11/09/25	**$8,700*** **	**2024 (Estimated)**
MMS Task Order – Option Period 1 09/30/24-09/29/25	**$3,086,643**	
Total	**$3,095,343**	

*** Annual IT cost for the SSL Certificate for CMIT

The technical support by the Measures Manager and its tools, resources, and education enables high caliber, meaningful quality measure development and alignment, which is critical for not only CMS and federally contracted work, but for all quality measure development work across the public and private sector to make data driven decisions. The MMS tools and education are used by the entire healthcare industry. Specific activities include:

- Continued maintenance and improvements to the CMS Measures Inventory Tool (CMIT) to capture all past, current, and potential quality measures in CMS programs to further transparency and alignment across the public-private sector. Additionally, CMIT houses time and resource saving tools, the Environmental Scan Tool and the De Novo Measure Scan, to aid measure developers in conceptualizing using machine learning. This tool also includes measure submissions for the entire quality measure industry to support CMS's statutorily mandated pre-rulemaking process under section 1890A(a) of the Act.
- Education and outreach to patients, caregivers, clinicians, measure developers, and others to encourage and facilitate their involvement in the measure development process and support patient-centered quality measurement through monthly communications to over 100,000 subscribers, and the MMS website.
- Continued support for measure developers, contracted by CMS and external to CMS, by providing a web-based Blueprint, allowing developers to find the information more easily. Additionally, for CMS-contracted measure developers and CMS staff the MMS provides a web-based library that houses many qualities related deliverables submitted to CMS across contractors to promote the sharing of best practices, collaboration across contracts and programs, and the streamlining of work, such as environmental scans and business cases.

As CMS evolves its quality footprint, it is critical that the Measures Manager continues to engage and educate stakeholders, while also documenting best practices and supporting measure

developers to ensure consistent and high caliber measures to improve health outcomes for beneficiaries. With the goal and focus of improved health outcomes, the Measures Manager tools, resources and technical assistance are intended to support improved measure development and alignment processes.

- The Quality Measure Index (QMI)

Period of Performance	Funding Amount	Fiscal Year
Option Period 4 07/01/23-06/30/24	**$839,438**	**2023 (Negotiated)**
Base Period 07/01/24-06/30/25	**$850,000**	**2024 (Estimated)**

CMS continues to refine the Quality Measure Index (QMI), a transparent and reliable scoring instrument based on standardized definitions of quantifiable measure characteristics, to systematically support the assessment and selection of individual quality measures that provide meaningful quality performance information. The QMI is a tool intended to support and enhance the standardized assessment and decision-making processes used by CMS for measure selection (like pre-rulemaking measures under consideration, which is managed by the Measures Manager), implementation, and continued use in CMS quality reporting programs.

The additional development and testing of the QMI provides meaningful, quantifiable, and replicable quality performance information to assess in a data-driven manner, the score of a measure based on certain measure characteristics. The foundational work began with section 1848(s) of the Act to assess measures intended for use in the Quality Payment Program. This funding allows for expanded testing, analyses, and use of the QMI across healthcare settings and CMS quality reporting programs; supports further testing and validation activities for the QMI related to measures across different phases of the measure lifecycle; allows for further integration of the QMI variables across measure submission pathways to support standardization of data being obtained and reviewed by CMS leading to the development of post-submission evaluation processes; and supports the solicitation and analyses of public comment on the QMI methodology as well as refinement of the scoring methodology based on feedback.

The project is foundational in helping to establish a systematic assessment of quality measures and to improve standardization, transparency, and alignment of CMS measure submission requirements. This tool will serve as a complement to the tools developed by the Measures Manager, like CMIT and the Blueprint, and will enhance measure information that can be provided to stakeholders to support consistent measure decision making.

- The Alignment of Quality and Public Reporting Programs and Websites

Period of Performance	Funding Amount	Fiscal Years
Option Period 4 03/22/23-03/21/24	**$1,254,527**	**2023 (Negotiated)**
Base Period 03/22/24-03/21/25	**$1,330,000**	**2024 (Estimated)**

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

Work under this five-year contract supported coordination efforts across the previous Compare websites, through the transition to human centered design public reporting and the current standardized website, allowing users to access information through a single point of entry and simplified navigation to find the quality of care information they need. The modernized compare sites launched in September 2020 to provide a single user-friendly interface, named Care Compare, that patients and caregivers can use to make informed decisions about healthcare based on cost, quality of care, volume of services, and other data as well as a more specific and technical provider data catalog for researchers and other stakeholders.

Efforts continue to maintain and manage the existing Compare website environment, including conducting and analyzing research, human centered design user and concept testing, and continuous improvement discussions with stakeholders to determine future enhancements. Project management from this contract supports current state and future state operations to align project goals, objectives, timelines and perceptions across all stakeholders with provision of effective communication, coordination, reporting, and development and maintenance of a master project management plan across contracts/tasks.

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

Total for Dissemination of Quality Measures

Funding Amount	Fiscal Year
$5,186,710	**2023**
$5,275,343	**2024**

(3) Program Assessment and Review

- Impact Assessment of CMS Quality and Efficiency Measures

Period of Performance	Funding Amount	Fiscal Year
Option Period 4 07/01/23-06/30/24	**$2,652,344**	**2023 (Negotiated)**
Base Period 07/01/24-06/30/25	**$2,713,348**	**2024 (Estimated)**

This five-year task order will support our work under section 1890A(a)(6) of the Act, a statutorily mandated evaluation of the impact and efficiency of CMS quality measures at the system level through the use of expert contracting services needed to conduct the Impact

Assessment Report. The statute requires CMS to publicly release a comprehensive document once every three years; therefore, work begins immediately following the publication of the previous Impact Assessment Report, to develop the content of the next Impact Assessment Report. The most recent Impact Assessment report was published in 2021.

For the next triennial report, to be published in 2024, CMS will conduct a comprehensive national evaluation to inform CMS on opportunities to use quality measurement as a lever to improve health equity for individuals served by Medicare, Medicaid, and the Marketplace Health Insurance Program. CMS's experience in measure use during the COVID-19 pandemic will be featured prominently. Of special interest is how CMS can heed lessons learned during the pandemic to use quality measures as levers to reduce disparities for vulnerable population groups. CMS will convene focus groups with leaders of community-based organizations (CBOs) that assist underserved communities. The purpose of these focus group discussions will help CMS better understand the disparities experienced by these CBO's constituents as they navigate the health care system.

The Technical Expert Panel of non-federal stakeholders and the Federal Assessment Steering Committee (FASC) who provided technical guidance on prior reports will be re-convened to shed light on promising pathways to leverage quality measurement to improve health equity. The 2024 report will examine how CMS responds to the lessons of the pandemic by using quality measures to strengthen patient and health care workforce safety, and to facilitate health care system readiness, and to continue the goals from before the pandemic to ensure patient-centered care affordability.

CMS anticipates improving the usability of the data and real-time access to data for both CMS internal and external stakeholders with an interactive, electronic version of the National Quality Dashboard[12] to highlight results for measures or groups of measures (defined as Key Indicators) used to gauge and track performance in Meaningful Measure areas. This information will enable CMS to apply data-driven results to the design and implementation of equity improvement efforts for underserved beneficiaries across quality programs and settings, and to be more targeted in our actions and initiatives, more possible now than ever before, to address the heterogeneity of healthcare needs more effectively.

Total for Program Assessment and Review

Funding Amount	Fiscal Year
$2,652,344	**2023**
$2,713,348	**2024**

[12] Introduced in the 2018 National Impact Assessment of CMS Quality Measures Report (2018 Impact Report).

(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

	FY 2023	FY 2024
Consensus-Based Entity Activities		
Subtotal, Consensus-Based Entity Activities	**$10,369,290**	**$10,351,637**
Dissemination of Quality Measures		
Measures Management System	$3,092,745	$3,095,343
QMI	$839,438	$850,000
Alignment of Compare Websites	$1,254,527	$1,330,000
Subtotal, Dissemination of Quality Measures	**$5,186,710**	**$5,275,343**
Impact Assessment of CMS Quality & Efficiency Measures	$2,652,344	$2,713,348
	$2,652,344	**$2,713,348**
Total, Consensus-Based Activities	**$10,369,290**	**$10,351,637**
Total, Secretarial Activities	**$7,839,054**	**$7,988,691**
Total 1890 and 1890A Activities	**$18,208,344**	**$18,340,328**

The upcoming work in FYs 2023 and 2024 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
ACA	Patient Protection and Affordable Care Act of 2010
AE	Adverse Event
AHIP	America's Health Insurance Plans
AHRQ	Agency for Healthcare Research and Quality
ASPE	Office of the Assistant Secretary for Planning and Evaluation
BBA	Bipartisan Budget Act of 2018
CARES Act	Coronavirus Aid, Relief, and Economic Security Act of 2020
CBE	Consensus-Based Entity
CMIT	CMS Measures Inventory Tool
CMS	Centers for Medicare & Medicaid Services
CQMC	Core Quality Measures Collaborative
DOD	Department of Defense
eCQM	Electronic Clinical Quality Measure
EHR	Electronic Health Record
FASC	Federal Assessment Steering Committee
FDA	U.S. Food and Drug Administration
FY	Fiscal Year
HH QRP	Home Health Quality Reporting Program
HHS	Department of Health and Human Services
HRSA	Health Resources and Services Administration
IHS	Indian Health Service
IPT	Integrated Project Team
LTC	Long Term Care
MACRA	Medicare Access and CHIP Reauthorization Act of 2015
MAP	Measure Applications Partnership
MIPS	Merit-based Incentive Payment System
MIPPA	Medicare Improvements for Patients and Providers Act of 2008
MMS	Measures Management System
MUC	Measures Under Consideration
NQF	National Quality Forum
ONC	Office of the National Coordinator for Health Information Technology
OUD	Opioid Use Disorder
OY	Option Year
PAC	Post-Acute Care
PAMA	Protecting Access to Medicare Act of 2014
PDC	Provider Data Catalog
PRAC	Public Reporting, Alignment and Coordination
PRO	Patient-Reported Outcome
PROM	Patient-Reported Outcome Measure
PRO-PM	Patient-Reported Outcome-Performance Measure
QMI	Quality Measure Index
SAMHSA	Substance Abuse and Mental Health Services Administration

SDOH	Social Determinants of Health
SES	Socioeconomic Status
SUPPORT Act	Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018
SOP	Standard Operating Procedures
SSSO	Synthetic and Semi-Synthetic Opioids
TEP	Technical Expert Panel
VA	Department of Veterans Affairs
VBP	Value-Based Purchasing
VHA	Veteran Health Administration

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

Report 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

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 – Description of the Activities and Work Performed under Sections 1890 and 1890A of the Act

Background

Appendix B lists activities and work performed by the CBE and other entities under the authority of sections 1890 and 1890A of the Act for FY 2022. The work is organized by sections 1890 and 1890A of the Act. The tasks 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. Note that the CBE's Annual Report to Congress that details the CBE activities for the prior year described below can be found at: http://www.qualityforum.org/Publications.aspx.

Details

2022

Section 1890 of the Act:

(1) Duties of the Consensus-Based Entity

Sections 1890(b)(2) and 1890(b)(3) of the Act

- Endorsement and Maintenance of Measures:

Period of Performance	Funding Amount	Fiscal Year
Option Period 4 Extension 09/27/22-03/26/23	**$3,774,201**	**2022**

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

- The CBE completed the Spring 2022 Endorsement and Maintenance cycle during the six-month contract extension.
- The CBE convened expert panelists to ensure that measures endorsed by the CBE are updated (or retired if obsolete) as new evidence was developed and remains relevant.
- The CBE convened topic-specific groups with specialized expertise that reviewed new measures submitted for endorsement to ensure these measures are evidence-based, reliable, valid, verifiable, relevant to enhanced health outcomes, actionable at the caregiver level, feasible to collect and report, and responsive to variations in patient characteristics, such as health status, language capabilities, race or ethnicity, and income level; and is consistent across types of health care providers, including hospitals and physicians, thus advancing quality in healthcare for beneficiaries.

- The process currently has two review cycles per year for each of the 14 topic-specific projects. Additional information about each of these projects and associated reports about the measures evaluated can be found at the links listed below:
    - All-Cause Admissions and Readmissions Project
    - Behavioral Health and Substance Use Project
    - Cancer Project
    - Cardiovascular Project
    - Cost and Efficiency Project
    - Geriatrics and Palliative Care Project
    - Neurology Project
    - Patient Experience and Function Project
    - Patient Safety Project
    - Perinatal and Women's Health Project
    - Prevention and Population Health Project
    - Primary Care and Chronic Illness Project
    - Renal Project
    - Surgery Project

Section 1890(b)(5) of the Act

- The CBE's Annual Report to Congress and Secretary of HHS

Period of Performance	Funding Amount	Fiscal Year
Option Period 4 Extension 09/27/2022-03/26/2023	**$144,341**	**2022**

With the variety of work the CBE, formerly the NQF, performed in support of sections 1890 and 1890A of the Act, it is critical to write a robust annual report to showcase the activities and outcomes for each project underway and/or completed. The CBE provided Congress and HHS Secretary with detailed information regarding the work completed in each task order awarded to the CBE. The 2022 report summarized the accomplishments-to-date and outcomes for the following task orders:

- Endorsement and Maintenance; MAP; Leveraging Quality Measures to Improve Rural Health
- Measurement Framework for Improving Opioid-related Behavioral Health and Quality Measurement for All-Payer Programs
- Building a Roadmap from PROMs to PRO-PMs
- Best Practices for Developing and Testing Risk Adjustment Models; and
- Leveraging Electronic Health Record-sourced Measures to Improve Care Communication and Coordination
- CQMC; and
- Patient and Caregiver Engagement Advisory Group.

Section 1890(b)(7)(A) of the Act

- Core Quality Measures Collaborative (CQMC)

Period of Performance	Funding Amount	Fiscal Year
Base Period Extension 09/17/22-03/26/23	**$348,018**	**2022**

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

- In 2022, the CQMC will have completed over 4years of work and efforts will continue with the newly awarded CBE, as funding permits. During the six-month extension, the CQMC work focused on basic maintenance of the core measure sets, project management and development of a communications plan and strategy to engage stakeholders through convening workgroup meetings.

- Leveraging Quality Measurement to Improve Rural Health

Period of Performance	Funding Amount	Fiscal Year
Option Period 2 12/14/2021-08/15/2022	**$274,023**	**2022**

The key intent of this work is to identify best practices in leveraging quality measurement to improve rural health outcomes.

- The CBE convened Rural Health stakeholders to identify high-priority rural-relevant measures with low case-volume for future testing of previously recommended statistical approaches recommended. The CBE led the Rural Telehealth and Healthcare System Readiness Committee in a review and update of the previously developed 2016-2017 Telehealth Framework, which links quality of care provided in rural areas with telehealth, healthcare system readiness, and health outcomes in disasters.

- Building a Roadmap from Patient Reported Outcome Measures to Patient Reported Outcome Performance Measures

Period of Performance	Funding Amount	Fiscal Year
Option Period 1 12/01/21-11/30/22	**$ 666,673**	**2022**

CMS's quality programs strive to design measures that champion individual patient preferences, needs, and values ensuring that patient values guide all clinical decisions. The purpose of this work is to provide measure developers with detailed guidance for developing quality measures that capture the patient

perspective to inform the performance of health care entities. This work will design a quality measurement approach from the point of view of the patient.

Section 1890A[13] of the Act:

(1) Duties of the Consensus-Based Entity

- The Measure Applications Partnership (MAP)

Period of Performance	Funding Amount	Fiscal Year
Option Period 3 03/27/21-09/26/22	**$1,543,483**	**2021**
Option Period 3 mod 06/28/21-09/26/22	**$1,440,728**	
TOTAL	**$2,984,211**	
Option Period 4 Extension 09/27/2022-03/26/2023	**$2,430,758**	**2022**

This task order enables HHS to receive input and recommendations on measure utilization and removal for Medicare quality programs from several interested parties. In 2022, the Measure Applications Partnership (MAP) provided input on the selection of quality and efficiency measures (as described in 1890(b)(7) of the Act, as part of the Federal pre-rulemaking process under Section 1890A of the Act) considered by the Secretary under the Measures Under Consideration list for use in Medicare payment and public reporting programs with the support of the federal liaisons including CDC, HRSA, IHS, ONC, and AHRQ.

Additionally, the Consolidated Appropriations Act, 2021 authorized an additional duty for the CBE to provide input to the Secretary on the removal of quality and efficiency measures (as described in Section 1890(b)(4) of the Act) for various Medicare quality programs. Given the alignment with the review of measures under consideration by the MAP for pre-rulemaking, CMS modified the task order to include this additional work, referred to as the Measure Set Review process. The Measure Set Review process was piloted in summer of 2021 and implemented in full in summer 2022.

- The CBE convened the MAP, a partnership of interested parties that provided recommendations to HHS on measure selection for Medicare quality reporting and VBP programs for hospitals, PAC/LTC, and clinician settings. During the 2021-2022 cycle:
  - Clinician: The MAP reviewed a total of thirteen measures under consideration for two clinician programs: MIPS and Medicare Part C and D Star Ratings Program.
  - Hospitals: The MAP Hospital Workgroup reviewed a total of twenty-three measures under consideration for seven hospital and setting-specific

[13] The performance period for Option Year 1 of the MAP task order started on April 1, 2019, and was supported by FY 2019 funding. Option Year 1 ended on March 31, 2020.

programs, with four measures crossing two programs and two measures crossing four programs:
    - Hospital Inpatient Quality Reporting Program (Hospital IQR Program)
    - Medicare Promoting Interoperability Program for Hospitals
    - Hospital Value-Based Purchasing (VBP) Program
    - Hospital-Acquired Conditions Reduction Program (HACRP)
    - Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting (PCHQR)
    - End-Stage Renal Disease Quality Incentive Program (ESRD QIP)
  - Post-Acute: The MAP reviewed eight measures for Post-Acute Care/Long-Term Care programs, with one measure crossing three programs:
    - Skilled Nursing Facility Quality Reporting Program (SNF QRP)
    - Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)
    - Long-Term Care Hospital\ Quality Reporting Program (LTCH QRP)
    - Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program
- The CBE convened the MAP, a partnership of interested parties that provided recommendations to HHS on measure removals for Medicare quality reporting and VBP programs for hospitals as a part of a Measure Set Review pilot in summer 2021. The MAP Coordinating Committee reviewed a total of twenty-three measures for potential removal across 5 hospital programs:
  - Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program
  - Ambulatory Surgical Center Quality Reporting (ASCQR)
  - Hospital Readmissions Reduction Program (HRRP)
  - Hospital Value-Based Purchasing (VBP) Program
  - Hospital Inpatient Quality Reporting (Hospital IQR) Program
- The CBE convened the MAP, a partnership of interested parties that provided recommendations to HHS on measure removals for Medicare quality reporting and VBP programs for hospitals, PAC/LTC, and clinician settings. During the fully implemented 2022 cycle:
  - Clinician: The MAP reviewed a total of fourteen for potential removal across two clinician programs: MIPS and Medicare Shared Savings Program (MSSP).
  - Hospitals: The MAP Hospital Workgroup reviewed a total of eight measures for potential removal across three hospital programs:
    - Hospital Outpatient Quality Reporting Program (Hospital OQR Program)
    - Ambulatory Surgical Center Quality Reporting (ASCQR) Program
    - Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting (PCHQR) Program
  - PAC-LTC: The PAC-LTC Workgroup reviewed a total of ten measures for potential removal in the Home Health Quality Reporting Program (HH QRP).

Total for Duties of the Consensus-Based Entity

Funding Amount	Fiscal Year
$7,638,014	**2022**

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

- The Measures Management System (MMS)

Period of Performance	Funding Amount	Fiscal Year
Option Period 4 mod 11/10/22-11/09/23	**$6,980 *** **	**2022**
Option Period 4 09/30/22-09/29/23	**$3,544,795**	
Total	**$3,551,775**	

***SSL Cert Funds

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

The funds for Option Year 3 supported the:

- development and implementation of a web-based MMS Blueprint seamlessly integrated into the MMS website to increase accessibility to stakeholders, especially those new to quality measurement who may be overwhelmed with 100+ page documents.
- alignment and harmonization of quality measures across CMS through the redesign of CMIT to allow users to identify families of measures, measure standards, and variations of measures. This new organization will better showcase existing measure alignments, as well as identify possible opportunities for alignment within and across CMS programs.

The funding for Option Year 3 will support the maintenance and continued evolution of the various IT systems, resources, and support provided by the Measures Manager with a focus on stakeholder engagement.

- The Alignment of Quality and Public Reporting Programs and Websites

Period of Performance	Funding Amount	Fiscal Year
Option Period 3 03/22/22-03/21/23	**$1,216,318**	**2022**

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

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

Total for Dissemination of Quality Measures

Funding Amount	Fiscal Year
$4,768,093	**2022**

(3) Program Assessment and Review

Section 1890A(a)(6) of the Act

- Impact Assessment of CMS Quality and Efficiency Measures

Period of Performance	Funding Amount	Fiscal Year
Option Period 3 07/01/22-06/30/23	**$3,605,200**	**2022**

This work obtains the expert services needed to conduct Impact Assessment work. The statutory mandate at section 1890A(a)(6) requires CMS to assess the quality and efficiency impact of the use of endorsed measures and make the assessment publicly available at least once every three years. The first comprehensive report was published in 2012 followed by subsequent comprehensive reports in 2015, 2018, and 2021. The next report, to be published in 2024, will focus on CMS's quality measurement efforts to improve health equity as the agency's response to the COVID-19 pandemic. This includes:

- A comprehensive national evaluation to inform CMS on opportunities to use quality measurement as a lever to improve health equity for CMS's beneficiaries, based on --

- Focus groups with leaders of community-based organizations serving vulnerable communities on barriers to affordable care and high-quality care, especially those resulting from the pandemic.
- Recommendations by the TEP and FASC on promising pathways to leverage quality measurement to improve health equity.
- Expanded discussion on the topic of safety, which encompasses not just patient but also health care workforce safety.
- A new discussion on health care system readiness
- Progress and opportunities to ensure patient-centered care and affordability.

- The Quality Measure Index (QMI)

Period of Performance	Funding Amount	Fiscal Year
Option Period 2 mod 12/21/21-06/30/22	**$822,755**	**2022**

This funding supported work to systematically assess and improve standardization of the decision-making processes used by CMS for measure selection (like pre-rulemaking measures under consideration, which is managed by the Measures Management System), implementation, and continued use in CMS quality reporting programs. The funding also supported refinements to the tool, methodology report, educational trainings and outreach related to the QMI to help ensure program and measure leads improve the utility and understanding of the QMI as part of the measure assessment process. Work was conducted, including an environmental scan and testing on Marketplace Quality Rating System measures, to adapt the QMI for use on health plan specified measures.

Total for Program Assessment and Review

Funding Amount	Fiscal Year
$4,427,955.00	**2022**

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

Ensuring Detailed Information on Quality Measurement Activities

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

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

Measure Selection

In this category, we have included the measure selection process that is undertaken through the statutory pre-rulemaking process, the endorsement and maintenance activities of the CBE, which are fundamental to the measure selection process, and the task orders of the CBE, which also provide us critical information that we can use, which feeds into the selection of measures.

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

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

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

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

Finally, the task orders 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 2021, CMS obligated an estimated $13.0 million from funding available under sections 1890 and 1890A that is considered Measure Selection. In FY 2022, CMS continued this work with estimated obligations of $7.6 million.

In future years (FY 2023 and 2024), CMS will need an estimated $10.4 million and $10.4 million respectively to continue this level of Measure Selection work.

Measure Development

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.

Public Reporting

Beginning in FY 2020, CMS modernized public reporting. CMS's original eight Compare Sites and Data.Medicare.gov were replaced with two new websites that meet the needs of the various stakeholder groups making quality, price, and volume data accessible and interpretable, and thereby enabling informed, personalized health care decision-making. By FY 2022, CMS efforts focused on maintaining the websites for Care Compare and Provider Data Catalog (PDC) and improving the user experience by enabling an intuitive searchable interface, meaningful and streamlined content and public reporting of quality measures. Efforts included CMS efforts to coordinate and support alignment, prioritization, risk assessment and mitigation, scheduling and timelines for the readiness of the new user interfaces. This contract oversees the global coordination and transition effort namely the Alignment of Quality and Public Reporting Programs and Websites. In 2022, the contractor increased communication, coordination and alignment through development, consolidation and dissemination of a comprehensive 2022 calendar year schedule including 75 release and refresh dates across all compare sites settings, a time-based workflow for planning resources around file creation, data validation and data deployment in the production environments.

CMS also utilizes appropriations for sections 1890 and 1890A of the Act for public reporting of measure information through the Measure Management System (MMS). The MMS supports important efforts to standardize and promote best practices in quality measurement. Developed by the MMS, the web-based CMS Measures Inventory Tool (CMIT) provides the public access to those measures used in CMS programs.[14]

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

The National Impact Assessment of CMS Quality Measures Report is published triennially and examines results that help to move CMS's goals to improve healthcare through the implementation of quality measures meaningful to both patients and providers. This report includes quality measures used in 26 CMS quality programs.

In FY 2022, CMS continued this work and obligated $9 million for public reporting activities.

In future years (FY 2023 and 2024), CMS will need an estimated $7.8 million and $7.9 million respectively to continue this level of Public Reporting work.

Education and Outreach

In FY 2022, CMS continued to increase CMS stakeholders' knowledge and engagement on quality measure and development topics through education and outreach by leveraging tools and outreach venues available through MMS. Given the role MMS plays at supporting standardization of measure development, transparency of quality measures across CMS programs, and promotion of best practices, MMS is in the unique position to provide education to a diverse group of CMS stakeholders, agnostic to any one individual program or setting. Through various quality measurement technical assistance resources and tools, the MMS engages patients, caregivers, measure developers, clinicians and others. Contractor responsibilities include bimonthly informational webinars, advertising technical expert panels and other engagement opportunities for other CMS contractors and quality programs, distributing monthly newsletter, maintaining a robust website, and developing resources to further engage and educate stakeholders in the measure development process.

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

The MMS provides education and outreach for patients, families, clinicians, caregivers, providers, hospitalists, measure developers, and others to engage with CMS in the measure development process and understand the impact quality measurement can have. The monthly MMS newsletter is distributed to over 100,000 subscribers across the quality measurement enterprise. The annual public webinars are attended by over 2,300 participants, with another 1,300 viewing the recording.

In FY 2021, CMS obligated $0.8 million from funding available under sections 1890 and 1890A to activities to be considered Education and Outreach. In FY 2022, CMS continued this work and obligated $0.8 million in education and outreach activities. In the next two years, FY 2023 and FY 2024, CMS will need an estimated $0.9 million for each fiscal year to continue this level of Education and Outreach work.