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CMS Quality Measure Development Plan

2024 Annual Report

For the Quality Payment Program

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For the Quality Payment Program

Prepared by Health Services Advisory Group, Inc.

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Executive Summary

The 2024 Centers for Medicare & Medicaid Services (CMS) Quality Measure Development Plan (MDP) Annual Report fulfills a statutory requirement to track the development of clinician quality measures for the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (Advanced APMs). This eighth annual report records measure development progress and expenditures in fiscal year (FY) 2023, the status of measurement gaps, and the Quality Payment Program (QPP) measure inventory for the current performance year.

CMS envisions a quality measurement system that reflects national priorities and supports clinicians reporting to the QPP. The accomplishments described in the report reflect CMS' commitment to reducing the reporting burden of quality measures while improving care for all. Adhering to the CMS National Quality Strategy goal of aligning quality measures across reporting programs, the QPP incorporated the Universal Foundation of Measures into MIPS, including 10 adult and six pediatric measures. Bundling clinically relevant measures into MIPS Value Pathways (MVPs) supported agency-wide efforts to eliminate overlap, streamline the measure inventory, and simplify reporting. Finally, by encouraging electronic clinical quality measures, or eCQMs, and the conversion of measures to the Fast Healthcare Interoperability Resources® (FHIR®) standard, CMS took pivotal steps toward seamless exchange of health care information and transition to digital quality measures (dQMs).

2024 Quality Payment Program Measure Inventory

Merit-based Incentive Payment System (MIPS)		***Qualified Clinical Data Registries (QCDRs)***	
Total quality measures for all specialties (23% eCQMs)	**198**	CMS-approved:	**44**
Process:	**130**	Number of specialties prioritized in the MDP and Annual Reports with an applicable QCDR:	**11**
Outcome/intermediate outcome:	**40**		
Patient-reported outcome-based performance measures (PRO-PMs):	**21**		
Efficiency:	**4**	***Advanced Alternative Payment Models (APMs)***	
Patient experience:	**2**		
Structural:	**1**	CMS-approved:	**9**

Key CMS Accomplishments Supporting Measure Development

- Advanced health equity by rewarding improved care of underserved populations and paying for auxiliary staff services to address health-related social needs
- Designated adult and pediatric sets of quality measures as a "Universal Foundation" to improve quality and health outcomes, focus provider attention, reduce burden, and allow for comparisons across programs
- Supported transition of measures to dQMs and conversion to the FHIR® standard for seamless exchange of health information
- Finalized five MIPS Value Pathways (MVPs) for women's health; infectious disorders; mental health and substance use; ear, nose, and throat disorders; and rehabilitative support for musculoskeletal care, making 16 MVPs available for the CY 2024 performance period

$1.1 million*

expended in FY 2023 for measure development

1 Measure Developed	
Process:	**1**
4 Measures Still in Development in FY 2024	
Outcome:	**1**
Patient engagement/ experience:	**1**
Process:	**1**
PRO-PM:	**1**

*From title XVIII of the Social Security Act (the Act)

$62.6 million**

cumulatively expended for measure development and related activities (FY 2016–2022)

36 quality measures developed, 11 in use in 2024 QPP

**Authorized by section 1848(s)(6) of the Act, as added by section 102 of the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 (MACRA)

1. Introduction

CMS annually reports progress in advancing the QPP in accordance with the *CMS Quality Measure Development Plan*[1] (the MDP), which established initial priorities for clinician quality measurement and guides ongoing efforts. This is the eighth annual report supporting the MDP.

This *2024 MDP Annual Report for the Quality Payment Program* details development of five quality measures in fiscal year (FY) 2023, funded by $1.1 million from title XVIII of the Social Security Act (the Act).

The report also retrospectively accounts for appropriations under section 1848(s)(6) of the Act,[i] which authorized $15 million annually from FY 2015 through FY 2019. Congress reduced the annual appropriations after FY 2016, as described in *Quality Measures Developed and In Development During the Previous Year* (Chapter 3). Funds were available through the end of FY 2022 to develop quality measures for the two tracks of the QPP—the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs)—and to carry out other provisions of the Act. Cumulatively, CMS spent $62.6 million and developed a total of 36 quality measures; as of this publication, 11 of those are in use for the 2024 performance period. Not all measures developed meet the measure selection criteria for implementation in a CMS program.

The CY 2024 Physician Fee Schedule (PFS) final rule[2] includes an inventory of 198 MIPS quality measures, of which 132 (67%) are high-priority. Electronic clinical quality measures (eCQMs) make up 23% of the inventory. Since the inception of MIPS, CMS has balanced measure development with removal of measures that are topped out, duplicative, and inconsistent with priorities highlighted in the Measure Development Plan[1] and CMS quality initiatives. Those efforts have reduced the QPP measure inventory overall by approximately 27% while increasing the proportion of high-priority measures by 5 percentage points.

Objectives

Section 1848(s)(3) of the Act requires the Secretary of Health and Human Services (HHS) to post online each year a report on the progress CMS has made in developing quality measures to support the QPP. The 2024 MDP Annual Report fulfills these specific statutory requirements (Appendix A):

- **Reports on the progress made in developing quality measures for the Quality Payment Program**[ii] **and the Secretary's efforts to implement the MDP**.[iii] One measure intended for MIPS, MIPS APMs, or Advanced APMs was completed in FY 2023, and four are continuing development.

[i] As added by section 102 of the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 (MACRA).
[ii] Section 1848(s)(3)(A) of the Act.
[iii] Section 1848(s)(3)(B)(i) of the Act.

- **Provides other information the Secretary determines to be appropriate.**[iv] HHS leads efforts to modernize measurement technology through standardized electronic collection and exchange of health care information.
- **Details updates to the MDP, including newly identified gaps and the status of previously identified gaps.**[v] CMS is targeting chronic conditions, the opioid epidemic, sickle cell disease, older adult/geriatric medicine, oral health, and maternal health for development of measures, especially including outcome measures.
- **Describes the quality measures developed during the previous year (FY 2023, October 1, 2022–September 30, 2023).**[vi] The report includes detailed measure information: name, health care quality priority; quality domain; developer, steward, type, endorsement status, whether electronically specified.
- **Describes quality measures in development at the time of the report (as of September 30, 2023).**[vii] An estimate of the time of completion is provided if available, along with the same details described for a fully developed measure.
- **Provides an inventory of applicable measures.**[viii] The inventory available in the QPP for the CY 2024 performance period consists of measures approved for MIPS (both traditional MIPS and MIPS Value Pathways [MVPs]), MIPS APM Performance Pathway (APP), MIPS qualified clinical data registries (QCDRs), and Advanced APMs.

Report Organization

Statutory Requirements for the CMS MDP Annual Report (Chapter 2) describes FY 2023 activities of CMS components, in partnership with contractors, to support implementation of the MDP, as well as endeavors by HHS to support and coordinate with measure developers. *Quality Measures Developed and In Development During the Previous Year* (Chapter 3) details progress in measure development. *Closing the Measurement Gaps by Advancing the MDP* (Chapter 4) examines the current status of measurement gaps in the QPP. *Inventory of Applicable Quality Measures* (Chapter 5) describes the measures approved for clinician reporting for performance year 2024 and is followed by a brief *Conclusion* (Chapter 6).

Appendices supplement the report information:

Appendix A –*Statutory Language Excerpts*
Appendix B – *Acknowledgments*
Appendix C – *CMS-Funded Quality Measures Developed During the Previous Year*
Appendix D – *CMS-Funded Quality Measures in Development*

[iv] Section 1848(s)(3)(B)(v) of the Act.
[v] Section 1848(s)(3)(B)(iv) of the Act.
[vi] Section 1848(s)(3)(B)(ii) of the Act.
[vii] Section 1848(s)(3)(B)(iii) of the Act.
[viii] Section 1848(s)(3)(B)(iv) of the Act.

2. Statutory Requirements for the CMS MDP Annual Report

Efforts to Implement the Measure Development Plan

The MDP establishes measure priorities for the two initial tracks of the Quality Payment Program while meeting the requirements of section 1848(s) of the Act and adhering to CMS' guiding principles. The MDP Annual Report records progress in developing clinician quality measures, updating policy to meet clinician and patient needs, and implementing the MDP.

Funding New Measure Development

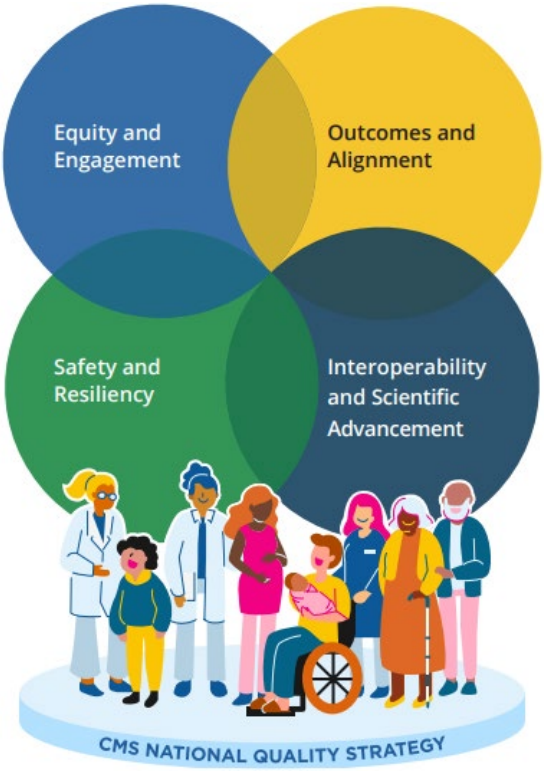
During FY 2023, CMS supported the development of one outcome measure, one patient-reported outcome performance measure (PRO-PM), one patient engagement/experience measure, and two process measures. Of those, one measure completed development and four remain in development.

Thirty-six measures were developed with section 1848(s)(6) of the Act funding through FY 2022. Details on measure development activities can be found in *Quality Measures Developed and in Development During the Previous Year* (Chapter 3).

Identifying and Developing Meaningful Measures

CMS National Quality Strategy

The CMS National Quality Strategy is a long-term initiative to improve quality and safety in health care. It promotes a person-centered approach across the continuum of care from birth to end of life and across payer types, including traditional Medicare, Medicare Advantage, Medicaid and Children's Health Insurance Program (CHIP), and Marketplace coverage.[3]



The National Quality Strategy has four priority areas: outcomes and alignment, equity and engagement, safety and resiliency, and interoperability and scientific advancement.[3] Approaches to achieve associated goals include the following:

- Establishing health and safety standards
- Public reporting of value-based payment programs and models
- Quality measurement
- Supporting quality improvement activities

Cascade of Meaningful Measures

Aligned with the goals of the National Quality Strategy are five interrelated goals of the Meaningful Measures Initiative, which addresses measurement gaps, reduces burden, and increases efficiency by:

- Aligning measures across value-based programs and across partners, including CMS, federal, and private entities.
- Developing and implementing measures reflecting social drivers of health.
- Prioritizing outcome and patient-reported measures.
- Transforming measures to incorporate all-payer data and be fully digital.
- Using only high-value measures impacting key quality domains.[4]

The Cascade of Meaningful Measures maps existing measures to the Meaningful Measures 2.0 framework and identifies opportunities for measure alignment and gaps for future measure development.[5] The Cascade shows in increasing detail how CMS measures aspects of health care by mapping goals and objectives to the eight Meaningful Measures health care quality priorities.

Universal Foundation of Measures

In 2023, CMS introduced a Universal Foundation of quality measures to further alignment across CMS programs. The Universal Foundation will focus provider attention, reduce burden, identify disparities in care, prioritize development of interoperable digital quality measures, allow for comparisons across programs, and help identify measurement gaps.[6] Component measures are currently stratified into adult and pediatric sets. MIPS includes all 10 adult Universal Foundation measures and six of 13 pediatric measures.

CMS recently added three population- and setting-specific measure sets—hospital, post-acute care, and maternity care—and will continue developing add-on sets for the Universal Foundation in 2024, including one for behavioral health. CMS will prioritize outcome and patient-reported measures, applying the following selection criteria for new component measures:

- Of high national impact
- Able to be benchmarked nationally and globally
- Applicable to multiple populations and settings
- Appropriate for stratification to identify disparity gaps
- Scientifically acceptable
- Feasible and computable (or capable of becoming digital)
- Not associated with unintended consequences[6]

CMS' Approach to Advancing Health Equity

CMS is advancing health equity by rewarding improved performance in quality metrics for underserved[ix] populations and providing payment for services that address health-related social needs. In CY 2023, CMS developed an approach to promoting equity within quality measurement called Rewarding Excellence for Underserved Populations (REUP).[7] This approach incentivizes health care organizations that treat higher percentages of underserved populations and rewards progress across multiple quality measures. For example, a health equity adjustment to an

[ix] The term "underserved" refers to populations and geographic communities that have been systematically denied the opportunity to participate fully in aspects of economic, social, and civic life, as defined in Executive Order 13985.

accountable care organization's quality score as part of the Medicare Shared Savings Program (MSSP) was added to incentivize improvement in care for vulnerable individuals.[7,8(p. 69781)]

The CY 2024 PFS final rule advances health equity by providing payment for three services addressing health-related social needs:

- Community health integration services
- Principal illness navigation services
- Social determinants of health risk assessment[2(p. 79173-79174)]

CMS finalized new coding for these services that auxiliary personnel (e.g., licensed addiction counselors) may provide under the billing practitioner's supervision. Such services incident to those of the billing physician or practitioner are permitted when reasonable and necessary to diagnose and treat the patient.[2(p. 78921)]

CMS is prioritizing quality measures focused on equity, behavioral health, and maternal health, as well as measures that support appropriate utilization and National Standards for Culturally and Linguistically Appropriate Services (CLAS) to advance "quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs."[9] For example, a CMS contractor developed a survey item set that aligns with CLAS standards in Health and Health Care for future use in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS.

In other work relevant to QPP partners advancing health equity:

- A CMS contractor is developing the *Addressing Social Needs eCQM* with feedback from a patient working group and a technical expert panel. The digital measure will advance the field of health-related social needs measurement by incorporating goal-oriented action in response to identified needs, a crucial step in addressing root causes of inequities in outcomes.
- The Gravity Project is a public collaborative that develops consensus-driven interoperability standards on social drivers of health. The Gravity Project identifies elements and associated value sets to represent relevant information documented in electronic health records (EHRs) across four clinical activities: screening, diagnosis, goal setting, and intervention activities.[10] The Gravity Project activities align with the first priority in the *CMS Framework for Health Equity 2022–2032*: "to improve our collection and use of comprehensive, interoperable, standardized individual-level demographic and [social drivers of health] data, including race, ethnicity, language, gender identity, sex, sexual orientation, [and] disability status."[11]

Other Strategic Initiatives

Quality Measure Index (QMI) – The QMI tool is a decision-support tool that provides an objective and standard methodology to rapidly assess the relative value of quality measures based on information submitted by measure stewards. The purpose of the tool is to transparently display strengths and limitations of individual quality measures, facilitate comparisons between measures, and aid CMS in selecting the best possible measures for development, implementation, or continued use. The QMI tool is intended to enhance, not replace, existing endorsement and measure selection processes. The QMI tool fills a critical gap, providing CMS a method to assess measures based on objective criteria, and can complement qualitative expert

reviews of measure information through public comment, consensus-based entity (CBE) endorsement, and pre-rulemaking.

The QMI tool was developed to address U.S. Government Accountability Office findings that CMS lacked a systematic method to assess measures to ensure they meet CMS quality measurement strategic objectives.[12] A multidisciplinary technical expert panel has provided input on the tool methodology throughout development, and CMS solicited public comment on the tool in 2022. The QMI tool has been used to score measures across CMS programs, levels of analysis, and stages of development. Since 2021 the QMI tool has been used to score measures submitted to the Annual Call for Measures, and the generation of QMI scores was automated in 2023.

Alignment of measures – CMS and America's Health Insurance Plans (AHIP) support the Core Quality Measures Collaborative (CQMC) as a public-private enterprise working toward measure alignment across the health care system. The CQMC develops and maintains 10 core sets of quality measures addressing high priorities. Information on the measure core sets is available at https://www.p4qm.org/CQMC/core-sets.

The CQMC 2023 report *Aligning Approaches to Measure Models* explores reducing quality measure reporting burden through measure model alignment (MMA).[13] Analysis of existing measurement models and feedback elicited from CQMC's more than 70 member organizations informed the report.

MMA models span the quality reporting process: collecting, transmitting, standardizing, aggregating, calculating, and disseminating measure data. The CQMC envisions three options for structuring such models:

- Regional: Health improvement collaboratives connect local entities pursuing common goals.
- Networked: Regional organizations (e.g., collaboratives, health insurance exchanges) connect and share data in a common network system.
- National: Third parties (e.g., regional collaboratives, registries) aggregate data from providers.

As CQMC creates and updates MMA models, key considerations to promote alignment and reduce burden include measure selection and adoption, data collection and transmission, stratification and risk adjustment, attribution, and scoring and reporting.

Partnering With Patients, Families, and Caregivers in Measure Development

CMS defines person and family engagement as involving such partners in "defining, designing, participating in and assessing the care practices and systems that serve them to assure they are respectful of and responsive to individual patient preferences, needs, and values."[14] CMS intentionally aligns its policies, programs, quality measures, and innovations in payment models with these strategic goals and desired outcomes.

In 2023, CMS updated the *Person and Family Engagement Toolkit: A Guide for Measure Developers,* a roadmap for involving partners throughout the lifecycle of a measure development project. The Toolkit seeks to standardize best practices across all CMS measure development

contractors during six critical phases of person and family engagement: strategic planning, recruitment, preparing partners and staff, facilitation, follow-up, and refining the approach.[15]

In other work relevant to the QPP:

- A CMS contractor pilot-tested the *Cancer Health Equity PRO-PM for Preventive Screening and Counseling* in clinician offices and is analyzing results and partner feedback.
- Another contractor recruited patients whose primary language is not English to participate in cognitive testing for the *Language Services Summary Survey Measure*. The contractor also recruited patients to complete a survey on the importance and usefulness of *Adult COVID-19 Vaccination Status*. The feedback informed recommendations for final survey items and Measures Under Consideration submission for both measures.

Partnering with Clinicians and Professional Societies

Measures Management System and Outreach

The Measures Management System (MMS) Hub is home for information about developing and maintaining CMS quality measures.[16] The MMS Hub contains the Blueprint, which guides interested parties through the measure lifecycle and informs them how to engage in measure development. In addition, the MMS Hub contains pre-rulemaking resources, MMS tools (e.g., CMS Measures Inventory Tool [CMIT], Measures Under Consideration Entry/Review Information Tool [MERIT], De Novo Measure Scan), CMS tools (e.g., Bonnie, Cypress, CMS Data Element Library), supplemental Blueprint materials, and educational resources. Examples of educational resources include recorded presentations and associated materials on the following topics:

- *Digital Quality Measures: Specifying the Future of Quality Measurement*
- *From Data to Action: How CMS and Stakeholders are Addressing Inequities in Healthcare*
- *Navigating Measure Implementation: Turning Data into Actionable Results*

A monthly MMS newsletter is also available for the latest quality measurement resources, events, and news updates.

Quality Payment Program Educational Resources

The CMS QPP website provides up-to-date resources for eligible clinicians and measure developers participating in either MIPS or Advanced APM tracks. The QPP website provides all pertinent information for participation, including eligibility, reporting options, and requirements. More features, such as the QPP timeline, resource library, and webinar library, are available for participants. A sample of available 2023 webinars for eligible clinicians and other interested parties includes:

- MIPS Call for Quality and Cost Measures Overview Webinar
- MIPS Value Pathways (MVPs) Overview and Office Hours
- QCDR Measure Development Webinar
- QCDR and Qualified Registry Self-Nomination and QCDR Measure Submission Demonstration
- Self-Nomination, Data Validation, and QCDR Measure Submission Q&A Session

Development of Episode-Based Cost Measures for MIPS

Five episode-based cost measures related to depression, emergency medicine, heart failure, low back pain, and psychoses and related conditions were finalized in the CY 2024 PFS final rule.[2(p. 79318)] Twenty-nine episode-based cost measures plus *Total Per Capita Cost* are available in the cost category for MIPS performance year 2024.[2(p. 79349)] Five more episode-based cost measures addressing chronic kidney disease, end-stage renal disease, kidney transplant management, prostate cancer, and rheumatoid arthritis were field-tested as part of Wave 5 development in 2023.[17] Clinician expert workgroups participated in Wave 6 field testing in March 2024 for two measures being considered to address movement disorders and non-pressure ulcers.[18,19]

Reducing Clinician Burden of Data Collection for Quality Measure Reporting

MIPS eligible clinicians have three QPP reporting options: traditional MIPS, APM Performance Pathway (APP), and the newest option in its second year, MIPS Value Pathways (MVPs).

MIPS Value Pathways

MVPs are specialty- or condition-specific measure bundles developed to support and encourage clinicians in their quality improvement efforts and reduce barriers to APM participation.[2(p. 79321)] Each MVP includes a suggested type of clinician that may be appropriate to report it.[2(p. 79978-79980)] Five new MVPs were finalized in the CY 2024 PFS final rule:

- Focusing on Women's Health
- Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV
- Quality Care in Mental Health and Substance Use Disorders
- Quality Care for the Treatment of Ear, Nose, and Throat Disorders
- Rehabilitative Support for Musculoskeletal Care[2(p. 79323)]

Modifications were made to the previous 12 MVPs, and two were combined, making 16 available for reporting for the 2024 MIPS performance period.[2(p. 79443)]

Specific efforts to align the established Value in Primary Care MVP and the APP measure set with the Universal Foundation of Measures allow clinicians to gain familiarity with APP measures while participating in MIPS, thus encouraging participation in APMs.[2(p. 79100)]

Additional HHS Efforts to Support the MDP

Consensus-Based Entity

The CBE gathers diverse health care experts to review and endorse quality measures for consideration in CMS reporting programs. The CBE conducts three main activities: Endorsement & Maintenance (E&M), Pre-Rulemaking Measure Review (PRMR), and Measure Set Review (MSR). The *Endorsement and Maintenance (E&M) Guidebook* was published in October 2023 after a public comment period.[20] The guidebook contains the E&M process and provides guidance for measure stewards, developers, and organizations submitting a measure for endorsement consideration.

Previously known as the Annual Review of Measures, PRMR is the CBE's process of providing recommendations to CMS on the selection of quality and efficiency measures under consideration for use in CMS programs. In addition, the CBE conducts MSR annually to assess each program's measures and determine whether the benefits of a measure outweigh the burden of implementation. Recommendations are shared on the removal of quality and efficiency

measures from CMS programs. *The Guidebook of Policies and Procedures for Pre-Rulemaking and Measure Review (PRMR) and Measure Set Review (MSR)*, released in September 2023, reviews timelines, measure selection and removal criteria, committee composition, and procedures for interested parties.[21]

eCQI Resource Center and eCQM Standardization

The Electronic Clinical Quality Improvement (eCQI) Resource Center is the main resource for eCQM developers and other interested parties. The eCQI website provides tools and resources for all phases of eCQM development and maintenance.

CMS is advancing the interoperability of health care data by transitioning quality measures used in CMS programs to digital quality measurement.[22] CMS supports converting measures from the Quality Data Model (QDM) to the FHIR® standard, which would allow clinicians to exchange health care information electronically regardless of differences in how data from EHRs are expressed and maintained.[23] CMS has defined digital quality measures (dQMs) as "quality measures that use standardized, digital data from one or more sources of health information that are captured and exchanged via interoperable systems; apply quality measure specifications that are standards-based and use code packages; and are computable in an integrated environment without additional effort."[24]

In other work relevant to the CMS FHIR® implementation plan:

- A CMS contractor continued work transitioning current quality measure specifications to FHIR standards and maintaining alignment with the QDM-based versions of the measures currently used in MIPS.
- The contractor also educated measure stewards on FHIR standards and provided support to stewards in the creation and maintenance of FHIR specifications.

The Office of the National Coordinator for Health Information Technology (ONC) launched the United States Core Data for Interoperability Plus (USCDI+) to help government and industry partners build on USCDI to support specific program needs.[25] One objective includes identifying opportunities to align policies for quality reporting programs. This work includes aligning data elements into a common list to streamline the development and reporting of quality measures.[25] In 2023, the ONC released the draft USCDI+ Quality Data Element List for public comment.[26] Once finalized, the USCDI+ Quality data elements will provide a consistent construct for technical specifications and FHIR® implementation guides that measure developers, measure implementers, and standards development professionals need.[26]

Updates to the Measure Database

The CMS Measure Inventory Tool (CMIT) is the online repository for CMS measures across the measure lifecycle—under development, under consideration, proposed, finalized, implemented, and removed. CMIT includes measure information for Medicaid, CMS Innovation Center, Marketplace Quality Rating System, Star Ratings Parts C & D, and Medicare quality programs for hospitals, post-acute/long-term care settings, and clinicians. CMIT 2.6 launched in 2023 with enhanced search functions, updates to measure terminology, and inclusion of CMS Innovation Center model and demonstration measures.[27] CMIT displays primary and secondary priorities and goals for each measure, mapped to the Cascade of Meaningful Measures 2.0.[28]

3. Quality Measures Developed and In Development During the Previous Year

Quality Measures Developed During the Previous Year

CMS stewarded the development of one measure intended for use in MIPS, MIPS APMs, or Advanced APMs. *Adult COVID-19 Vaccination Status* is a general medicine/crosscutting process measure developed by Mathematica. Although the 2023 MDP Annual Report listed this measure as having completed development, an estimated $161,077 was spent in FY 2023 to modify the specifications in response to feedback during the 2022–2023 pre-rulemaking process. The measure was then resubmitted for the next cycle. See *CMS-Funded Quality Measures Developed During the Previous Year* (Appendix C) for measure details.[x]

Quality Measures in Development at the Time of This Report

Four measures intended for potential inclusion in MIPS, MIPS APMs, or Advanced APMs were in development during FY 2023 (Table 1). Combined expenditures were estimated at $940,845[xi]:

- $82,621 for one outcome measure
- $94,710 for one patient engagement/experience measure
- $364,089 for one PRO-PM
- $399,425 for one process measure being developed as an eCQM

Table 1: Summary of CMS-Funded Measures in Development in FY 2023[xii] (10/1/2022–9/30/2023)

Meaningful Measures 2.0 Priority/Quality Domain* - *Measure Name* (Steward/Developer[s])	# of Measures	# of eCQMs
Chronic Conditions/Clinical Care Outcome measure: *Hepatitis C Virus: Sustained Virological Response*** (American Gastroenterological Association [AGA]/AGA)	1	0
Equity/Patient and Caregiver Experience Patient engagement/experience measure: *Language Services Summary Survey Measure* (CMS/Mathematica) Patient-reported outcome performance measure: *Cancer Health Equity PRO-PM for Preventive Screening and Counseling* (CMS/Yale New Haven Health Services Corporation/Center for Outcomes Research and Evaluation [Yale CORE]) Process measure: *Addressing Social Needs (ASN) eCQM* [E] (CMS/Yale CORE)	3	1
Total	**4**	**1**

* CMS will update the measure priority/domain if a more suitable option is identified during development.
** CMS supported the American Gastroenterological Association (AGA) in specifying the measure for MIPS, alpha testing, and creating a plan for beta testing.
[E] Planned to be electronically specified

[x] Section 1848(s)(3)(B)(ii) of the Act.
[xi] This figure includes measure development activities but not measure maintenance, production support, or overhead costs.
[xii] As of November 1, 2023, to allow for estimated funding for the entire FY 2023 and for federal review and clearance of this report.

Measure conceptualization, specification, and testing phases in the measure lifecycle are critical to assess the viability of a measure concept.[29] Table 1 describes measures in different phases of development at the time of this report.[xiii] *Addressing Social Needs eCQM* is in the specification phase. The remaining three measures—*Cancer Health Equity PRO-PM for Preventive Screening and Counseling*, *Hepatitis C Virus: Sustained Virological Response*, and *Language Services Summary Survey Measure*—all are in the testing phase. These measures can be considered for inclusion in the QPP once all testing has been completed. See *CMS-Funded Quality Measures in Development* (Appendix D) for additional measure details, including timelines for completion.[xiv]

Cumulative Section 1848(s)(6) Expenditures

Section 1848(s)(6) authorized yearly transfers of $15 million (FY 2015–2019), available through FY 2022. Congressional sequestration, or across-the-board budget reductions in certain kinds of federal spending, reduced appropriations for some years. Table 2 records the amounts received, obligated, and expended in each year.

Table 2: Receipts and Expenditures From Section 1848(s)(6), FY 2015–2022

FY	$ Received	$ Obligated	$ Expended
2015	15,000,000	–	–
2016	15,000,000	4,108,484	4,108,484
2017	13,965,000*	5,111,810	5,111,810
2018	14,010,000*	14,971,305	14,971,305
2019	14,070,000*	11,460,542	11,435,989
2020	–	12,252,660	12,222,637
2021	–	6,487,406	6,301,305
2022	–	8,559,555	8,454,625
Total	72,045,000	62,951,762**	62,606,155

Source: CMS Office of Financial Management

*After sequestration

**While CMS awarded contracts obligating $67,836,941, $4,885,179 of that amount was deobligated over the course of the contracts; thus, the obligated amount totaled $62,951,762.

Using the appropriations from section 1848(s)(6), CMS collaborated with professional societies, academic medical centers, and other entities to successfully develop 36 measures—mostly specific to a condition or clinician specialty—intended for potential inclusion in MIPS, MIPS APMs, or Advanced APMs. Table 3 groups the 36 measures by Meaningful Measures 2.0 priority/quality domain, which CMS may update if a more suitable option is identified. The table identifies each measure's steward and developer, whether it was developed as part of a CMS cooperative agreement, and whether it is or is planned to be electronically specified. Eleven measures (designated Ω) are finalized for reporting for the CY 2024 performance period.

Because of the rigorous process of measure selection, not all developed measures will be implemented in a CMS quality program. CMS also assesses burden on providers and the potential impact of a measure. It must be fully developed with valid and reliable testing results.

[xiii] As of November 1, 2023, to allow for estimated funding for the entire FY 2023 and for federal review and clearance of this report.
[xiv] Section 1848(s)(3)(B)(iii) of the Act.

Table 3: Summary of Quality Measures Developed Through FY 2022 With Section 1848(s)(6) Funding

Affordability and Efficiency
Outcome measure
Eligible Clinician- or Eligible Clinician Group-Level Hospital-Wide All-Cause Unplanned Readmission Measure [P] (CMS/Yale CORE)
Behavioral Health/Clinical Care
Outcome measures
Improvement or Maintenance in Recovery for Individuals with a Mental Health and/or Substance Use Disorder [^] (APA | NCQA/APA)
Improvement or Maintenance of Functioning for Individuals with a Mental and/or Substance Use Disorder [^, P] (APA | NCQA/APA)
Reduction in Suicidal Ideation or Behavior Symptoms [^, P] (APA | NCQA/APA)
Process measures
Continuity of Pharmacotherapy for Opioid Use Disorder (OUD) [^, P] (USC/USC)
Initiation and Update to Suicide Safety Plan for Individuals with Suicidal Ideation, Behavior or Suicide Risk [^, P] (APA | NCQA/APA)
Measurement-based Care Processes: Baseline Assessment, Monitoring and Treatment Adjustment [^] (APA | NCQA/APA)
Prolonged opioid prescribing following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) (eCQM) [^, E] (BWH/BWH)
Chronic Conditions/Clinical Care
Outcome measures
Clinician and Clinician Group Risk-Standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions [P] (CMS/Yale CORE)
Risk-Standardized Acute Unplanned Cardiovascular-Related Admission Rates for Patients with Heart Failure for the Merit-based Incentive Payment System [P] (CMS/Yale CORE)
Person-Centered Care/Patient and Caregiver Experience
Patient-reported outcome performance measures
Care goal achievement following total hip arthroplasty and/or total knee arthroplasty [^] (BWH/BWH)
Palliative care outpatients' experience of feeling heard and understood [^, P] (AAHPM/AAHPM)
Palliative care outpatients' experience of receiving desired help for pain [^] (AAHPM/AAHPM)
Patient-Reported Fatigue Following Chemotherapy among Adults with Breast Cancer, Colon Cancer, and Non-Small Cell Lung Cancer [^] (SCCA/PBGH)
Patient-Reported Overall Mental Health Following Chemotherapy among Adults with Breast Cancer, Colon Cancer, and Non-Small Cell Lung Cancer [^] (SCCA/PBGH)
Patient-Reported Overall Physical Health Following Chemotherapy among Adults with Breast Cancer, Colon Cancer, and Non-Small Cell Lung Cancer [^] (SCCA/PBGH)
Patient-Reported Pain Intensity Following Chemotherapy among Adults with Breast Cancer, Colon Cancer, and Non-Small Cell Lung Cancer [^] (SCCA/PBGH)
Patient-Reported Pain Interference Following Chemotherapy among Adults with Breast Cancer, Colon Cancer, and Non-Small Cell Lung Cancer [^] (SCCA/PBGH)
Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty (THA/TKA) (CMS/Yale CORE)

[^] Developed under CMS cooperative agreement

[E] Electronically specified or planned to be

[P] Implemented for the CY 2024 performance period. Measure titles may not be 100% congruent with title as implemented.

Person-Centered Care/Patient and Caregiver Experience (cont.)
Process measures
First Year Standardized Waitlist Ratio (FYSWR) (CMS/UM-KECC)
Percentage of Prevalent Patients Waitlisted (PPPW) (CMS/UM-KECC)
Percentage of Prevalent Patients Waitlisted in Active Status (aPPPW) (CMS/UM-KECC)
Prevalent Standardized Waitlist Ratio (PSWR) (CMS/UM-KECC)
Safety/Safety
Intermediate outcome measures
Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults ^ (UCSF/UCSF)
Hemodialysis Vascular Access: Practitioner-Level Long-Term Catheter Rate P (CMS/UM-KECC)
Unsafe Opioid Prescriptions at the Dialysis Practitioner Group Level (CMS/UM-KECC)
Unsafe Opioid Prescriptions at the Prescriber Group Level (CMS/UM-KECC)
Outcome measures
Eligible Clinician- or Eligible Clinician Group-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty P (CMS/Yale CORE)
Patient Safety Indicator for Hypoglycemia (CMS/Yale CORE)
Risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty and/or total knee arthroplasty (eCQM) ^, E (BWH/BWH)
Risk-standardized inpatient respiratory depression rate following elective primary total hip arthroplasty and/or total knee arthroplasty (eCQM) ^, E (BWH/BWH)
Risk-standardized major bleeding and venous thromboembolism rate following elective primary total hip arthroplasty and/or total knee arthroplasty (eCQM) ^, E (BWH/BWH)
Seamless Care Coordination/Care Coordination
Process measures
Rate of communicating results of an amended report with a major discrepancy to the responsible provider ^, E (ASCP/ASCP)
Rate of notification of a new diagnosis of malignancy to the responsible provider ^, E (ASCP/ASCP)
Wellness and Prevention/Population Health and Prevention
Composite measure
Preventive Care and Wellness (composite) E, P (CMS/Mathematica)
Process measure
Adult COVID-19 Vaccination Status (CMS/Mathematica)

^ Developed under CMS cooperative agreement

E Electronically specified or planned to be

P Implemented for the CY 2024 performance period. Measure titles may not be 100% congruent with title as implemented.

Measure stewards and developers

AAHPM	American Academy of Hospice and Palliative Medicine
AGA	American Gastroenterological Association
APA	American Psychiatric Association
ASCP	American Society for Clinical Pathology
BWH	Brigham and Women's Hospital
CMS	Centers for Medicare & Medicaid Services
NCQA	National Committee for Quality Assurance
PBGH	Purchaser Business Group on Health
SCCA	Seattle Cancer Care Alliance
UCSF	University of California, San Francisco
UM-KECC	University of Michigan Kidney Epidemiology and Cost Center
USC	University of Southern California
Yale CORE	Yale New Haven Health Services Corporation/Center for Outcomes Research and Evaluation

4. Closing the Measurement Gaps by Advancing the MDP

Closing Previously Identified Gaps

Measure development activities in FY 2023 demonstrate progress toward addressing the measurement gaps identified in the 2017–2023 MDP Annual Reports.[30-36] Four measures in development (Table 4) could fill identified gaps in two prioritized specialties for which no measures were found in the *2017 CMS MDP Environmental Scan for the Quality Payment Program*[37] or the *2018 CMS MDP Environmental Scan and Gap Analysis Report*.[38]

Table 4: Measures in Development Corresponding to Identified Gaps

Measure Title	Gap Identified in MDP E-Scan
Oncology	
Cancer Health Equity PRO-PM for Preventive Screening and Counseling	Patient activation/engagement
General Medicine/Crosscutting	
Addressing Social Needs (ASN) eCQM	Collaboration across health and non-health sectors to improve equity of care
Hepatitis C Virus: Sustained Virological Response	Treatment outcomes
Language Services Summary Survey Measure	Patient understanding

Measures Under Consideration List Applicable to Identified Gaps

Each year the Measures Under Consideration List identifies quality and efficiency measures under review by the Secretary of HHS for use in certain Medicare quality programs.[39] The *2023 MDP Annual Report*[36] mentioned 16 potential quality measures for MIPS on the 2022 Measures Under Consideration List.[40] After proposing 14 of those measures and considering feedback from interested parties, CMS implemented 11 measures for the CY 2024 performance period.

Six potential MIPS quality measures were on the 2023 Measures Under Consideration List.[41] To obtain feedback from interested parties on all measures, the CBE conducts a Pre-Rulemaking Measure Review (PRMR).[42]

Three of the measures submitted for consideration directly relate to subtopic gaps identified in the 2017 *MDP Environmental Scan and Gap Analysis Report*[37] (Table 5). The Partnership for Quality Measurement (PQM), which conducts the PRMR, recommended one measure with conditions but did not reach consensus on the other two measures.[43] CMS considers the PRMR recommendations when reviewing measures for potential use in programs.

Table 5: Measures Under Consideration Corresponding to Identified Gaps

Measure Title	Gap Noted in MDP E-Scans	PQM PRMR Recommendation
Oncology		
Melanoma: Tracking and Evaluation of Recurrence	Outcomes for medical, surgical, radiation treatment (0)	Consensus not reached
Patient-Reported Fatigue Following Chemotherapy among Adults with Breast Cancer	Health-related quality of life (0)	Consensus not reached
Patient-Reported Pain Interference Following Chemotherapy among Adults with Breast Cancer	Pain control (0)	Recommend with conditions

Identifying New Gaps for Measure Development

CMS annually publishes needs and priorities for each program that falls under the pre-rulemaking process.[44] High-priority measurement gaps for MIPS include the following:

- Specialties: interventional cardiology, non-patient facing (e.g., pathology, radiology), dentistry, podiatry, nutrition/dietician, pain management, plastic surgery, hospitalist, nephrology, pulmonology, radiation oncology, speech language pathology
- Clinical conditions: opioid overdose epidemic, maternal health, mental/behavioral health, chronic conditions (e.g., arrhythmias, chronic obstructive pulmonary disease [COPD], hepatitis B, septicemia, respiratory failure, asthma), avoidance of amputation for diabetes, "age friendly" (older adult/geriatrics), cardiovascular (including hypertension), kidney care/organ transplantation, sickle cell disease, HIV, hepatitis C, cancer (e.g., lung cancer screening), oral health
- Other topics: outcome measures, coordination/communication/team-based care, interoperability/digital measures, new measure options for topped out specialty areas, health equity, COVID-19, shared decision-making

5. Inventory of Applicable Quality Measures

The inventory of MIPS quality measures available for eligible clinicians and clinician groups to report for the CY 2024 performance period consists of MIPS measures, a subset of which are designated for the APP; measures approved for use in MVPs; QCDR measures; and measures approved for use in Advanced APMs.

MIPS Measures Included in the CY 2024 PFS Final Rule

MIPS measures were posted for public review and input through the rulemaking process, which culminated in the publication of the CY 2024 PFS final rule, taking effect on January 1, 2024.[2] The MIPS quality measures inventory is assessed annually to determine gaps and identify measures to remove. For the CY 2024 performance period, the inventory includes 198 MIPS quality measures[2(p. 79556-79592)] consisting of 40 intermediate outcome or outcome measures, 21 PRO-PMs, 130 process measures, four efficiency measures, two patient engagement/experience measures, and one structural measure(s). Of those 198 measures, 131 are categorized as high-priority, a designation that encompasses outcome (including intermediate outcome and patient-reported outcome), appropriate use, patient safety, efficiency, patient experience, care coordination, and opioid- or health equity–related quality measures.

MIPS eligible clinicians must report a minimum of six quality measures, including one outcome measure or, in the absence of an applicable outcome measure, another high-priority measure. CMS includes at least one high-priority measure in every specialty set.[2(p. 79590-79884)] CMS modified specialty measure sets based upon review of updates to existing quality measure specifications, the addition of new measures for MIPS, and feedback provided by specialty societies.[2(p. 79590)] An interactive tool to view the comprehensive list of MIPS measures and specialty sets is available at https://qpp.cms.gov/mips/explore-measures.

Three of the 198 measures are for MVPs only. CMS finalized five new MVPs and modified those previously finalized.[2(p. 79978-80047)] Sixteen MVPs are available for MIPS eligible clinicians to voluntarily report for the CY 2024 performance period. The MVPs are posted at https://qpp.cms.gov/mips/explore-mips-value-pathways.

APM Performance Pathway

The APP is a reporting option available to MIPS eligible clinicians participating in MIPS APMs, who are scored on the quality performance category for a fixed set of MIPS clinical quality measures (Table 6):

- 10 measures via the Web Interface[2(p. 79112),xv] or three MIPS eCQMs
- CAHPS for MIPS patient experience survey
- Two readmission measures calculated from administrative claims

[xv] The APP is required for all Medicare Shared Savings Program accountable care organizations (ACOs). The CMS Web Interface will be available only through the CY 2024 performance period.

Table 6: Measures Included in the Final APM Performance Pathway Measure Set for Performance Year 2022 and Subsequent Performance Years[2(p. 79113)]

Quality ID #	Measure Title	Collection Type	Submitter Type	Meaningful Measures 2.0 Priority	Measure Type
321	CAHPS for MIPS	CAHPS for MIPS Survey	Third party intermediary	Person-Centered Care	PRO-PM
479	Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups	Administrative claims	N/A	Affordability and Efficiency	Outcome
484	Clinician and Clinician Group Risk-Standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions	Administrative claims	N/A	Affordability and Efficiency	Outcome
001	Diabetes: Hemoglobin A1c (HbA1c) Poor Control	eCQM/ MIPS CQM/ CMS Web Interface	APM entity/ third party intermediary	Chronic Conditions	Intermediate outcome
134	Preventive Care and Screening: Screening for Depression and Follow-up Plan	eCQM/ MIPS CQM/ CMS Web Interface	APM entity/ third party intermediary	Behavioral Health	Process
236	Controlling High Blood Pressure	eCQM/ MIPS CQM/ CMS Web Interface	APM entity/ third party intermediary	Chronic Conditions	Intermediate outcome
318	Falls: Screening for Future Fall Risk	CMS Web Interface	APM entity/ third party intermediary	Safety	Process
110	Preventive Care and Screening: Influenza Immunization	CMS Web Interface	APM entity/ third party intermediary	Wellness and Prevention	Process
226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	CMS Web Interface	APM entity/ third party intermediary	Behavioral Health	Process
113	Colorectal Cancer Screening	CMS Web Interface	APM entity/ third party intermediary	Wellness and Prevention	Process
112	Breast Cancer Screening	CMS Web Interface	APM entity/ third party intermediary	Wellness and Prevention	Process
438	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	CMS Web Interface	APM entity/ third party intermediary	Chronic Conditions	Process
370	Depression Remission at Twelve Months	CMS Web Interface	APM entity/ third party intermediary	Behavioral Health	Outcome

Additional information about MIPS APMs and the APP is available in the CY 2024 PFS final rule[2] and on the Quality Payment Program website at https://qpp.cms.gov/apms/mips-apms or https://qpp.cms.gov/mips/apm-performance-pathway.

QCDR Measures Approved for 2024 MIPS Reporting

CMS approves qualified clinical data registries to expand reporting options for MIPS eligible clinicians, including those without sufficient MIPS quality measures applicable to their specialties. QCDRs may report on MIPS quality measures and/or measures developed for those registries and submitted for CMS consideration.

The 2024 QCDR measure specifications are available on the QPP Resource Library. For the CY 2024 MIPS performance period, CMS approved 44 unique QCDRs, listed in the 2024 *Qualified Clinical Data Registries (QCDRs) Qualified Posting*. Most clinical specialties prioritized in the MDP or subsequent gap analyses, including general medicine/ crosscutting, are well-represented among the approved QCDRs. Counts in Table 7 add up to more than 44 because some QCDRs apply to more than one prioritized specialty.

Each QCDR has at least one outcome or other high-priority measure among six or more quality measures, consistent with the 2024 requirement for eligible clinicians reporting under MIPS.[2(p.79385)]

Table 7: QCDRs Applicable to MDP-Prioritized Specialties

Specialty	# of QCDRs
Allergy/immunology	0
Behavioral health/substance use	1
Emergency medicine	8
General medicine/crosscutting	8
Neurology	1
Nephrology	1
Oncology	2
Orthopedic surgery	5
Pathology	3
Physical medicine and rehabilitation	6
Radiology	5
Rheumatology	4

A QCDR was counted as applicable if it self-identified as specialty-specific and reports at least one relevant condition- or specialty-specific QCDR measure.[45]

Advanced APM Quality Measures

This track of the QPP offers incentives for meeting participation thresholds based on the level of payments or patients served through Advanced APMs. A clinician who achieves these thresholds becomes a Qualifying APM Participant (QP).[46] For the 2024 QP Performance Period, the following are expected to be Advanced APMs:

- Bundled Payments for Care Improvement Advanced Model
- Comprehensive Care for Joint Replacement Payment Model (CEHRT Track)
- ACO Realizing Equity, Access, and Community Health (ACO REACH, formerly Global and Professional Direct Contracting) Model
- Kidney Care Choices Model (Comprehensive Kidney Care Contracting Options, Professional Option, and Global Option)
- Maryland Total Cost of Care Model (Care Redesign Program; Maryland Primary Care Program)
- Medicare Shared Savings Program (Level E of the BASIC Track and the ENHANCED Track)
- Primary Care First (PCF) Model
- Vermont All-Payer ACO Model (Vermont Medicare ACO Initiative)
- Making Care Primary (MCP) Tracks 2 and 3[2(p. 79504-79505)]

The inventory of measures associated with Advanced APMs is in CMIT at https://cmit.cms.gov/cmit/#/. For more information about Advanced APMs, visit: https://qpp.cms.gov/apms/advanced-apms.

6. Conclusion

The 2024 MDP Annual Report provides a cumulative account of progress in developing quality measures intended for the QPP. Section 1848(s)(6) funding totaling $62.6 million, available from 2015 through FY 2022, supported development of 36 quality measures intended for the QPP, along with related activities. During FY 2023, one more measure completed development; four measures continue development. The CY 2024 PFS final rule established an inventory of 198 MIPS quality measures, 11 of which were developed with section 1848(s)(6) funding. Nine Advanced APMs are expected for use in the QPP. CMS made 44 QCDRs available for the 2024 performance period through a process separate from rulemaking. With the expiration of the appropriations under section 1848(s), this will be the final Measure Development Plan Annual Report. CMS will continue to internally track measure development work to support the QPP, as well as gaps indicating the need for new measures.[xvi]

CMS took major steps to reduce reporting burden by aligning quality measures and pursuing the seamless exchange of health information. MIPS incorporated all 10 adult measures and six pediatric measures designated for the Universal Foundation, which can be used to compare measures across CMS programs. While preparing for an eventual transition to dQMs, CMS is providing educational outreach and assistance to measure stewards converting to the FHIR standard for measure specifications.

Health equity remains a leading CMS priority that the Universal Foundation was engineered to advance by tracking and identifying disparities. Efforts are underway to collect more standardized demographic data to better target improvement efforts. CMS also initiated two new approaches to advance equity in 2023: Rewarding Excellence for Underserved Populations (REUP) established incentives and rewards for providers and health care systems to improve care. A second approach added payment for activities by providers and auxiliary staff such as assessing risks from health-related social needs.

CMS annually identifies high-priority measurement gaps across specialties and clinical conditions to assess and enhance care. Four measures in development in FY 2023 could address these measurement gaps identified in the 2017–2023 *MDP Environmental Scan and Gap Analysis Reports*: patient activation/engagement, collaboration across health and non-health sectors to improve equity of care, treatment outcomes, and patient understanding. CMS has expanded reporting options for eligible clinicians with five new MVPs designed to reduce reporting burden. Up-to-date and detailed resources are available on the CMS MMS Hub, the QPP website, the eCQI Resource Center, and CMIT.

CMS supports eligible clinicians, measure developers, and other interested parties through many avenues. Patients and families are encouraged to participate in technical expert panels and share their experiences in the health care system, perspectives on measure concepts, and feedback on patient-reported outcome measures and survey items. CMS strives to be transparent with its external partners in this 2024 MDP Annual Report, a detailed accounting of progress in implementing the objectives of the CMS Quality Measure Development Plan.

[xvi] President Biden's proposed FY 2025 budget requests an additional $10 million per year (FY 2025–FY 2029) for CMS to fund the provisions in section 1848(s) and cost provisions described in section 1848(r). CMS would consider any additional funding, if enacted, to continue supporting Measure Development Plan work.

Glossary of Abbreviations

Acronym / Initialism	Full Term
ACO	accountable care organization
AHIP	America's Health Insurance Plans
AHRQ	Agency for Healthcare Research and Quality
APM	alternative payment model
APP	APM Performance Pathway
CAHPS®	Consumer Assessment of Healthcare Providers and Systems®
CBE	consensus-based entity
CEHRT	certified electronic health record technology
CHIP	Children's Health Insurance Program
CLAS	culturally and linguistically appropriate services
CMIT	CMS Measures Inventory Tool
CMS	Centers for Medicare & Medicaid Services
COPD	chronic obstructive pulmonary disease
COVID-19	coronavirus disease 2019
CQM	clinical quality measure
CQMC	Core Quality Measures Collaborative
eCQM	electronic clinical quality measure
EHR	electronic health record
FHIR®	Fast Healthcare Interoperability Resources®
FY	fiscal year
HHS	Health and Human Services (U.S. Department of)
HIV	human immunodeficiency virus
HSAG	Health Services Advisory Group, Inc.
MACRA	Medicare Access and Children's Health Insurance Program Reauthorization Act of 2015
MDP	Measure Development Plan
MERIT	Measures Under Consideration Entry/Review Information Tool
MIPS	Merit-based Incentive Payment System
MMA	measure model alignment
MMS	Measures Management System
MSR	Measure Set Review
MVP	MIPS Value Pathway
ONC	Office of the National Coordinator for Health Information Technology
OUD	opioid use disorder
PFS	Physician Fee Schedule
PQM	Partnership for Quality Measurement
PRMR	Pre-Rulemaking Measure Review
PRO-PM	patient-reported outcome performance measure

Acronym / Initialism	Full Term
QCDR	qualified clinical data registry
QDM	Quality Data Model
QMI	Quality Measure Index
QP	Qualifying APM Participant
QPP	Quality Payment Program
REUP	Rewarding Excellence for Underserved Populations
RSCR	risk-standardized complication rate
THA	total hip arthroplasty
TKA	total knee arthroplasty
USCDI+	United States Core Data for Interoperability Plus

Advanced Alternative Payment Models

ACO REACH	ACO Realizing Equity, Access, and Community Health
MCP	Making Care Primary
MSSP	Medicare Shared Savings Program
PCF	Primary Care First

Measure Abbreviations

ASN	*Addressing Social Needs eCQM*
FYSWR	*First Year Standardized Waitlist Ratio*
HWR	*Hospital-Wide, 30-day, All-Cause Unplanned Readmission*
PPPW	*Percentage of Prevalent Patients Waitlisted*
PSWR	*Prevalent Standardized Waitlist Ratio*

Measure Stewards and Developers

AAHPM	American Academy of Hospice and Palliative Medicine
AGA	American Gastroenterological Association
APA	American Psychiatric Association
ASCP	American Society for Clinical Pathology
BWH	Brigham and Women's Hospital
NCQA	National Committee for Quality Assurance
PBGH	Purchaser Business Group on Health
SCCA	Seattle Cancer Care Alliance
UCSF	University of California, San Francisco
UM-KECC	University of Michigan Kidney Epidemiology and Cost Center
USC	University of Southern California
Yale CORE	Yale New Haven Health Services Corporation Center for Outcomes Research and Evaluation

References

1. Centers for Medicare & Medicaid Services, Center for Clinical Standards and Quality. *CMS Quality Measure Development Plan: Supporting the Transition to the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs).* Baltimore, MD: US Department of Health and Human Services; 2016.
2. Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program Final Rule. *Fed Regist.* 2023; 88(220): 78818-80047.
3. Centers for Medicare & Medicaid Services. CMS National Quality Strategy. Baltimore, MD: US Department of Health and Human Services; 2024. https://www.cms.gov/medicare/quality/meaningful-measures-initiative/cms-quality-strategy. Accessed April 1, 2024.
4. Centers for Medicare & Medicaid Services. Meaningful Measures 2.0: Moving from measure reduction to modernization. Baltimore, MD: US Department of Health and Human Services; 2022. https://www.cms.gov/meaningful-measures-20-moving-measure-reduction-modernization. Accessed April 1, 2024.
5. Centers for Medicare & Medicaid Services. Cascade of Meaningful Measures. Baltimore, MD: US Department of Health and Human Services; 2022. https://www.cms.gov/medicare/meaningful-measures-framework/cascade-measures. Accessed April 1, 2024.
6. Centers for Medicare & Medicaid Services. Aligning Quality Measures Across CMS — The Universal Foundation. Baltimore, MD: US Department of Health and Human Services; 2024. https://www.cms.gov/aligning-quality-measures-across-cms-universal-foundation. Accessed April 1, 2024.
7. Jacobs DB, Schreiber M, Seshamani M. The CMS strategy to promote equity in quality and value programs. *JAMA Health Forum.* 2023;4(10):e233557. doi: 10.1001/jamahealthforum.2023.3557.
8. Medicare and Medicaid Programs; CY 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Implementing Requirements for Manufacturers of Certain Single-dose Container or Single-use Package Drugs To Provide Refunds With Respect to Discarded Amounts; and COVID–19 Interim Final Rules; Final Rule. *Fed Regist*. 2022; 87(222): 69404-70699.
9. US Department of Health and Human Services, Office of Minority Health. National culturally and linguistically appropriate services standards. Baltimore, MD: US Department of Health and Human Services; n.d. https://thinkculturalhealth.hhs.gov/clas/standards. Accessed April 1, 2024.

10. Gravity Project. Overview. Washington, DC: Gravity Project; n.d. https://thegravityproject.net/overview/. Accessed April 1, 2024.

11. Centers for Medicare & Medicaid Services Office of Minority Health. *CMS Framework for Health Equity 2022-2032.* Baltimore, MD: US Department of Health and Human Services; 2022.

12. US Government Accountability Office. *Health Care Quality: CMS Could More Effectively Ensure Its Quality Measurement Activities Promote Its Objectives.* Washington, DC: US Government Accountability Office; 2019.

13. Core Quality Measures Collaborative. *Core Quality Measures Collaborative: Aligning Approaches to Measure Models.* Washington, DC: National Quality Forum; 2023.

14. Centers for Medicare & Medicaid Services. *Person & Family Engagement Strategy. Sharing with our Partners.* Baltimore, MD: US Department of Health and Human Services; n.d.

15. Centers for Medicare & Medicaid Services. *Person and Family Engagement Toolkit: A Guide For Measure Developers.* Baltimore, MD: US Department of Health and Human Services; 2023.

16. Centers for Medicare & Medicaid Services. Measures Management System Hub. Baltimore, MD: US Department of Health and Human Services; 2023. https://mmshub.cms.gov/. Accessed April 1, 2024.

17. Centers for Medicare & Medicaid Services. *2023 Episode-Based Cost Measures Field Testing Wave 5 Measure Development Process.* Baltimore, MD: US Department of Health and Human Services; 2023.

18. Centers for Medicare & Medicaid Services. Current cost measure activities. Baltimore, MD: US Department of Health and Human Services; 2023. https://www.cms.gov/medicare/quality/value-based-programs/cost-measures/current. Accessed April 1, 2024.

19. Centers for Medicare & Medicaid Services. *MACRA Episode-Based Cost Measures Wave 6 Clinician Expert Workgroup (Membership) List.* Baltimore, MD: US Department of Health and Human Services; 2023.

20. Partnership for Quality Measurement. *Endorsement and Maintenance (E&M) Guidebook.* Columbus, OH: Partnership for Quality Measurement; 2023.

21. Partnership for Quality Measurement. *The Guidebook of Policies and Procedures for Pre-Rulemaking and Measure Review (PRMR) and Measure Set Review (MSR).* Columbus, OH: Partnership for Quality Measurement; 2023.

22. Centers for Medicare & Medicaid Services. dQMs - Digital Quality Measures: dQM Strategic Roadmap. Baltimore, MD: US Department of Health and Human Services; 2023. https://ecqi.healthit.gov/dqm. Accessed April 1, 2024.

23. Centers for Medicare & Medicaid Services. FHIR® - Fast Healthcare Interoperability Resources®: About. Baltimore, MD: US Department of Health and Human Services; 2023. https://ecqi.healthit.gov/fhir?qt-tabs_fhir=0. Accessed April 1, 2024.

24. Centers for Medicare & Medicaid Services. dQMs - Digital Quality Measures: About dQMs. Baltimore, MD: US Department of Health and Human Services; 2023. https://ecqi.healthit.gov/dqm?qt-tabs_dqm=1. Accessed April 1, 2024.

25. Centers for Medicare & Medicaid Services. United States Core Data for Interoperability Plus (USCDI+) Quality - Draft Data Element List. Baltimore, MD: US Department of Health and Human Services; 2023. https://ecqi.healthit.gov/uscdi-quality. Accessed April 1, 2024.

26. Office of the National Coordinator for Health Information Technology. *USCDI+Quality Data Element List.* Baltimore, MD: US Department of Health and Human Services; 2023.

27. Gross M, Brown T, Angel M, Eastman M. *Unveiling CMS Measures Inventory Tool (CMIT) 2.6!* Baltimore, MD: US Department of Health & Human Services; 2023.

28. Centers for Medicare & Medicaid Services. *Public Access Quick Start Guide for CMIT.* Baltimore, MD: US Department of Health & Human Services; 2023.

29. Centers for Medicare & Medicaid Services, Measures Management System. Blueprint measure lifecycle overview. Baltimore, MD: US Department of Health and Human Services; 2023. https://mmshub.cms.gov/blueprint-measure-lifecycle-overview. Accessed April 1, 2024.

30. Centers for Medicare & Medicaid Services, Center for Clinical Standards and Quality. *CMS Quality Measure Development Plan: Supporting the Transition to The Quality Payment Program 2017 Annual Report.* Baltimore, MD: US Department of Health and Human Services; 2017.

31. Centers for Medicare & Medicaid Services, Center for Clinical Standards and Quality. *CMS Quality Measure Development Plan 2018 Annual Report.* Baltimore, MD: US Department of Health and Human Services; 2018.

32. Centers for Medicare & Medicaid Services, Center for Clinical Standards and Quality. *CMS Quality Measure Development Plan 2019 Annual Report.* Baltimore, MD: US Department of Health and Human Services; 2019.

33. Centers for Medicare & Medicaid Services, Center for Clinical Standards and Quality. *CMS Quality Measure Development Plan 2020 Annual Report For the Quality Payment Program.* Baltimore, MD: US Department of Health and Human Services; 2020.

34. Centers for Medicare & Medicaid Services, Center for Clinical Standards and Quality. *CMS Quality Measure Development Plan 2021 Annual Report for the Quality Payment Program.* Baltimore, MD: US Department of Health and Human Services; 2021.

35. Centers for Medicare & Medicaid Services, Health Services Advisory Group. *CMS Quality Measure Development Plan 2022 Annual Report for the Quality Payment Program.* Baltimore, MD: US Department of Health and Human Services; 2022.

36. Centers for Medicare & Medicaid Services, Health Services Advisory Group. *CMS Quality Measure Development Plan 2023 Annual Report for the Quality Payment Program.* Baltimore, MD: US Department of Health and Human Services; 2023.

37. Centers for Medicare & Medicaid Services, Health Services Advisory Group. *CMS Quality Measure Development Plan Environmental Scan and Gap Analysis Report (MACRA, Section 102).* Baltimore, MD: US Department of Health and Human Services; 2017.

38. Centers for Medicare & Medicaid Services, Health Services Advisory Group. *2018 CMS Quality Measure Development Plan Environmental Scan and Gap Analysis Report.* Baltimore, MD: US Department of Health and Human Services; 2018.

39. Centers for Medicare & Medicaid Services. Measure implementation: pre-rulemaking overview. Baltimore, MD: US Department of Health and Human Services; 2024. https://mmshub.cms.gov/measure-lifecycle/measure-implementation/pre-rulemaking/overview. Accessed April 1, 2024.

40. Centers for Medicare & Medicaid Services. *List of Measures Under Consideration for December 1, 2022.* Baltimore, MD: US Department of Health and Human Services; 2022.

41. Centers for Medicare & Medicaid Services. *List of Measures Under Consideration for December 1, 2023.* Baltimore, MD: US Department of Health and Human Services; 2023.

42. Partnership for Quality Measurement. Pre-Rulemaking Measure Review (PRMR). Columbus, OH: Battelle; n.d. https://www.p4qm.org/PRMR. Accessed April 1, 2024.

43. Battelle. *2023 PRMR Final MUC Recommendation Spreadsheet.* Columbus, OH: Battelle; 2024.

44. Centers for Medicare & Medicaid Services. *2023 Measures Under Consideration List Program-Specific Measure Needs and Priorities.* Baltimore, MD: US Department of Health and Human Services; 2023.

45. Centers for Medicare & Medicaid Services. *2024 Qualified Clinical Data Registries (QCDR) Qualified Posting.* Baltimore, MD: US Department of Health and Human Services; 2024.

46. Centers for Medicare & Medicaid Services. Advanced Alternative Payment Models (APMs). Baltimore, MD: US Department of Health and Human Services; n.d. https://qpp.cms.gov/apms/advanced-apms. Accessed April 1, 2024.

Appendix A – Statutory Language Excerpts

Section 1848(s)(3) of the Social Security Act, as amended by section 102 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

"(3) ANNUAL REPORT BY THE SECRETARY.—

''(A) IN GENERAL.—Not later than May 1, 2017, and annually thereafter, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a report on the progress made in developing quality measures for application under the applicable provisions.

''(B) REQUIREMENTS.—Each report submitted pursuant to subparagraph (A) shall include the following:

''(i) A description of the Secretary's efforts to implement this paragraph.

''(ii) With respect to the measures developed during the previous year—

''(I) a description of the total number of quality measures developed and the types of such measures, such as an outcome or patient experience measure;

''(II) the name of each measure developed;

''(III) the name of the developer and steward of each measure;

''(IV) with respect to each type of measure, an estimate of the total amount expended under this title to develop all measures of such type; and

''(V) whether the measure would be electronically specified.

''(iii) With respect to measures in development at the time of the report—

''(I) the information described in clause (ii), if available; and

''(II) a timeline for completion of the development of such measures.

''(iv) A description of any updates to the plan under paragraph (1) (including newly identified gaps and the status of previously identified gaps) and the inventory of measures applicable under the applicable provisions.

''(v) Other information the Secretary determines to be appropriate."

Section 1848(s)(6) of the Social Security Act, as amended by section 102 of MACRA

''(6) FUNDING.—For purposes of carrying out this sub-section, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, of $15,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each of fiscal years 2015 through 2019. Amounts transferred under this paragraph shall remain available through the end of fiscal year 2022.

Appendix B – Acknowledgments

The 2024 MDP Annual Report is the product of collaboration between the Centers for Medicare & Medicaid Services, other HHS agencies, and the private sector. Specifically, we thank:

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MACRA MDP/QMI Technical Expert Panel (2022–2024)

Mary Baliker, BS, retired Health Care Consultant, Middleton, WI

Crystal Barter, MS, Director of Programs & Services, Michigan Center for Rural Health, East Lansing, MI

Heidi Bossley, MSN, MBA, Independent Health Care Consultant, Bossley Consulting, LLC, Alexandria, VA

Zeeshan Butt, PhD, Director of Clinical Content, Phreesia, Raleigh, NC; Licensed Clinical Psychologist

Catherine Eppes, MD, MPH, Chief of Obstetrics and Maternal Medical Director, Ben Taub Hospital; Assistant Professor of Obstetrics and Gynecology, Baylor College of Medicine, Houston, TX

Nupur Gupta, MD, Assistant Professor of Medicine and Program Director of home dialysis fellowship in Division of Nephrology, Indiana University, Carmel, IN; Medical Director, DaVita Home Dialysis of Indianapolis

Amy Nguyen Howell, MD, MBA, FAAFP, Chief of the Office for Provider Advancement, Optum Care, El Segundo, CA

Shu-Xia Li, PhD, Associate Director of Data Management and Analytics, Yale-New Haven Hospital Center for Outcomes Research and Evaluation (CORE), New Haven, CT

John Martin, PhD, MPH, Vice President of Data Science, Information and Technology Services (TEP Co-Chair), Premier Inc., Charlotte, NC

Gregg Miller, MD, FACEP, FAAEM, Chief Medical Officer, Vituity®; Emergency Physician, Edmonds, WA

Connie L. Montgomery, BS, OTR/L (retired), Pawleys Island, SC

Sarah Hudson Scholle, MPH, DrPH, Principal, Leavitt Partners, Washington, DC

Anita Somplasky, RN, CHTS-CP, CHTS-PW, Principal and Program Advisor, Mathematica Policy Research, Princeton, NJ

Samantha Tierney, MPH, Senior Scientist, Clinical Policy, American College of Physicians, Philadelphia, PA (TEP Co-Chair)

Lindsey Wisham, MPA, volunteer advocate for patient and families; Director of Federal Health Solutions, Telligen, Johnson, IA

Appendix C – CMS-Funded Quality Measures Developed During the Previous Year

See *Quality Measures Developed During the Previous Year* (Chapter 3 of the report), which estimates the amount expended under title XVIII to complete development of this quality measure for the Merit-based Incentive Payment System (MIPS). The Meaningful Measures (MM) 2.0 priority is assigned according to the Cascade of Meaningful Measures.

Table C-1: CMS-Funded Measures Developed Between October 1, 2022, and September 30, 2023 (n = 1)

Steward/ Developer	Title	CBE#/ MIPS ID	eCQM ID	Type	MM 2.0 Priority/ MACRA Domain
CMS/ Mathematica	Adult COVID-19 Vaccination Status	N/A/ N/A	N/A	Process	Wellness and Prevention/ Population Health and Prevention

CBE consensus-based entity
eCQM electronic clinical quality measure

Appendix D – CMS-Funded Quality Measures in Development

See *Quality Measures in Development at the Time of This Report* (Chapter 3 of the report), which estimates amounts expended under title XVIII for ongoing development of quality measures for MIPS. Meaningful Measures (MM) 2.0 priorities are assigned in this appendix according to the Cascade of Meaningful Measures.

Key: Measure Stewards and Developers:

AGA	American Gastroenterological Association
CMS	Centers for Medicare & Medicaid Services
Yale CORE	Yale New Haven Health Services Corporation/Center for Outcomes Research and Evaluation

Table D-1: CMS-Funded Measures Being Specified at the Time of This Report (n = 1)

Steward/ Developer	Title	eCQM ID	Type	MM 2.0 Priority/ MACRA Domain	Est. Date of Completion
CMS/ Yale CORE	Addressing Social Needs (ASN) eCQM	TBD	Process	Equity/ Patient and Caregiver Experience	March 2024

Table D-2: CMS-Funded Measures in Testing Phase at the Time of This Report (n = 3)

Steward/ Developer	Title	eCQM ID	Type	MM 2.0 Priority/ MACRA Domain	Est. Date of Completion
AGA/AGA	Hepatitis C Virus: Sustained Virological Response	N/A	Outcome	Chronic Conditions/ Clinical Care/	May 2024
CMS/ Mathematica	Language Services Summary Survey Measure	N/A	Patient engagement/ experience	Equity/ Patient and Caregiver Experience	May 2025
CMS/ Yale CORE	Cancer Health Equity PRO-PM for Preventive Screening and Counseling	N/A	PRO-PM	Equity/ Patient and Caregiver Experience	September 2024