requests for enhanced federal financial participation for expenditures related to Medicaid eligibility determination systems, we will review the submitted information and documentation to make an approval determination for the advanced planning document. *Form Number:* CMS–10536 (OMB control number: 0938–1268); *Frequency:* Yearly, once, and occasionally; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 56; *Total Annual Responses: 168; Total Annual Hours:* 2,688. (For policy questions regarding this collection contact Loren Palestino at 410–786–8842.)

3. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Medicaid Drug Use Review (DUR) Program; *Use:* States must provide for a review of drug therapy before each prescription is filled or delivered to a Medicaid patient. This review includes screening for potential drug therapy problems due to therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, drug-allergy interactions, and clinical abuse/misuse. Pharmacists must make a reasonable effort to obtain, record, and maintain Medicaid patient profiles. These profiles must reflect at least the patient's name, address, telephone number, date of birth/age, gender, history, *e.g.,* allergies, drug reactions, list of medications, and pharmacist's comments relevant to the individual's drug therapy. The State must conduct retrospective drug use review which provides for the ongoing periodic examination of claims data and other records in order to identify patterns of fraud, abuse, inappropriate or medically unnecessary care. Patterns or trends of drug therapy problems are identified and reviewed to determine the need for intervention activity with pharmacists and/or physicians. States may conduct interventions via telephone, correspondence, or face-to-face contact. The states and managed care organizations (MCOs) are provided the reporting instrument (a survey) by CMS, and by responding to the survey, the states generate annual reports which are submitted to CMS for the purposes of monitoring compliance and evaluating the progress of states' DUR programs. The survey and the annual recordkeeping and reporting requirements under the pertinent regulations, are completed by pharmacists employed by, or contracted with the various state Medicaid programs and their MCOs. The annual reports submitted by states are reviewed and results are compiled by CMS in a format intended to provide information, comparisons and trends related to states' experiences with DUR. The states benefit from the information and may enhance their programs each year based on state reported innovative practices that are compiled by CMS from the annual reports. A comparison/summary of the data from the annual reports is published on *Medicaid.gov* annually, and serves as a resource for stakeholders, including but not limited to states, manufacturers, researchers, congress, CMS, the Office of Inspector General, non-governmental payers and clinicians on the topic of DUR in state Medicaid programs. *Form Number:* CMS–R–153 (OMB control number: 0938–0659); *Frequency:* Yearly, quarterly, and occasionally; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 52; *Total Annual Responses:* 676; *Total Annual Hours:* 41,860. (For policy questions regarding this collection contact Mike Forman at 410–786–2666.)

William N. Parham, III,

Director, Division of Information Collections and Regulatory Impacts, Office of Strategic Operations and Regulatory Affairs.

[FR Doc. 2024–19733 Filed 8–30–24; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3447–N]

Secretarial Review and Publication of the Consensus Based Entity Report of 2023 Activities to Congress and the Secretary of the Department of Health and Human Services

AGENCY: Office of the Secretary of Health and Human Services, HHS.

ACTION: Notice.

SUMMARY: This notice acknowledges receipt and review by the Secretary of the Department of Health and Human Services (the Secretary) of the 2023 Consensus Based Entity Annual Report to Congress as mandated by section 1890(b)(5) of the Social Security Act (the Act). The Secretary has reviewed and is publishing the report in the **Federal Register** together with the Secretary's comments on the report.

FOR FURTHER INFORMATION CONTACT: Charlayne Van, (410) 786–8659.

SUPPLEMENTARY INFORMATION:

I. Background

The United States (U.S.) Department of Health and Human Services (HHS) has long recognized that a high functioning health care system that provides higher quality care requires accurate, valid, and reliable measurement of quality and efficiency. The Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. 110–275) added section 1890 of the Social Security Act (the Act), which requires the Secretary of HHS (the Secretary) to contract with a consensus-based entity (CBE) to help improve performance measurement. Section 3014 of the Patient Protection and Affordable Care Act (the Affordable Care Act) (Pub. L. 111–148) expanded the duties of the CBE to include the identification of gaps in available measures and to improve the selection of measures used in health care programs. The Secretary extends his appreciation to the CBE in their partnership for the fulfillment of these statutory requirements.

Section 1890(b) of the Act requires the following:

Priority Setting Process: Formulation of a National Strategy and Priorities for Health Care Performance Measurement. The CBE must synthesize evidence and convene key stakeholders to make recommendations on an integrated national strategy and priorities for health care performance measurement in all applicable settings. In doing so, the CBE must give priority to measures that: (1) address the health care provided to patients with prevalent, high-cost chronic diseases; (2) have the greatest potential for improving quality, efficiency, and patient-centered health care; and (3) may be implemented rapidly due to existing evidence, standards of care, or other reasons. Additionally, the CBE must take into account measures that: (1) may assist consumers and patients in making informed health care decisions; (2) address health disparities across groups and areas; and (3) address the continuum of care furnished by multiple providers or practitioners across multiple settings.

Endorsement of Measures. The CBE must provide for the endorsement of standardized health care performance measures. This process must consider whether measures are evidence-based, reliable, valid, verifiable, relevant to enhanced health outcomes, actionable at the caregiver level, feasible to collect and report, responsive to variations in patient characteristics such as health status, language capabilities, race or ethnicity, and income level and are

consistent across types of health care providers, including hospitals and physicians.

Maintenance of CBE Endorsed Measures. The CBE is required to establish and implement a process to ensure that endorsed measures are updated (or retired if obsolete) as new evidence is developed.

Removal of Measures. Section 102(c) of Division CC of the Consolidated Appropriations Act, 2021 (Pub. L. 116–260) amended section 1890(b) of the Act to permit the CBE to provide input to the Secretary on measures that may be considered for removal.

Convening Multi-Stakeholder Groups. The CBE must convene multistakeholder groups to provide input on: (1) the selection of certain categories of quality and efficiency measures, from among such measures that have been endorsed by the entity and from among such measures that have not been considered for endorsement by such entity but are used or proposed to be used by the Secretary for the collection or reporting of quality and efficiency measures; and (2) national priorities for improvement in population health and in the delivery of health care services for consideration under the national strategy. The CBE provides input on measures for use in certain specific Medicare programs, for use in programs that report performance information to the public, and for use in health care programs that are not included under the Act. The multi-stakeholder groups provide input on quality and efficiency measures for various federal health care quality reporting and quality improvement programs including those that address certain Medicare services provided through hospices, ambulatory surgical centers, hospital inpatient and outpatient facilities, physician offices, cancer hospitals, end stage renal disease (ESRD) facilities, inpatient rehabilitation facilities, long-term care hospitals, psychiatric hospitals, and home health care programs.

Transmission of Multi-Stakeholder Input. Not later than February 1 of each year, the CBE must transmit to the Secretary the input of multi-stakeholder groups.

Annual Report to Congress and the Secretary. Not later than March 1 of each year, the CBE is required to submit to Congress and the Secretary an annual report. The report is to describe:

- The implementation of quality and efficiency measurement initiatives and the coordination of such initiatives with quality and efficiency initiatives implemented by other payers;
- Recommendations on an integrated national strategy and priorities for health care performance measurement;
- Performance of the CBE's duties required under its contract with the Secretary;
- Gaps in endorsed quality and efficiency measures, including measures that are within priority areas identified by the Secretary under the national strategy established under section 399HH of the Public Health Service Act (National Quality Strategy), and where quality and efficiency measures are unavailable or inadequate to identify or address such gaps;
- Areas in which evidence is insufficient to support endorsement of quality and efficiency measures in priority areas identified by the Secretary under the National Quality Strategy, and where targeted research may address such gaps; and
- The convening of multi-stakeholder groups to provide input on: (1) the selection of quality and efficiency measures from among such measures that have been endorsed by the CBE and such measures that have not been considered for endorsement by the CBE but are used or proposed to be used by the Secretary for the collection or reporting of quality and efficiency measures; and (2) national priorities for improvement in population health and the delivery of health care services for consideration under the National Quality Strategy.

Section 50206(c)(1) of the Bipartisan Budget Act of 2018 (Pub. L. 115–123) amended section 1890(b)(5)(A) of the Act to require the CBE's annual report to Congress to include the following: (1) an itemization of financial information for the previous fiscal year ending September 30th, including annual revenues of the entity, annual expenses of the entity, and a breakdown of the amount awarded per contracted task order and the specific projects funded in each task order assigned to the entity; and (2) any updates or modifications to internal policies and procedures of the entity as they relate to the duties of the CBE including specifically identifying any modifications to the disclosure of interests and conflicts of interests for committees, work groups, task forces, and advisory panels of the entity, and information on external stakeholder participation in the duties of the entity.

The statutory requirements for the CBE to annually report to Congress and the Secretary also specify that the Secretary must review and publish the CBE's annual report in the **Federal Register**, together with any comments of the Secretary on the report, not later than 6 months after receiving it.

This **Federal Register** notice implements the statutory requirement for Secretarial review and publication of the CBE's annual report. The CBE submitted a report on its 2023 activities to Congress and the Secretary on February 26, 2024. The Secretary's Comments on this report are presented in section II of this notice, and the CBE's 2023 Activities Report to Congress and the Secretary is provided, as submitted to HHS, in the addendum to this **Federal Register** notice in section IV.

II. Secretarial Comments on the CBE's (Battelle Memorial Institute) 2023 Activities: Report to Congress and the Secretary of the Department of Health and Human Services

As part of its core mission, HHS seeks to stabilize and improve the quality of health care throughout the country. In response to recent public health crises and to prudently prepare for imminent threats in the future, HHS must continue to focus on advancing equity and inclusion, strengthening public trust, and building meaningful engagement and learning across the health care system. By embedding the cross-cutting principles [1] of equity, public trust and collaboration into its diverse programs and initiatives, HHS is working to improve the health and well-being of individuals and families. The following comments are regarding the 2023 activities performed within the Partnership for Quality Measurement (PQM) forum, created by Battelle in its capacity as the CBE.

Over the past year, the CBE has supported HHS' commitment to promoting a resilient, high value, and safe health care system for all Americans. In 2023, HHS supported the work conducted by the CBE to identify health care quality measurement priorities and to provide consensus-based recommendations about measures to use for assessing and improving quality. As the new CBE beginning in 2023, Battelle established the PQM and continued the use of rigorous standards to review measures for quality measure endorsement and maintain highly reliable and scientifically sound measures across priority health care topic areas.

The PQM is comprised of diverse representatives in health care that engage with the health care quality improvement community. Members of the PQM help shape the future of health care by taking an active role in the quality measurement process, using

[1] HHS Strategic Cross-Cutting Principles available at *https://www.hhs.gov/about/strategic-plan/2022-2026/overview/index.html.*

their health care experiences and/or professional expertise to review and provide feedback on quality measures HHS is considering for use in Medicare programs. The CBE's processes have evolved with a renewed focus on advancing measurement science, ensuring transparency, and increasing diversity in engagement of interested parties as evidenced by its Annual Report and feedback received by the Centers for Medicare & Medicaid Services (CMS). This focus has resulted in increased engagement from patients, patient advocacy groups, and clinicians, as well as a shared sense of ownership.

The CBE focused on four key initiatives, including Endorsement & Maintenance (E&M) of clinical quality measures, Pre-Rulemaking Measure Review, Measure Set Review and Core Quality Measures Collaborative (CQMC). In 2023, the CBE completed three endorsement cycles. A combined 81 measures were submitted for endorsement consideration in the first two cycles (Fall 2022 and Spring 2023) that were started under the previous CBE. The third cycle (Fall 2023) which launched the revised process, began in October 2023 and was completed in March 2024.

Over the past year, the CBE expanded committee and public engagement by creating five new project committees that are focused on a patient's journey through the health care system. A description of these five new committees can be found on the CBE's website at *https://p4qm.org/EM/projects.* The committee structure is not based solely on a health care condition or disease state but by the type of function the health care system is performing (for example, prevention/screening, advanced illness, and post-acute care), including the type of evidence submitted in support of that function (for example, screening results in a referral). The focus areas of the committees include primary prevention; initial recognition and management; management of acute events, chronic disease, surgery and behavioral health; advanced illness and post-acute care and cost and efficiency.

HHS recognizes that, concurrent with the CBE's efforts to engage the quality measurement community on enhancing the E&M process, the CBE engaged the same community on ways to create a more transparent and impactful measure review process to support quality reporting and value-based purchasing programs as evidenced in the CBE's Annual Report and feedback received by CMS. Like E&M, enhancements were centered around increasing efficiency in the process while expanding committee and public engagement. HHS believes that these process enhancements resulted in increased quantity and quality of the feedback CMS received on quality measures.

The CBE convened the CQMC Full Collaborative in late 2023 to set priorities for the upcoming year. The goal of the meeting was to explore the CQMC's role in three key areas, including health equity measurement, movement to digital measures and alignment around measurement models. In addition, the CQMC discussed the leading barriers to adoption of measures within the core sets and achieving the desired impact of the core sets and how these can be overcome. The CQMC also began to develop a vision and strategy for the next phases of work.

HHS and the CBE both recognize the importance of clinical quality and cost/resource use measures in improving U.S. health care. Maintaining these measures through transparent, periodic, and consensus-based reviews is critical for ensuring health care quality performance can not only be measured but can also be improved upon. HHS and the CBE recognize that a true consensus process must be transparent, reliable, and equitable. The CBE is building relationships within the health care quality community, including patients and clinicians, necessary to advancing the national goal of attaining the highest level of health and wellness for the widest range of individuals possible as evidenced by its Annual Report and feedback received by CMS.

III. Collection of Information Requirements

This document does not impose information collection requirements, that is, reporting, recordkeeping, or third-party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

IV. Addendum

In this Addendum, we are publishing the *CBE Report on 2023 Activities to Congress and the Secretary of the Department of Health and Human Services,* as submitted to HHS.

Xavier Becerra,

Secretary, Department of Health and Human Services.

BILLING CODE 4120–01–P

CONSENSUS-BASED ENTITY 2023

Annual Report to Congress and the Secretary of Health and Human Services

FINAL REPORT

FEBRUARY 2024

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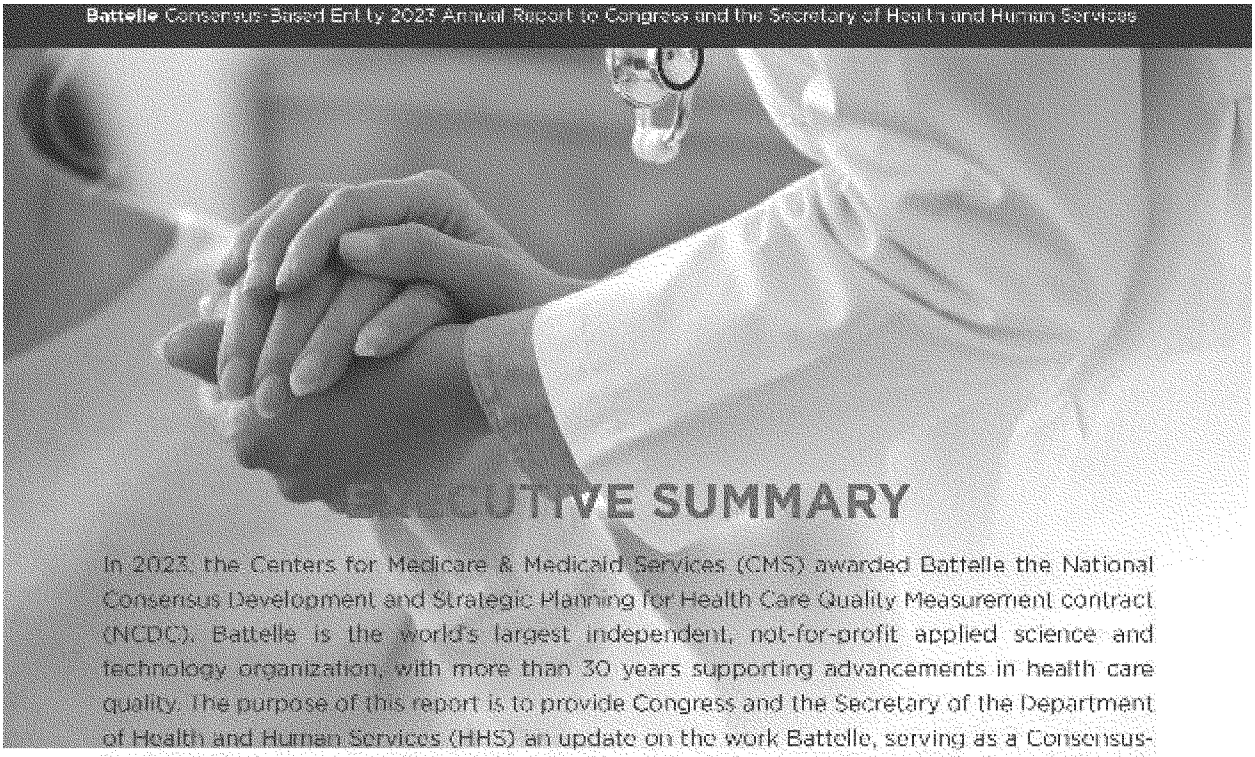


In 2023, the Centers for Medicare & Medicaid Services (CMS) awarded Battelle the National Consensus Development and Strategic Planning for Health Care Quality Measurement contract (NCDC). Battelle is the world's largest independent, not-for-profit applied science and technology organization, with more than 30 years supporting advancements in health care quality. The purpose of this report is to provide Congress and the Secretary of the Department of Health and Human Services (HHS) an update on the work Battelle, serving as a Consensus-Based Entity (CBE), accomplished between February 27, 2023, and December 31, 2023.

Partnership for Quality Measurement
Powered by Battelle

WHO WE ARE

Partnership of members across the health care and quality landscape in promoting meaningful quality measurement

VISION

The quality measure endorsement process should be reliable, transparent, attainable, equitable, and most of all, meaningful

APPROACH

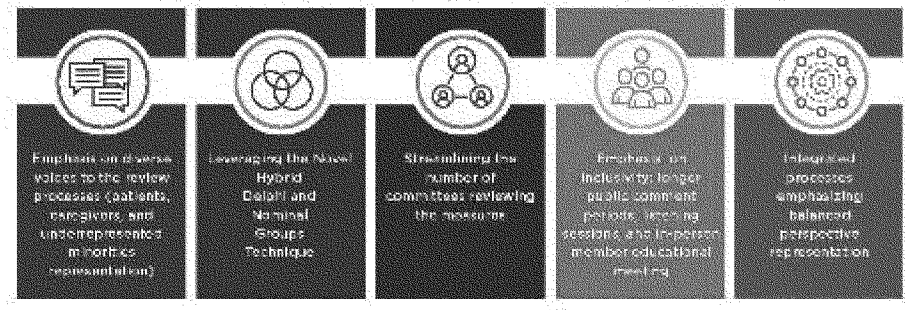
Consensus-based process involving a variety of experts: clinicians, patients, caregivers, measure experts, policymakers, and health information technology specialists.

To facilitate measure reviews, Battelle, as a CBE, formed the Partnership for Quality Measurement (PQM), which comprises diverse health care voices. Battelle is committed to engaging the health care quality improvement community and therefore made membership to PQM free of cost to all persons and organizations.

Members of PQM help shape the future of health care by taking an active role in the quality measurement process, using their health care experiences and/or professional expertise to review and provide feedback on quality measures HHS is considering for use in Medicare programs. Members can join teams or committees that evaluate whether measures should be endorsed based on their supporting evidence, scientific rigor, safety and effectiveness, feasibility for implementation, and importance to patients and clinicians.

The processes of the CBE went through an extraordinary evolution in 2023, focusing on advancing measurement science, ensuring transparency, and increasing diversity in engagement of interested parties. This focus has resulted in increased engagement from patients, patient advocacy groups, and clinicians, and a shared sense of ownership.

INTRODUCING MORE RIGOR, ENGAGEMENT, AND TRANSPARENCY TO THE PROCESS



The key initiatives in 2023 were:

Endorsement and Maintenance (E&M) of clinical quality measures: Battelle convenes PQM Committee members to evaluate quality measures submitted for endorsement or up for routine maintenance. Committee members answer the question: is the measure safe and effective for general use, and unlikely to result in negative unintended consequences?

Pre-Rulemaking Measure Review (PRMR): Battelle convenes PQM Committee members to review measures submitted to CMS as part of the pre-rulemaking process. Committee members answer the question: is the measure reasonable and necessary for use in the intended CMS value-based program(s)?

Measure Set Review (MSR): Battelle convenes PQM committee Committee members to review measures within the CMS portfolio of active measures. Committee members answer the question: is the measure aligned with CMS's current needs and priorities?

Core Quality Measures Collaborative (CQMC): Battelle partners with CMS and the American Health Insurance Partnership (AHIP), as part of a public-private partnership, tasked with aligning quality measures across payers to reduce burden on clinicians.

NEW: Advisory Group and Recommendation Group

Battelle's PQM committees are structured into an Advisory Group and a Recommendation Group. Members of the Advisory Group review and provide recommendations on measures prior to Recommendation Group meetings. These inputs ensure that a larger number of voices contribute to the consensus-building process.

New and Multiple Opportunities for Public Comment

All aspects of our work include multiple opportunities for public comment. Public comment times were placed at points where they could be influential in decision making.

Endorsement and Maintenance: The E&M process ensures measures submitted for endorsement are evidence-based, scientifically sound, safe, and effective, meaning use of the measure will increase the likelihood of desired health outcomes; will not increase the likelihood of unintended, adverse health outcomes; and is consistent with current professional knowledge. In 2023, Battelle worked with the quality measurement community (i.e., measure developers, E&M Committee members, patients and consumers, policymakers) to identify barriers to quality measure endorsement. The primary barrier identified was the resources (time and monetary) needed to submit a measure for endorsement. In response, Battelle re-designed the endorsement process, decreasing the cycle time from 12 months to 6 months. To achieve this result, the team reduced duplications in the process, while increasing the importance of public comment and engagement duration.

In 2023, Battelle oversaw three endorsement cycles. The first two cycles (Fall 2022 and Spring 2023) were started under the previous CBE, and the third (Fall 2023) launched the revised process. One additional change in the process was a transition to viewing measures as part of a patient's journey through the healthcare system. The new committee structure is not based solely on a health care condition or disease state, but by the type of function the health care system is performing, including primary prevention, initial recognition and management, management of acute events, advanced illness and post-acute care, and cost and efficiency. With the Fall 2023 cycle, Battelle began using a Novel Hybrid Delphi and Nominal Groups technique for measure endorsement reviews (Davies et al. 2011). This technique relies on balancing broad representation with committee and subcommittee discussion to support better policy outcomes. The purpose of this technique is to significantly increase the number of interested parties participating in the consensus building process and to ensure that one voice does not dominate the committee's endorsement decisions.

A combined 81 measures were submitted to the previous CBE (Fall 2022 and Spring 2023 cycles) or Battelle (Fall 2023 cycle) for endorsement consideration. The Fall 2023 cycle, which started in October 2023, will complete in March 2024.

PUBLIC COMMENTS RELATED TO THE NEW E&M PROCESS

"We support the continuation of the rigorous criteria used to develop and evaluate measures."

"We support consolidating the committees and removing the redundant CSAC Committee."

Pre-Rulemaking Measure Review (PRMR): Battelle convenes stakeholders for the purpose of making recommendations on the selection of quality and efficiency measures in accordance with section (§) 1890 of the Social Security Act via the Pre-Rulemaking Measure Review (PRMR) process. The PRMR process supports consensus recommendations regarding the inclusion of measures under consideration for CMS quality reporting and value-based programs.

Concurrent with our efforts to engage the quality measurement community on enhancing the E&M process, Battelle engaged the same community on ways to create a more transparent and impactful measure review process. Like E&M, enhancements were centered around increasing efficiency in the process while expanding committee and public engagement.

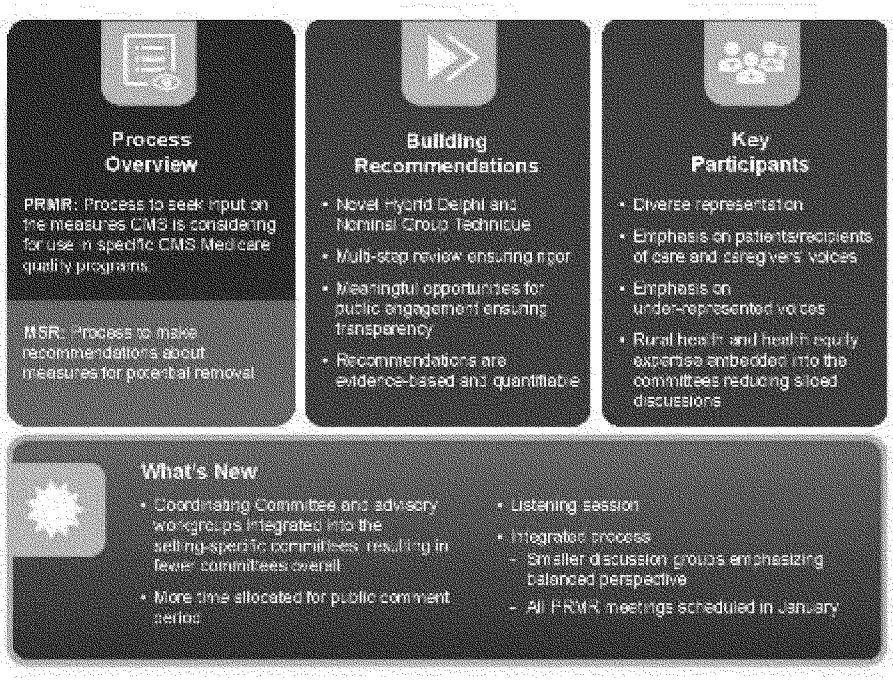


Figure 1. Overview of PRMR and MSR activities and recent changes.

Interested parties relayed to Battelle a desire to clearly define the role of E&M vs. PRMR. As such, Battelle streamlined the evaluation focus of each measure to three domains.

- **Meaningfulness:** Has it been demonstrated that the measure meets criteria associated with importance, scientific acceptability, feasibility, usability, and use for the target population and entities of the program under consideration?
- **Appropriateness of scale:** How is implementation of the measure applied to optimize the measure value across segments of the target population and entities of the program under consideration?
- **Time to value realization:** To what extent does current evidence suggest a clear pathway from measurement to performance improvement?

Meaningfulness

- Data describing the evidence of importance, scientific acceptability, feasibility, usability, and use for the target population and entities of the program under consideration

Appropriateness of Scale

- Data describing the implementation of the measure for patients/recipients of care addressed by the program
- Data describing the appropriateness of the measure for evaluating measured entities

Time to Value Realization

- Data demonstrating the measure will have short- and long-term positive impacts in the targeted program and/or in the targeted population

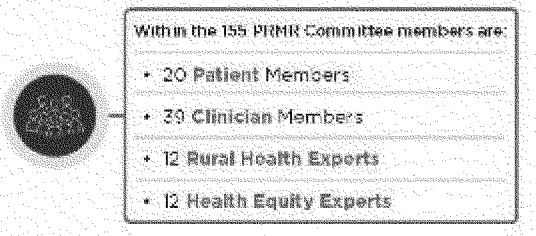
PUBLIC COMMENTS

"We are supportive of PQM's efforts to ensure that the processes emphasize consensus and input not only from the committees but also from key stakeholders and the public as well as revisions to the evaluation criteria."

"This process is more understandable and cohesive than previous measure review committee structures."

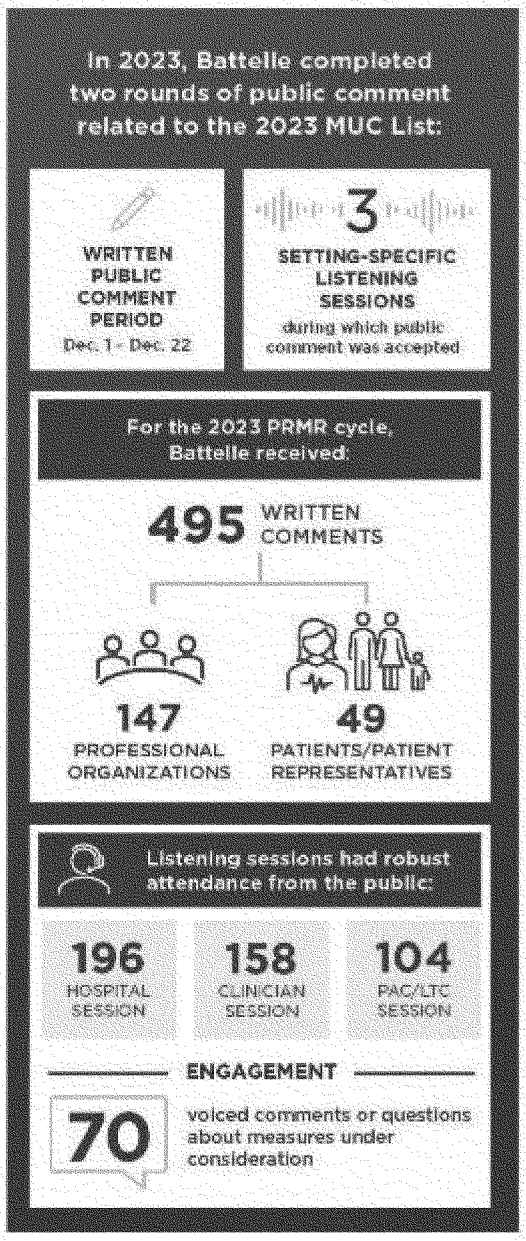
"We appreciate the level of transparency and outreach that Battelle has established since earning the opportunity to lead the review and selection of quality and efficiency measures under consideration for use by the U.S. Department of Health and Human Services (HHS)."

"I appreciate the thoughtful redesign to improve efficiency and increase public engagement."



The driving purpose behind our evolving measure review process was to increase the quantity and quality of the feedback CMS could expect to receive on each measure. As with the E&M process, Battelle began using a Novel Hybrid Delphi and Nominal Groups technique for pre-rulemaking measure reviews (Davies et al. 2011). The purpose of this technique is to significantly increase the number of interested parties participating in the consensus building process. In 2023, PRMR had 155 committee members, including 20 patients and 39 clinicians.

In order to allow more time for committee members to review measures and Battelle to collect public comment, PRMR meetings were moved from the end of each calendar year to the beginning of the calendar year. Therefore, final recommendations on the 2023 Measures under Consideration (MUC) List will be made in January of 2024. This increase time for commenting has resulted in the largest number of public comments ever received during the MUC process. For the 2023 PRMR cycle, Battelle received a total of 495 written comments from 147 professional organizations and 49 patients/patient representatives. Listening sessions had robust attendance from the public with more than 458 attendees across three sessions.



Measure Set Review (MSR): MSR centers on interested party reviews of measures across various CMS programs. The purpose of the MSR process is to optimize the CMS measure portfolio via measure removal recommendations. Committees recommend measures for removal based on updated information on the measure's properties, performance trends, and whether the measure continues to support the program's needs and priorities. The MSR process builds consensus around measure removals to optimize the CMS measure portfolio in the value-based programs.

The PRMR process makes consensus recommendations about measures on the MUC List. The MSR process builds consensus around measure removals to optimize the CMS measure portfolio in the value-based programs.

Whereas PRMR measures are evaluated through the domains of meaningfulness, appropriateness of scale and time to value realization, the three MSR domains are:

- **Impact**: The measure meets criteria for importance, feasibility, scientific acceptability, and usability & use, considering its use across programs and populations.
- **Clinician data streams:** Measure redundancy in data streams has been identified and mitigated.
- **Patient journey**: The measure is implemented across the patient journey as intended per a measure impact model, which illustrates how a measure "works" to have the greatest impact on patient outcomes.

In 2023, the MSR Recommendation Committee (see Section 4.2.2) was assigned to review the CMS End-Stage Renal Disease Quality Incentives Program (ESRD QIP). During the meeting members created an open and productive dialogue with CMS to provide insightful feedback on each measure. Two measures were recommended for removal and 13 measures were recommended for retention in the ESRD QIP.

During the discussion members voiced interest in seeing progress made in the areas of equity across multiple social determinants of health, flexibility in measure specification to account for patient choice and personalized medicine, risk adjustment and measure exclusions that reflect real-world care scenarios, consideration of the unique needs of rural communities, and exploration of ways to increase measure utility to patients and measured entities.

FEEDBACK RECEIVED FROM PARTICIPANTS IN OCTOBER 2023 IN-PERSON PRMR AND MSR MEETINGS:

"A quick word of thanks for the meeting. Thanks for putting all the work towards such important work. Please share my gratitude to your staff for all their hard work behind the scenes."

"Dear Battelle Colleagues, I wanted to take a moment to express my earnest gratitude for the privilege of collaborating with you during Tuesday's Measure Set Review Meeting. Working alongside you all was truly enriching, and I am sincerely thankful for the opportunity to learn from your dedication and leadership... Once again, thank you for your invaluable insights and collaboration."

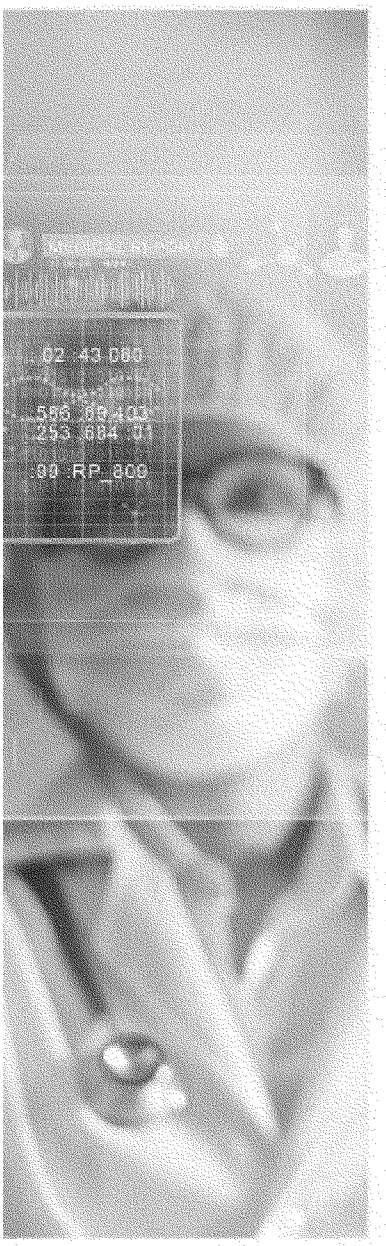
Core Quality Measures Collaborative (CQMC): Battelle supports CMS and AHIP in helping CQMC achieve its annual goals. The CQMC is made up of more than 75 healthcare organizations, including payers, purchasers, and medical and consumer groups. The collaborative is a broad-based coalition of health care leaders working to facilitate cross-payer measure alignment through the development of core sets of measures to assess the quality of health care in the United States. "Core measure sets" are defined as measures organized around a specific condition or topic; they can be implemented together, or users in the field can decide which measure(s) to use.

Battelle convened the CQMC Full Collaborative in late 2023 to set priorities for the upcoming year. The goal of the meeting was to explore the CQMC's role in three key areas:

- Health equity measurement
- Movement to digital measures
- Alignment around measurement models.

In addition, the CQMC discussed the leading barriers to adoption of measures within the core sets and achieving the desired impact of the core sets and how these can be overcome. The CQMC also began to develop a vision and strategy for the next phases of work.

Conclusion. Clinical quality and cost/resource use measures are useful for improving U.S. health care. Maintaining these measures through transparent, periodic, and consensus-based reviews is critical for ensuring health care quality performance can not only be measured, but can also be improved upon. A true consensus process must be transparent, reliable, and equitable. Battelle is dedicated to building the relationships within the health care quality community, including patients and clinicians, essential for advancing the national goal of attaining the highest level of health and wellness for the widest range of individuals possible.



1.0 Introduction

1.1 Background

Battelle is the world's largest independent, not-for-profit applied science and technology organization. We deliver cutting-edge outcomes that impact people's lives and the well-being of the world, today and for the future. Battelle's mission is to translate scientific discovery and technological advances into societal benefits. In 2023, the Centers for Medicare & Medicaid Services (CMS) awarded Battelle the National Consensus Development and Strategic Planning for Health Care Quality Measurement contract (NCDC).

The Medicare Improvement for Patients and Providers Act of 2008 (MIPPA) added section (§) 1890 of the Social Security Act (SSA) and requires the Secretary of the Department of Health and Human Services (HHS) to contract with a consensus-based entity (CBE) to synthesize evidence and convene key stakeholders to make recommendations focused on improving performance within the health care system. These activities include reviewing and endorsing standardized health care performance measures and reviewing previously endorsed measures through a maintenance review process. Section 3014 of the Patient Protection and Affordable Care Act (the Affordable Care Act, or ACA 2010) expanded the duties of the CBE to include convening stakeholder groups. These groups provide input on the selection of quality measures used in reporting performance information to the public and in specific value-based performance programs. A further evolution of the CBE's role has included the recent addition of convening stakeholders to provide CMS with guidance on which measures should be considered for removal from its programs.

The scope of the NCDC aligns with the requirements listed in §1890 of the Social Security Act. The National Quality Forum (NQF) held a contract with similar scope from 2009 to 2023. Battelle and NQF collaborated from February 27 to March 27, 2023, to transition all applicable documents and data to Battelle to provide a seamless transition of services.

Subsequently, Battelle worked closely with CMS to achieve the goals of the statutorily required CBE through key initiatives including:

- **Endorsement and Maintenance (E&M) of clinical quality measures:** Battelle convenes Partnership for Quality Measurement (PQM) Committee members to evaluate quality measures submitted for endorsement or up for routine maintenance. Committee members answer the question: is the measure safe and effective for general use and unlikely to result in negative unintended consequences?
- **Pre-Rulemaking Measure Review (PRMR):** Battelle convenes PQM Committee members to review measures submitted to CMS as part of the pre-rulemaking process. Committee members answer the question: is the measure reasonable and necessary for use in the intended CMS value-based program(s)?
- **Measure Set Review (MSR):** Battelle convenes PQM Committee members to review measures within the CMS portfolio of active measures. Committee members answer the question: is the measure aligned with CMS's current needs and priorities? If not, the committee may recommend that the measure be removed from the program.
- **Core Quality Measures Collaborative (CQMC):** Battelle partners with CMS and the American Health Insurance Partnership (AHIP), as part of a public-private partnership, tasked with aligning quality measures across payers to reduce burden on clinicians.

THREE DISTINCT PROCESSES (AND DECISIONS):

Endorsement & Maintenance (E&M)	Pre-Rulemaking Measure Review (PRMR)	Measure Set Review (MSR)
Consensus-based endorsement of measure	***Recommendation to add measure to program***	***Recommendation to remove measure from program***
• "Safe and effective" • Use of the measure in health care will increase the likelihood of desired health outcome (net benefit)	• "Reasonable and necessary" • Consider the context of specific CMS program and population of CMS entities and beneficiaries	• "Market optimization" • Explicit consideration of trade-offs in measure implementation experience, benefit, and burden within a measure domain

1.2 Partnership for Quality Measurement (PQM)

To facilitate measure reviews, Battelle, as a CBE, formed the Partnership for Quality Measurement (PQM), which comprises diverse health care voices, including but not limited to patients and caregivers, health care providers (e.g., clinicians, health plans, health systems), measure experts (e.g., developers, stewards, researchers), policymakers and measure implementers, and health information technology specialists. The vision of PQM is to develop a reliable, transparent, attainable, equitable, and meaningful measure review process. To help reduce barriers to participating in consensus-based work, Battelle made membership in PQM free of cost.

1.3 Audience

The primary audiences for this report are members of the U.S. Congress, congressional staff, the Secretary of HHS, and other government officials. Secondary audiences are parties interested in health care quality and efficiency measures, such as providers, patients, caregivers, insurers and other payers, measure developers, measure stewards, professional associations, policymakers, and those who research measurement science in academic, commercial, or private settings.

1.4 Importance

Battelle's transparent, streamlined approach to consensus-building through evidence-based policy and meaningful community engagement is designed to yield performance measures for use in accountability applications that are worthy of trust. This approach may be applied widely for the improvement of health care quality, safety, efficiency, and equity, in areas such as reviews of algorithms using artificial intelligence, alternative payment models, clinical decision support, cost and efficiency measures, and quality improvement tools. Our processes are designed to distinguish candidate or fielded measures whose benefits to patients, persons, facilities, clinicians, and payers outweigh potential burdens and risks to implement and report them.

Members of PQM help shape the future of health care by taking an active role in the quality measurement process, using their health care experiences and/or professional expertise to review and provide feedback on quality measures that HHS is considering for use in Medicare programs. Members can join teams or committees that evaluate whether measures should be endorsed based on their supporting evidence, their scientific rigor such as reliability and validity, their feasibility, their importance to patients and clinicians, and whether the measures themselves—or the treatments and procedures being measured—are safe and effective. The ultimate ends of PQM are to strengthen partnerships and alliances in quality measurement, expand knowledge of measurement science, and improve population health and health care programs and policies.

1.5 Report Organization

Pursuant to §1890(b)(5)(A), the CBE is required to submit a report to Congress and the Secretary of HHS by March 1 of each year. Table 1 depicts the required content of the report and where it can be located.

Table 1. Contents of the 2023 Annual Report to Congress and the Secretary of HHS

ELEMENT	SECTION
The implementation of quality and efficiency measurement initiatives and the coordination of such initiatives with quality and efficiency initiatives implemented by other payers	3.0, 6.0
Recommendations on an integrated national strategy and priorities for health care performance measurement	2.0
Performance of the CBE's duties required under its contract with the Secretary	1.0–10.0, Appendix
Gaps in endorsed quality and efficiency measures, including measures that are within priority areas identified by the Secretary under the national strategy established under §399HH of the Public Health Service Act (National Quality Strategy), and where quality and efficiency measures are unavailable or inadequate to identify or address such gaps	2.0, 3.5, 4.5, 5.5
Areas in which evidence is insufficient to support endorsement of quality and efficiency measures in priority areas identified by the Secretary under the National Quality Strategy, and where targeted research may address such gaps	2.0, 3.5, 4.5, 5.5, 6.0
The convening of multi-stakeholder groups to provide input on: (1) the selection of quality and efficiency measures from among such measures that have been endorsed by the CBE and such measures that have not been considered for endorsement by the CBE but are used or proposed to be used by the Secretary for the collection or reporting of quality and efficiency measures; and (2) national priorities for improvement in population health and the delivery of health care services for consideration under the National Quality Strategy	2.0, 4.0, 5.0, 6.0, Appendix
An itemization of financial information for the previous fiscal year ending September 30, including	8.0
Annual revenues of the entity	8.1
Annual expenses of the entity	8.1
A breakdown of the amount awarded per contracted task order and the specific projects funded in each task order assigned to the entity	8.2
Any updates or modifications to internal policies and procedures of the entity as they relate to the duties of the CBE	9.0
Any modifications to the disclosure of interests and conflicts of interests for committees, workgroups, task forces, and advisory panels of the entity	9.0
Information on external stakeholder participation in the duties of the entity	9.0, Appendix
Complete rosters for all committees, work groups, task forces, and advisory panels funded through government contracts	Appendix
Descriptions of relevant interests and any conflicts of interest for members of all committees, work groups, task forces, and advisory panels	9.0
Total percentage by health care sector of all convened committees, work groups, task forces, and advisory panels	9.0

2.0 Recommendations on National Strategy

Pursuant to §1890(b)(1) of the SSA, the CBE must "synthesize evidence and convene key stakeholders to make recommendations, with respect to activities conducted under this Act, on an integrated national strategy and priorities for health care performance measurement in all applicable settings. In making such recommendations, the entity shall (A) ensure that priority is given to measures—(i) that address the health care provided to patients with prevalent, high-cost chronic diseases; (ii) with the greatest potential for improving the quality, efficiency, and patient-centeredness of health care; and (iii) that may be implemented rapidly due to existing evidence, standards of care, or other reasons; and (B) take into account measures that—(i) may assist consumers and patients in making informed health care decisions; (ii) address health disparities across groups and areas; and (iii) address the continuum of care a patient receives, including services furnished by multiple health care providers or practitioners and across multiple settings."

2.1 Consensus-Based Entity Quality Measurement Strategy

Battelle seeks to support implementation of the requirements of §1890 by leveraging the CBE processes to realize a vision for sustainable health care system change through the integration and alignment of quality measurement and quality improvement processes. Lack of integration and alignment has been a major contributor to the perceived burden of quality measurement. Integration means applying uniform and coherent measure review processes that consider measurement and improvement across E&M, PRMR, and MSR. Alignment means leveraging both evidence-based policy and meaningful community engagement to identify and implement opportunities for high-impact system change.

In 2022, CMS launched the National Quality Strategy (NQS), with a mission of achieving optimal health and well-being for the broadest possible population of individuals (CMS 2022).

Of note, the NQS integrates several initiatives including the Meaningful Measure Initiative, the Cascade of Meaningful Measures, and the Universal Foundation. In 2023, Battelle partnered with CMS to launch the Consensus-Based Entity Quality Measurement Strategy (CBE Strategy). The goal of the CBE Strategy is to:

- Identify opportunities to further integrate the CBE work with the NQS
- Create an ecosystem supportive of advancing measurement science
- Develop a plan for optimizing all elements of the CBE work to ensure voices of interested parties are provided to the government in a timeframe in which they are most impactful
- Generate a model for addressing measure science's largest challenges
- Prioritize areas of importance such as health equity and patient choice.

2.2 Convene Stakeholders to Make Recommendations

As part of the transition of the NCDC, Battelle prioritized meeting with interested parties to introduce the Battelle CBE team and collect feedback related to areas for improvement in CBE processes. In consultation with CMS, Battelle selected the CMS End-Stage Renal Disease Quality Improvement Program (ESRD QIP) to pilot the new MSR process, due in part to the inherent importance of ESRD to the Medicare program. This also allowed stakeholders to review ESRD QIP measures under the accelerated timeline in the first year of the NCDC. In October 2023, Battelle held the first meeting of the MSR Committee. The purpose of the meeting was to review measures in the CMS End Stage Renal Disease Quality Improvement Program (ESRD QIP) and to assess if those measures were still aligned with the needs of CMS, clinicians, patients, and other interested parties.

During the MSR meeting, committee members expressed several recurring themes for revising and improving quality measures. While these recommendations primarily focused on the ESRD QIP, many themes are cross-cutting and aligned with the priorities of the NQS (CMS 2022). Figure 2 shows the four emerging themes, centered around equity, rural perspectives, patient choice, and real-world care.

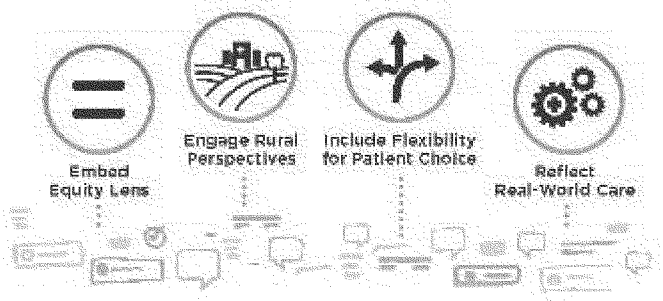


Figure 2. Growth Opportunities for ESRD QIP

2.2.1 Embed Equity Lens

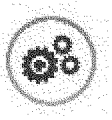
Embed an equity lens at all points of the measurement process, from data collection through reporting and across multiple social determinants of health. MSR Committee members asked for clarity from CMS on the availability of data on the performance of measures across patient sociodemographic subgroups and regional variation for facilities. In considering the best ways to advance equity, members encouraged developers and CMS to look for ways to pair patient education with measurement targets. Further, for facilities to advance health equity for the communities they serve, they need data that include patient-level factors that address equity concerns in the risk model and stratify results by these factors.

2.2.2 Engage Rural Perspectives

Consider the unique challenges experienced in rural communities in measure thresholds and reporting requirements. Representatives for rural health facilities as well as patients and clinicians from traditionally underserved communities shared their perspectives on how measures could be used to identify care access gaps and move progress on health equity. The MSR Committee encouraged CMS and developers to consider how national norms for setting thresholds and risk adjustment models relate to equity concerns for traditionally underserved populations and facilities in rural communities. Members encouraged CMS to consider measuring usability of measures at a facility level across regions and population subgroups.

2.2.3 Include Flexibility for Patient Choice

Include flexibility in measure specification to account for patient choice, desired quality of life, and personalized medicine. During discussions, MSR Committee members voiced concern for how patient choice and personalized treatment plans were not considered by current measures. The lack of patient choice reflected in measures was frequently accompanied by discussions of how lack of choice may negatively impact patient quality of life in instances where processes or thresholds required for measure satisfaction conflicted with a patient's individualized goals and desired quality of life. Patient and clinician representatives shared examples of how patient education and engagement in clinical decision making are critical to overall quality of care. Committee members encouraged measure developers and CMS to explore ways to include flexibility within measure specification, risk adjustment, or other means in the future to better support the patient choice inherent in personalized medicine.



2.2.4 Reflect Real-World Care

Incorporate measure exclusions and risk adjustment models that reflect real-world patient care scenarios and patient-level factors to increase measure usability and validity. Several measure reviews included in-depth discussions about the use of measure exclusions (as defined in the measure specifications) to address incomplete data and confounding concerns. In examples of care decisions given by clinician members of the Recommendation Group, attendees heard cases where the clinically appropriate care choice would negatively impact an entity's score on a measure. Measure developers are encouraged to collaborate with Technical Expert Panel (TEP) members to explore a diverse set of use cases when determining exclusion criteria. Members of the MSR Committee also expressed concern that some populations were excluded from measures as a proxy for a condition or illness to improve ease of data collection—for example, excluding residents in long-term care settings under the assumption all may have impaired functional status. As another example, regarding one measure related to ultrafiltration rate among ESRD patients, the committee cited potential unintended consequences of a "one size fits all" approach. The committee felt it was important to factor in patient choice and other patient-level factors such as comorbidities when determining an appropriate course

of action. Similarly, for a measure related to the standardized fistula ratio, the committee expressed concern that patient choice was not adequately reflected. The committee cited a general lack of patient education and engagement in decision-making, and emphasized the importance of considering a patient's personal goals and wishes for quality of life.

2.3 Measure Prioritization

In 2023, the CBE had the capacity to review all measures submitted for E&M, PRMR, and MSR. In accordance with the SSA, the CBE is to prioritize measures, should there be limited resources available to review all measures submitted in a cycle. Table 2 provides a summary of measures reviewed fitting within the categories listed within Section 2.0. While prioritization of measures was not necessary, some key changes ensure we continue to have the ability to review all measures and optimize the process for efficiency and effectiveness. In the sections below, we provide additional detail on the changes made between Battelle's and the prior CBE's processes and procedures for E&M, PRMR, and MSR.

Table 2. Crosswalk from National Priority Areas to PQM Activities in 2023

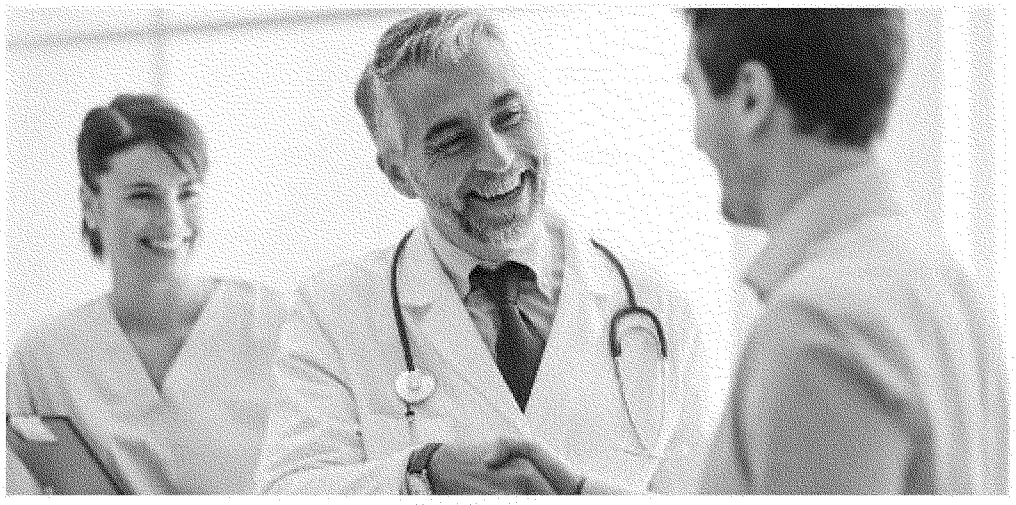
MEASURE PRIORITY (CATEGORY)	NUMBER OF MEASURES UNDER REVIEW IN 2023*		
	E&M*	PRMR	MSR
Address health care provided to patient with prevalent, high cost chronic disease	30	30	4
Greatest potential for improving quality, efficiency, and patient-centeredness of health care.	29	9	8
May be implemented rapidly due to existing evidence, standards of care, or other reasons	23	8	3

Measure counts across table rows are not mutually exclusive.

As of December 31, 2023, only measures in the E&M Fall 2022 and Spring 2023 cycles had been reviewed. The E&M Fall 2023 cycle measures (n=28) will receive endorsement decisions in February 2024.

3.0 Implementation of Quality and Efficiency Measurement Initiatives (E&M)

Pursuant to §1890(b)(2) of the SSA, the CBE shall "provide for the endorsement of standardized health care performance measures. The endorsement process under the preceding sentence shall consider whether a measure is (A) 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 (B) is consistent across types of health care providers, including hospitals and physicians." Section 1890 (b)(3) notes "the entity shall establish and implement a process to ensure that measures endorsed under paragraph (2) are updated (or retired if obsolete) as new evidence is developed." The CBE is required to describe the results of these processes pursuant to §1890(b)(5)(i)(I) of the SSA.



In this section we present Battelle's approach to the E&M process, as well as the results. Additional details can be found in the Endorsement and Maintenance (E&M) Guidebook on the PQM website www.p4qm.org.

3.1 Endorsement and Maintenance (E&M) Overview

The E&M process ensures measures submitted for endorsement are evidence based, scientifically sound (i.e., reliable and valid), and both safe and effective, meaning use of the measure will increase the likelihood of desired health outcomes; will not increase the likelihood of unintended, adverse health outcomes; and is consistent with current professional knowledge. During each E&M cycle, an E&M Committee reviews submitted measures and renders a decision of endorsement. Final outcomes are endorsed, endorsed with conditions, endorsement removed (maintenance measures only), or not endorsed (new measures only).

Committees evaluate measures for endorsement across five domains. These domains are important because they help depict the measure's scientific rigor, the feasibility of implementing the measure, and the business case for the measure, including the relationship between the measure and improvements in health care quality and/or cost. The five domains are:

- Importance
- Feasibility
- Scientific Acceptability (i.e., Reliability and Validity)
- Equity
- Use and Usability.

Appendix D of the E&M Guidebook contains the PQM Measure Evaluation Rubric, which describes these domains and the criteria needed to meet each of them. The PQM Measure Evaluation Worksheet provides additional guidance on the interpretation and application of the PQM Measure Evaluation Rubric.

3.2 Enhanced E&M Process

Battelle's first step in implementation of quality and efficiency measurement initiatives was to work with the quality measurement community (i.e., measure developers, E&M Committee members, patients and consumers, policymakers) to identify barriers to quality measure endorsement. Perceived barriers included the length of time of the endorsement process, and limited diversity in perspectives. With this feedback, Battelle designed a new endorsement process increasing efficiency while expanding committee and public engagement (Figure 3).

3.2.1 Increased Efficiency

The primary barrier identified by interested parties seeking measure endorsement was the length of the endorsement process. Measure developers noted the significant financial investment and resources needed to develop a measure and put it through the endorsement process. Measure developers wanted a process that was attainable, efficient, and transparent. To address these concerns, Battelle reduced the E&M process from 12 months to 6 months. The 6-month process prioritizes transparency and engagement from the broadest possible population of interested parties.

To achieve a 6-month E&M process, starting with the Fall 2023 cycle, we:

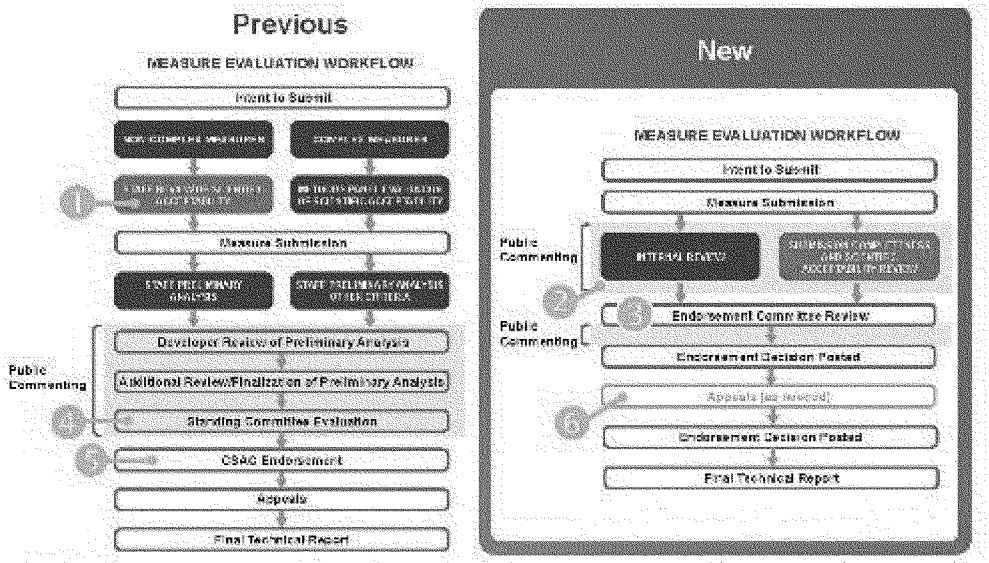
- Reduced redundancies in committee reviews by retiring the Consensus Standards Approval Committee (CSAC);
- Retired 14 existing E&M project committees more focused on clinical subspecialities and replaced with five (5) new project committees more reflective of the person health care journey;
- Transitioned the Scientific Methods Panel (SMP) away from individual measure reviews to harness the expertise of the panel in solving complex measure science challenges;
- Leveraged a Novel Hybrid Delphi and Nominal Groups (NHDNG) technique to increase engagement of all committee members and structure measure review facilitation to build consensus;
- Established a more robust and transparent appeals process.

To further gain input from the quality measurement community, we solicited public comments on the enhancements to the E&M process. Following this public review and comment period, the new 6-month E&M process launched in October 2023 (Fall 2023 E&M cycle). Prior to the start of the Fall 2023 cycle, Battelle oversaw the completion of the Fall 2022 and Spring 2023 cycles, which were started under the previous CBE's E&M process.

PUBLIC COMMENTS RELATED TO THE NEW E&M PROCESS

"We support greater individual review of the measure based on specific criteria to help mitigate the risks of 'group think' at the recommendation meeting."

"We applaud the revised role of the Scientific Methods Panel (SMP), wherein its members' considerable expertise can be better leveraged on a measure-by-measure basis to assist developers struggling with methodological challenges."



Key Changes

1. **Repurpose Scientific Methods Panel:** To create flexibility in the period between Intent to Submit and committee review, staff with extensive measure science and methodological knowledge will internally conduct initial scientific acceptability reviews to inform committee review.
2. **Concurrent Public Comment:** A lengthier public comment period will occur in two sessions: 1) concurrent with internal scientific acceptability review to inform endorsement decision making, and 2) after endorsement decision has been posted.
3. **Use of Novel Hybrid Delphi and Nominal Groups Technique:** To mitigate the removal of the SMP and CSAC, and to address previously stated concerns about consistency across committees, the NHDNG technique will build consensus among review panelists, and leverage experienced and trained facilitators.
4. **Reduced Multi-stakeholder groups:** Maintaining fewer committees with more general topic coverage will enable each committee to comment on a wider range of measures, maximizing the engagement of a given group each cycle.
5. **Eliminate the CSAC:** Eliminating the "rubber stamp" step previously overseen by the CSAC will save time and eliminate redundancies in the process, allowing endorsement decisions by standing committees to stand unless appealed.
6. **Robust Appeals Process:** Information about the appeals process will be included in relevant educational materials shared with measure developers, committees, and CMS in order to increase buy-in, transparency, and flexibility in the E&M process.

Figure 3. New Fall 2023 Changes to Measure Endorsement and Maintenance Process

3.2.2 Expanding Committee and Public Engagement

PROJECT COMMITTEES:

One critical part to increasing consistency was reducing the 14 project committees to five project committees. Under the previous E&M process, committees generally focused on a health care condition or type of measure as seen below:

1. All Cause Admission/Readmissions
2. Behavioral Health and Substance Use
3. Cancer
4. Cardiovascular
5. Cost and Efficiency
6. Geriatric and Palliative Care
7. Neurology
8. Patient Experience and Function
9. Patient Safety
10. Perinatal and Women's Health
11. Prevention and Population Health
12. Primary Care and Chronic Illness
13. Renal
14. Surgery.

Under the new E&M process, the five new project committees are focused on a patient's journey through the health care system. The committee structure is not based solely on a health care condition or disease state but by the type of function the health care system is performing (e.g., prevention/screening, advanced illness, and post-acute care), including the type of evidence submitted in support of that function (e.g., screening results in a referral). Each new project committee is listed below, with a description of the committee and an example measure the committee would review:

1. **Primary Prevention**—Education, prevention, and screening related to health status and/or health risk.

   Example measure: *CBE #0028 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention.*

2. **Initial Recognition and Management**—Recognition and timely diagnosis of conditions, including diagnostic accuracy, monitoring of early signs and symptoms of disease/condition.

   Example measure: *CBE #0058 Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB).*

3. **Management of Acute Events, Chronic Disease, Surgery, Behavioral Health**—Treatment of acute events, management of chronic disease, including structural or functional changes related to chronic disease, surgery, and related outcomes.

   Example measure: *CBE #0711 Depression Remission at Six Months.*

4. **Advanced Illness and Post-Acute Care**—Advanced illness and/or end-stage disease management, palliative and hospice care, post-acute care, and home care.

   Example measure: *CBE #0384e Oncology: Medical and Radiation—Pain Intensity Quantified.*

5. **Cost and Efficiency**—Total health care spending for a health care service or group of services associated with a specified patient population, time period, and/or unit of clinical accountability.

   Example measure: *CBE #2158 Medicare Spending Per Beneficiary (MSPB)—Hospital.*

COMMITTEE STRUCTURE

Beginning with the Fall 2023 cycle, Battelle began using a Novel Hybrid Delphi and Nominal Groups technique for measure endorsement reviews (Davies et al. 2011). Each E&M project has a committee consisting of an Advisory (Delphi) Group and a Recommendation (Nominal) Group. Each group has a specific role and function with respect to evaluating and voting on measures up for endorsement review (Figure 3). The purpose of this technique is to significantly increase the number of interested parties participating in the consensus-building process and to ensure that one voice does not dominate the committee's endorsement decision. As seen in Figure 4, each project has between 45 and 60 committee members. Each committee comprises patients, clinicians, facilities, purchasers, rural health experts, health equity experts, researchers, and other interested parties.

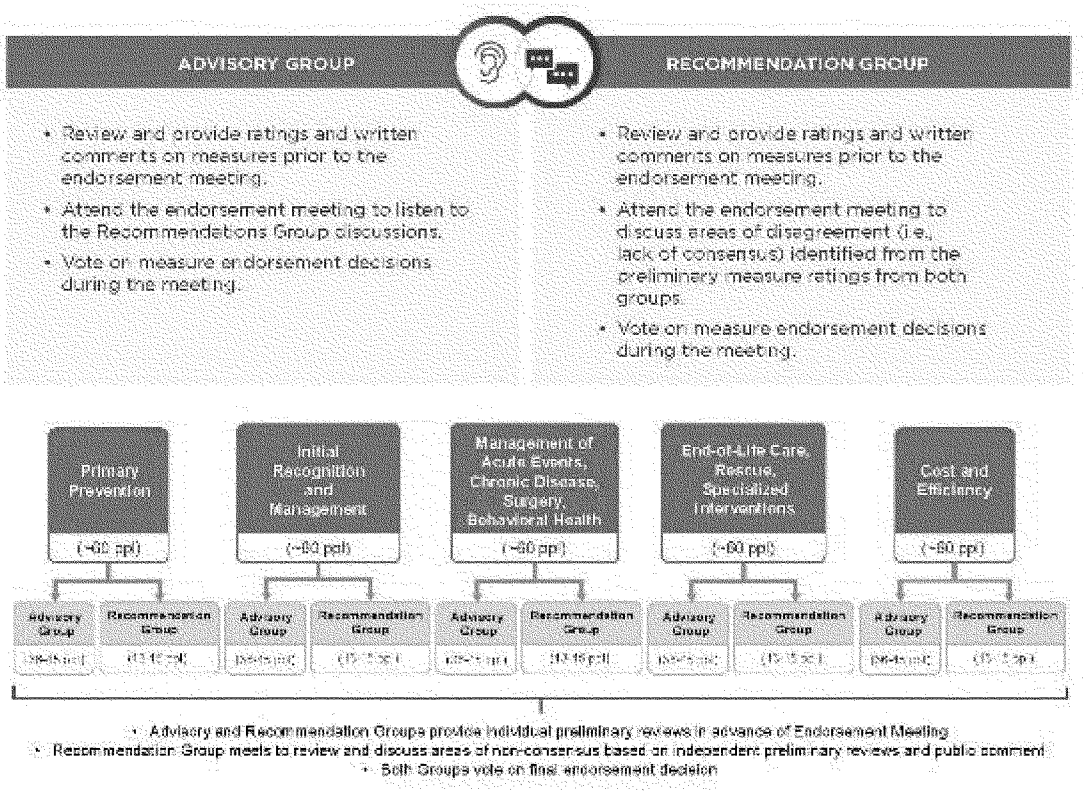
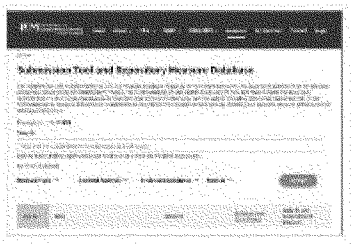


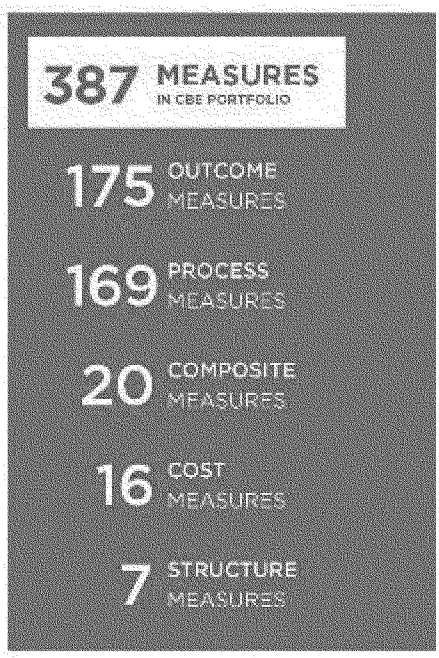
Figure 4. E&M Committee Structure

3.3 CBE Measure Portfolio

To house all measures that have been submitted to the CBE, we created and launched a new online database, the Submission Tool and Repository (STAR), which serves as: 1) a searchable database of all measures submitted to the CBE for endorsement consideration, and 2) an online platform for submitting measures to Battelle for PQM endorsement review.



As of December 31, 2023, the STAR database contained 1,199 records on measures submitted to the previous CBE for endorsement review. The database is regularly updated as new and maintenance measures are submitted to PQM. For each record, the database provides a unique identifier (CBE ID), E&M project, endorsement status and date, indicator of new or maintenance status, current endorsement cycle, description, corresponding measures, measure specifications and characteristics, importance, feasibility, scientific acceptability, equity, use and usability, record of most recent activity, measure steward/point of contact, public comments, staff preliminary assessment, and committee independent reviews.



As of March 2023 (month of CBE transition), 387 measures within the CBE portfolio were endorsed, of which 175 were outcome measures, including patient-reported outcome performance measures; 169 were process measures; 20 were composite measures; 16 were cost measures; and seven were structure measures. In addition to the 387 endorsed measures, other measures were never endorsed (new measures), had their endorsement removed (maintenance measures), or received the previous CBE's designation of inactive endorsement with reserve status.

According to the previous CBE, the purpose of an inactive endorsement with reserve status is to retain endorsement of reliable and valid quality performance measures that have overall high levels of performance with little variability, so that performance could be monitored, as necessary, to ensure performance does not decline. This status applies only to highly credible, reliable, and valid measures that have high levels of performance due to incorporation into standardized patient care processes and quality improvement actions.

Lastly, during the Base Period of performance, Battelle has been curating the CBE portfolio to ensure accuracy of measure records and confirming continued interest in maintaining endorsement for measures last endorsed more than 5 years ago. These continuing activities will facilitate quality measurement gap discussions with Battelle-convened committees.

3.4 Annual Endorsement Results

Within the Base Period of performance (March 27, 2023, through February 26, 2024), Battelle convened E&M project committees to review and render endorsement decisions on quality and/or cost/resource use measures submitted to the Fall 2022, Spring 2023, and Fall 2023 E&M cycles. A combined 81 measures were submitted to the previous CBE (Fall 2022 and Spring 2023 cycles) or Battelle (Fall 2023 cycle) for endorsement consideration during the Base Period. Of the 81 measures, 53 were submitted to the Fall 2022 and Spring 2023 cycles. Forty of the 53 measures were reviewed by E&M Committees, while 13 measures were withdrawn due to unfavorable Scientific Methods Panel (SMP) review (Fall 2022 cycle), requests from developers/stewards to defer measures to a future cycle, or the measure's endorsement no longer being maintained by the measure steward (Table 3 and Table 4).

The remaining 28 of the 81 measures were submitted to the Fall 2023 cycle (Table 5). Since the Fall 2023 endorsement meetings will not occur until February 2024, the endorsement decision results will be incorporated into next year's report.

FALL 2022 CYCLE MEASURES

For the Fall 2022 cycle, 39 measures were submitted, including 20 new measures and 19 maintenance measures. Developers/stewards withdrew 11 measures due to poor SMP ratings for reliability and/or validity, deferral requests to a future cycle, or no longer pursuing endorsement (Table 3).

Table 3. Overview of Fall 2022 CBE Endorsement Decisions by E&M Cycle and Project

E&M Project	Number of Measures Submitted	Number of Measures Reviewed	Number of Measures Withdrawn	Endorsement Decision Counts
Fall 2022	**39**	**28**	**11**	Endorsed: 19 *(14 maintenance/5 new)* Not Endorsed/Endorsement Removed: 8 *(new measures)* Sent Back for Reconsideration: 1 *(maintenance measure)*
All-Cause Admissions & Readmissions	6	2	4	Endorsed: 2 Not Endorsed/Endorsement Removed: 0 Sent Back for Reconsideration: 1
Cardiovascular	4	4	0	Endorsed: 2 Not Endorsed/Endorsement Removed: 2 Sent Back for Reconsideration: 0
Geriatrics and Palliative Care	8	6	2	Endorsed: 3 Not Endorsed/Endorsement Removed: 3 Sent Back for Reconsideration: 0
Patient Experience & Function	7	5	2	Endorsed: 5 Not Endorsed/Endorsement Removed: 0 Sent Back for Reconsideration: 0
Patient Safety	7	5	2	Endorsed: 5 Not Endorsed/Endorsement Removed: 0 Sent Back for Reconsideration: 0
Prevention and Population Health	4	3	1	Endorsed: 3 Not Endorsed/Endorsement Removed: 0 Sent Back for Reconsideration: 0
Renal	3	3	0	Endorsed: 0 Not Endorsed/Endorsement Removed: 3 Sent Back for Reconsideration: 0

SPRING 2023 CYCLE MEASURES

For the Spring 2023 cycle, 14 measures were submitted, including 12 new measures and two maintenance measures. Developers/stewards withdrew two measures as they no longer intended to pursue endorsement (Table 4).

Table 4. Overview of Spring 2023 CBE Endorsement Decisions by E&M Cycle and Project

E&M Project	Number of Measures Submitted	Number of Measures Reviewed	Number of Measures Withdrawn	Endorsement Decision Counts
Spring 2023	**14**	**12**	**2**	Endorsed: 9 Not Endorsed/Endorsement Removed: 2 Approved for Trial Use: 1 Sent Back for Reconsideration: 0
Patient Safety	5	5	0	Endorsed: 4 Not Endorsed/Endorsement Removed: 0 Approved for Trial Use: 1 Sent Back for Reconsideration: 0
Prevention and Population Health	3	3	0	Endorsed: 2 Not Endorsed/Endorsement Removed: 1 Sent Back for Reconsideration: 0
Primary Care and Chronic Illness	6	4	2	Endorsed: 3 Not Endorsed/Endorsement Removed: 1 Sent Back for Reconsideration: 0

FALL 2023 CYCLE MEASURES

For the Fall 2023 cycle, 28 measures were submitted, including eight new measures and 20 maintenance measures (Table 5). Endorsement decisions for these measures will be rendered by the five E&M project committees in February 2024, and these results will be incorporated into next year's report.

Table 5. Overview of Fall 2023 CBE Endorsement Decisions by E&M Cycle and Project

E&M Project	Number of Measures Submitted	Number of Measures Reviewed	Number of Measures Withdrawn	Endorsement Decision Counts
Fall 2023	**28**	--	--	*To be determined in February 2024*
Primary Prevention	2	--	--	*To be determined in February 2024*
Initial Recognition and Management	3	--	--	*To be determined in February 2024*
Management of Acute Events, Chronic Disease, Surgery, and Behavioral Health	11	--	--	*To be determined in February 2024*
Advanced Illness and Post-Acute Care	4	--	--	*To be determined in February 2024*
Cost and Efficiency	8	--	--	*To be determined in February 2024*

3.5 Quality Measurement Gap Areas and Insufficient Evidence Identified

In addition to the changes and enhancements made to the E&M process noted above, several topics emerged from E&M Committees during their review of measures due to insufficient evidence to support the measure and its evaluation. This lack of evidence indicates a perceived need to develop additional quality measures to fill potential gap areas and/or E&M evaluation guidance. These include:

- **Linking Cost and Quality Measures.** Current endorsement criteria do not require cost measures to be correlated to a clinical quality measure. However, E&M Committee members have expressed the need for requiring correlation analyses between cost measures and clinical quality measures, because the absence of a clearly defined relationship between quality and cost makes it challenging for patients to truly know whether lower cost is better. To address this need, a group of methodologists and other experts in health care costs should carefully consider cost measure evaluation in conjunction with clinical quality measures. This same group should advise and to create potential guidance and/or recommendations that could be integrated into the Battelle process.
- **Cognitive Impairment and Dementia.** During the Fall 2022 cycle, members of the Geriatrics and Palliative Care Committee considered new measures that focused on the rates of observed over predicted rates for diagnosis of mild cognitive impairment (CBE #3707), dementia (CBE #3672), and cognitive impairment of any stage (CBE #3729). Although the committee did not pass these measures due to a lack of evidence supporting the measure concept, it did recognize that cognitive impairment and dementia remain underdiagnosed, and that more measurement is needed in this area.
- **Diagnostic Excellence.** During the Spring 2023 cycle, the Patient Safety Committee evaluated a diagnostic excellence measure (CBE #3746). Committee members recognized the importance of diagnostic excellence and the emergence of more measures focusing on improving diagnostic delay and/or misdiagnosis. The committee expressed interest in greater education about how these measures should be reviewed for maximum appropriateness and scientific rigor. One committee member suggested any guidance development should include relevant medical specialty societies. The committee further recommended developers/stewards tailor their evidence submissions to show how diagnostic excellence measures impact outcomes. The committee also expressed interest in clustering diagnostic measures and in educating and empowering clinicians to improve diagnostic excellence.

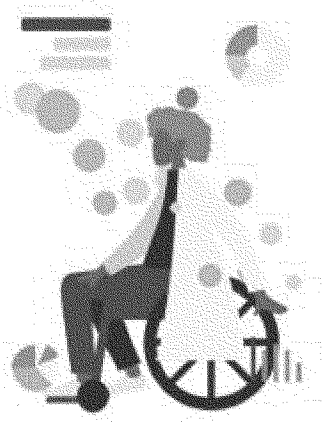
  To address this need, CMS should consider any special requirements and/or expectations for the endorsement of diagnostic excellence measures. The committee also recommended convening a group of methodologists and experts in diagnostic excellence to advise and to create potential guidance and/or recommendations that could be integrated into the Battelle process.

4.0 Multi-Stakeholder Engagement: Pre-Rulemaking Measure Review (PRMR)

Section 1890A(a) of the SSA states "The Secretary shall establish a pre-rulemaking process under which the following steps occur with respect to the selection of quality and efficiency measures described in §1890(b)(7)(B)." Pursuant to §1890(b)(7), the entity with a contract under §1890 (Battelle) shall convene multi-stakeholder groups to provide input to the Secretary on the selection of quality and efficiency measures described in subparagraph (B).

Pursuant to §1890A(2), the Secretary of HHS is required to publish a list of quality and efficiency measures being considered for inclusion in a CMS program. Battelle convenes stakeholders to review and make recommendations on the inclusion of the published measures. By February 1, Battelle must publish those recommendations.

Battelle convenes stakeholders for the purpose of making recommendations on the selection of quality and efficiency measures in accordance with §1890 via the PRMR process. In a separate but related process known as MSR, Battelle convenes stakeholders to consider measure removals. The previous CBE contractor conducted this work using their Measure Applications Partnership (MAP).



4.1 Pre-Rulemaking Measure Review (PRMR) Overview

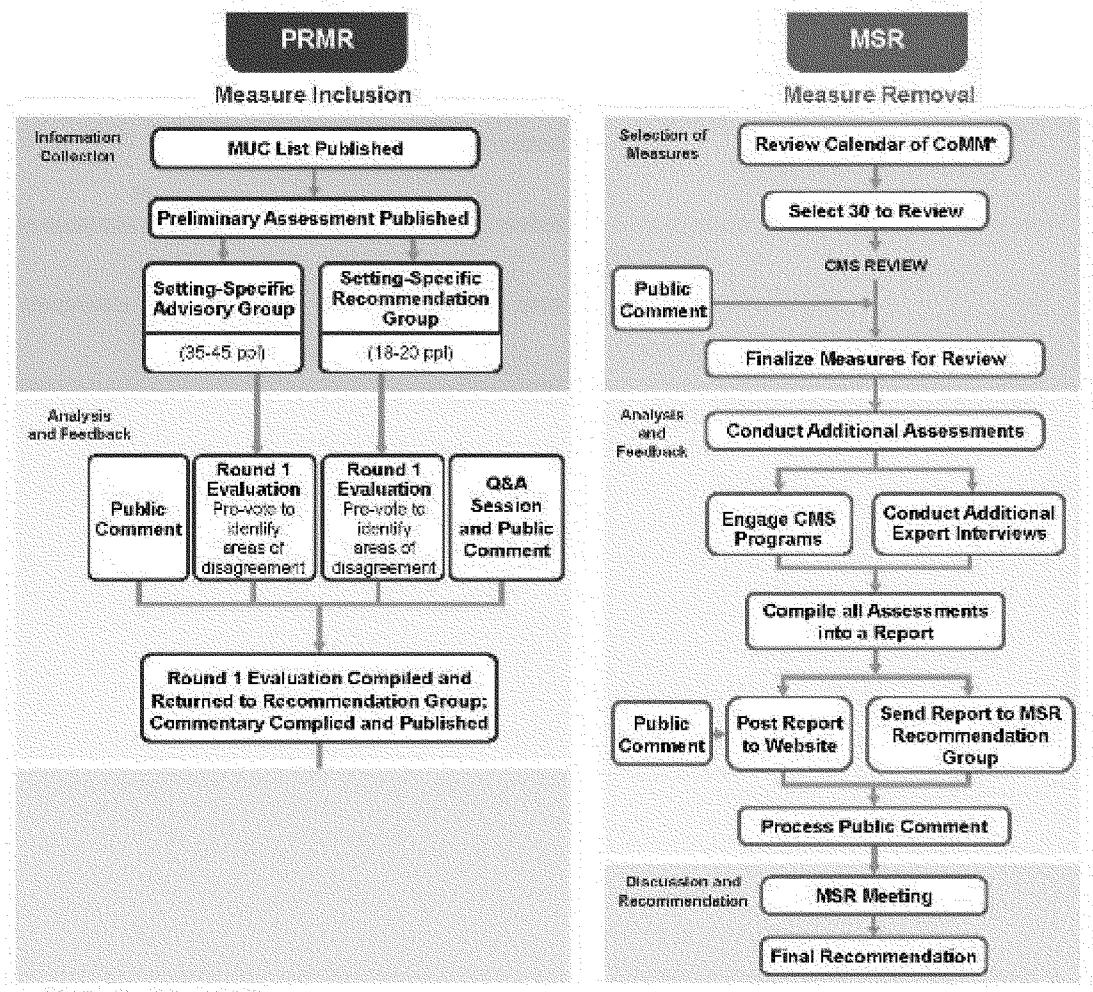
The PRMR process is conducted yearly to provide recommendations to HHS on the selection of quality and efficiency measures under consideration (MUC) for use by HHS. The PRMR process supports consensus recommendations regarding the inclusion of measures under consideration for CMS quality reporting and value-based programs. In the context of a specific CMS program and population of Medicare beneficiaries (e.g., Skilled Nursing Facility Quality Reporting Program), the measure is appropriate for use if it is meaningful, tailored to specific program or population needs, balanced and scaled to meet program-specific goals, and demonstrates a clear vision of near- and long-term program impacts. The Measures Management System website (MMS Hub) provides detailed information on the process, purpose, and timeline of the MUC process.

While the PRMR and MSR processes are similar in approach, they have distinct goals and purposes as shown in Table 6 and Figure 5. The PRMR and MSR processes are both structured to foster collaboration and to balance the input of various interested parties, enabling committees to generate well-informed recommendations regarding measures to be included or removed from a specific CMS reporting program. PRMR's objective is to assess the appropriateness of the measures included on the MUC List, specifically in the context of the program and population for which they are being considered. In contrast, MSR conducts a voluntary review of relative strengths and weaknesses of CMS's current measure portfolio and how the removal of an individual measure would reduce redundancy or create a measurement gap. Compared to the PRMR process, the MSR process is less structured to allow for a more holistic review involving qualitative assessment of portfolios of measures across programs and is guided by interested parties' input (Figure 5).

Table 6. Overview of PRMR and MSR Task Areas

	PRE-RULEMAKING MEASURE REVIEW (PRMR)	MEASURE SET REVIEW (MSR)
GOAL	To achieve consensus regarding NQF-list measures as to whether they are reasonable and necessary to CMS programs and target populations	To build consensus around measure removal recommendations through the identification of opportunities for optimization of the CMS measure portfolio
REQUIREMENT	Process required by statute or federal rulemaking process	None, though the process is enabled by statute
FOCUS	Within targeted program and population (though in future cycles, the process may look across programs in the interest of alignment and burden reduction)	Across the entire CMS measure portfolio
APPROACH	Evaluate the appropriateness of each measure for a specific intended use	Evaluate sunsetting of measures in the context of the program portfolio and how the purpose might best be achieved
EVALUATION CRITERIA	1. **Meaningfulness:** Measure is evaluated and tailored to unique needs of specific program target population 2. **Appropriateness of scale:** measure portfolio is balanced and scaled to meet target program- and population-specific goals, specifically, measure is evaluated in the context of all the measures currently within the program measure portfolio 3. **Time to value realization:** measure has plan for near- and long-term positive impacts on the targeted program and population as measure matures	1. **Impact:** Measure set evaluated across program, target population, and time 2. **Clinician data streams:** measure set redundancy in data streams is identified and mitigated, specifically by evaluating the burden associated with reporting the measure, considering other related measures 3. **Patient journey:** measure set redundancy is identified and mitigated, specifically by evaluating if the measure addresses the right aspect of care, in the right setting, and at the right point in a patient's journey to maximize the desired outcome

PRMR and MSR processes recommend selection or removal to address national health care priorities, fill critical measurement gaps, and increase alignment of measures among programs. The MSR process is detailed further in Section 5.0 of this report.



*CoMM: Cascade of Meaningful Measures

Figure 5: Comparison of Workflows in PRMR and MSR Committee Activities

4.2 Enhanced PRMR Process

Concurrent with our efforts to engage the quality measurement community on enhancing the E&M process, Battelle engaged that community (i.e., measure developers, former MAP Committee members, patients and consumers, policymakers) on ways to create a more transparent and impactful measure review process (Figure 6). The results of those engagements can be found in the Guidebook of Policies and Procedures for Pre-Rulemaking Measure Review (PRMR) and Measure Set Review (MSR), published in September 2023. Like E&M, enhancements centered around increasing efficiency in the process while expanding committee and public engagement.

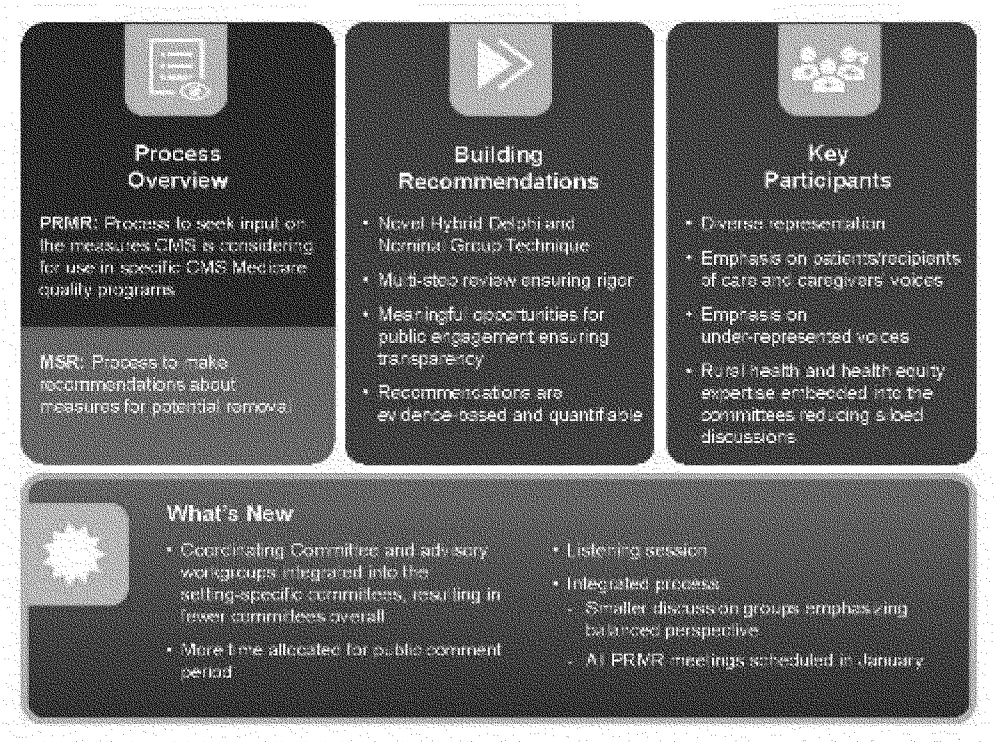


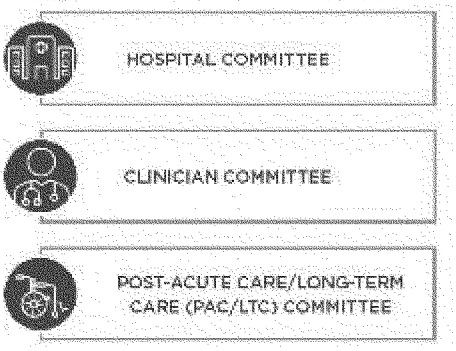
Figure 6. Improvements in PRMR process for 2023.

4.2.1 Increased Efficiency

Battelle took several steps to increase the efficiency and effectiveness of the PRMR process. The first was to streamline the measure review process by eliminating duplicative steps, including the MAP Coordinating Committee's re-adjudication of recommendations and the separate, concurrent reviews by specialized advisory workgroups (e.g., rural health and health equity). The advisory workgroups were integrated into established clinician, hospital, and post-acute care/long-term care (PAC/LTC) Committees under the PRMR process, which ensures all measures receive the attention of rural health and health equity experts, as well as increasing the amount of time available for public comment.

Battelle also streamlined the evaluation focus of each measure to three domains, to more meaningfully distinguish the PRMR process from E&M:

- **Meaningfulness:** Has it been demonstrated that the measure meets criteria associated with importance, scientific acceptability, feasibility, usability, and use for the target population and entities of the program under consideration?
- **Appropriateness of scale:** How is implementation of the measure applied to optimize the measure value across segments of the target population and entities of the program under consideration?
- **Time to value realization:** To what extent does current evidence suggest a clear pathway from measurement to performance improvement?



Based on the assertions made by measure developers in these domains, committees classify the measures' evaluation criteria into one of three categories: evidence is complete and adequate; evidence is either incomplete or inadequate but there is a plausible path forward; or evidence is either incomplete or inadequate and there is no plausible path forward.

Following committee evaluations, discussions, and votes, CMS receives one of three recommendations for each measure:

- **Recommends:** The committee recommends CMS add the measure to the specified program as presented.
- **Recommends with conditions:** The committee recommends CMS add the measure to the specified program with the consideration of conditions such as additional testing, or submission for endorsement by a CBE.
- **Does not recommend:** The committee does not recommend CMS add the measure into the specified program.

PUBLIC COMMENTS

"Great way to manage the process."

"We support the PQM's efforts to ensure that consensus is achieved through the design of the committees and public comment as well as the revised evaluation criteria."

"We also like the idea of integrating the previous coordinating and advisory committees with the setting-specific committees, as this should allow more time for public comment and for more impactful engagement from those who can provide rural health and/or equity perspectives." (The Joint Health Commission)

"The AHA appreciates and agrees with these three recommendation categories [recommend, recommend with conditions, do not recommend]. The previous cycles of pre-rulemaking review have at times employed categories that were poorly defined and failed to provide definitive feedback to policymakers. The use of these streamlined categories is more likely to result in consensus."

"The AAMC supports this approach to allow greater time for measure evaluation and to prepare feedback. We agree it likely to increase public engagement with the MUC List in advance of the January recommendation meetings."

4.2.2 Expanding Committee and Public Engagement

The driving purpose behind our evolving measure review process was to increase the quantity and quality of the feedback CMS could expect to receive on each measure. Therefore, Battelle implemented a new committee structure and increased the amount of time and opportunities for public comment.

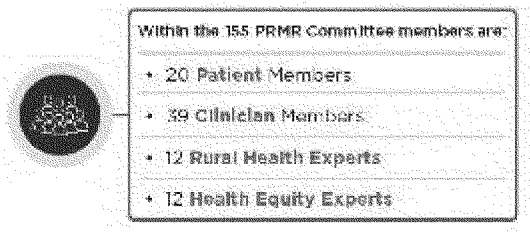
COMMITTEE STRUCTURE

Like the E&M process, Battelle began using a Novel Hybrid Delphi and Nominal Groups technique for pre-rulemaking measure reviews (Davies et al. 2011). Each PRMR Committee consists of an Advisory (Delphi) Group and a Recommendation (Nominal) Group. Each group has a specific role and function with respect to evaluating and voting on measures. Due to statutory time constraints, both the Advisory and Recommendation Group members review and evaluate measures. Only the members of Recommendation Groups vote on measures.

NEW: Advisory Group vs. Recommendation Group

Battelle's PRMR and MSR committees are structured into an Advisory Group and a Recommendation Group. Members of the Advisory Group review and provide recommendations on measures prior to Recommendation Group meetings. These inputs ensure that a larger number of voices contribute to the consensus-building process.

The purpose of this technique is to significantly increase the number of interested parties participating in the consensus-building process and to ensure that one voice does not dominate the committees' decision-making process. As seen in Figure 7, each committee has between 45 and 60 members. Each committee comprises patients, clinicians, facilities, purchasers, rural health experts, health equity experts, researchers, and other interested parties.



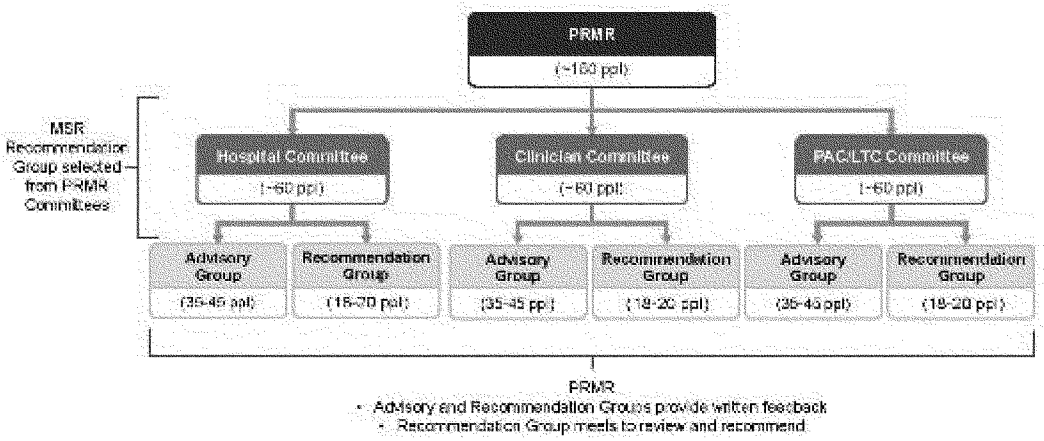


Figure 7. PRMR Committee Structure

PUBLIC COMMENTS

"We support both Advisory and Recommendation Group structures, in particular, the expansion of participants in the Advisory Group to 35-45 members and inclusion of 18-20 members within the Recommendation Group. This set-up will allow additional opportunities for anesthesiologists to participate." (American Society of Anesthesiologists)

"Overall, The Joint Commission supports the revised process, Novel Hybrid Delphi and Nominal Group (NHDNG), described in the Guidebook. We agree with the proposal to increase the number of members reviewing measures and collecting pre-evaluation independent ratings. This change will facilitate consensus and permit an unbiased and stronger evaluation. When committee members are held responsible to review and provide feedback in advance of meetings, all voices can more easily be heard. The Joint Commission appreciates the desire to focus meeting time on areas of disagreement and agrees that this can support consensus building."

"We support the use of the Novel Hybrid Delphi and Nominal Group (NHDNG) technique and believe that this technique will increase engagement of members and structure facilitation by using standard criteria and practices."

PUBLIC ENGAGEMENT

In addition to reducing the number of committees reviewing the measures, which streamlines the measure review process, Battelle moved annual PRMR meetings from December to January. These changes allow for a longer window for public comment and committee reviews. In 2023 there were three opportunities for public comment on MUC measures:

- **Written comments:** the public has from December 1 to December 22 to provide written comments on each measure. All comments appear on the public PQM website.
- **Verbal comments:** Battelle provides the opportunity for verbal comments via listening sessions. The public may register to make a comment in advance or on the day of the meeting. During this time, the public and committee members may also ask CMS questions about specific measures on the MUC List.
- **Post recommendation comment:** Following final recommendations, the public may provide written comments for CMS's further consideration.

PUBLIC COMMENTS

"Holding meetings in January rather than mid-December will provide more time for in-depth evaluation of the MUC List, which AHA believes is paramount to meaningful discussion. We also appreciate that CMS plans to hold dedicated public listening sessions, one per 'setting' (hospital, post-acute/long-term care, and clinician); we believe that this system will better allow for robust and relevant public comment."

"The new listening sessions are a great addition to the measure review process. It is a good opportunity for committee members to ask questions on measures prior to submitting their ratings. Allowing measure developers to clarify items on their submissions is valuable, as developers were previously not allowed to provide feedback during the meetings."

4.3 PRMR Engagement

In 2023, as detailed above, Battelle completed two rounds of public comment related to the 2023 MUC List: a written public comment period from December 1 through December 22 and three setting-specific listening sessions for verbal public comments. For the 2023 PRMR cycle, Battelle received 495 written comments from 147 professional organizations and 49 patients/patient representatives. The listening sessions had robust attendance from the public: 196 attendees (Hospital session), 158 attendees (Clinician session), and 104 attendees (PAC/LTC session). During these listening sessions, over 70 attendees voiced comments or questions, engaging with both CMS and PQM leadership about the measures under consideration. Public comments are available via the PQM website and will be included in the 2023 PRMR Recommendations Report, to be published in February 2024.

4.4 Annual PRMR Results

In 2023, 42 measures were published on the CMS MUC List. Of these, 19 measures were assigned to the Clinician Committee, 22 measures were assigned to the Hospital Committee, and three measures were assigned to the PAC/LTC Committee. (Two measures, MUC 199 and MUC 210, were proposed for programs under both Clinician and Hospital Committees). This report covers the time period of January 1 to December 31, 2023. The annual PRMR meetings are now held in January. Recommendations made by the PRMR Committee will be made public by February 1, 2024, and will be included in the 2024 Annual Report to Congress.

4.5 PRMR Gaps Identified

In October 2023, Battelle convened PRMR members to provide an orientation to the new PRMR process, answer questions, and discuss potential gap areas. The areas of health equity and rural health persist as enduring areas of concern. Committee members continue to assert measure developers, clinicians, and payers need additional guidance on how to accurately measure and account for practices treating patients who are at the highest-risk, and who may have the fewest resources.

5.0 Multi-Stakeholder Engagement: Measure Set Review (MSR)

The MSR process is statutorily enabled by the Consolidated Appropriations Act, 2021, Public Law 116–260, which reads: "Section 1890(b) of the Social Security Act (42 U.S.C. 1395aaa(b)) is amended by inserting after paragraph (3) the following new paragraph: "(4) REMOVAL OF MEASURES.—The entity may provide input to the Secretary on quality and efficiency measures described in paragraph (7)(B) that could be considered for removal."

5.1 MSR Overview

MSR centers on interested party reviews of measures across various CMS programs. The purpose of the MSR process is to optimize the CMS measure portfolio via measure removal recommendations. Committees recommend measures for removal based on updated information on the measure's properties, performance trends, and whether the measure continues to support the program's needs and priorities.

The **PRMR process** makes consensus recommendations about measures on the MUC List.

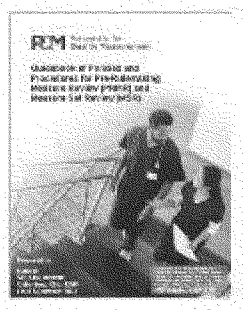
The **MSR process** builds consensus around measure removals to optimize the CMS measure portfolio in the value-based programs.

Whereas PRMR measures are evaluated through the domains of meaningfulness, appropriateness of scale, and time to value realization, the three MSR domains are:

- **Impact:** The measure meets criteria for importance, feasibility, scientific acceptability, and usability & use, considering its use across programs and populations.
- **Clinician data streams:** Measure redundancy in data streams has been identified and mitigated.
- **Patient journey:** The measure is implemented across the patient journey as intended per a measure impact model, which illustrates how a measure "works" to have the greatest impact on patient outcomes.

5.2 Enhanced MSR Process

The "Guidebook of Policies and Procedures for Pre-Rulemaking Measure Review (PRMR) and Measure Set Review (MSR)" was published in September 2023, along with an accompanying set of answers to frequently asked questions (FAQs). Battelle enhanced the MSR process by using the CMS Quality Strategy (Cascade of Meaningful Measures) to select measure domains (e.g., patient safety) for review, providing additional and earlier opportunities for public comment, and assigning CBE staff to prepare pre-assessments using review methods aligned with E&M and PRMR to inform committee reviews. The goal was to achieve more effective committee reviews by providing more information from public comment and staff assessments.



5.3 MSR Engagement

In 2023, PQM tasked the MSR Recommendations Committee to review measures within the CMS End-Stage Renal Disease Quality Incentives Program (ESRD QIP). The ESRD QIP is authorized by §1881(h) of MIPPA (U.S. DHHS 2024). The program establishes incentives for facilities to achieve high-quality performance on measures with the goal of improving outcomes for ESRD beneficiaries. ESRD QIP policies are outlined in 42 CFR 413.177 and 413.178. The technical specifications for ESRD QIP measures are available for review on the CMS website

MSR Committee members were selected from among the individuals suitable for the ESRD QIP review and already serving on the PRMR Committees. As such, recruitment for the MSR Committee mirrored the approach laid out in Section 4.0. Battelle staff conducted a public call for nominations and targeted outreach to solicit nominees for PRMR Committees. Battelle prioritized individuals who had previously participated in similar panels/committees or had a demonstrated knowledge of these processes; fit into more than one roster category; and possessed lived experience interacting with the health care system. Battelle considered members with often under-represented voices, including individuals with relevant background and experience who may not have had a previous opportunity to participate in these processes.

Battelle's goal was to create an inclusive Recommendation Group that balanced experience, expertise, and perspectives. Battelle solicited one patient co-chair and one clinician co-chair to help facilitate the meeting.

Prior to the MSR meeting on October 17, 2023, MSR Recommendation Group members received a preliminary analysis of the 15 ESRD QIP measures in the 2023 Measure Set Review (MSR): End-Stage Renal Disease Quality Incentive Program (ESRD QIP) Report and were asked to submit initial feedback on potential benefits and risks of retention or removal for each measure.

5.4 Annual MSR Results

During the October 17 meeting, 21 of the 23 MSR Recommendation Group members attended the meeting either in person (13) or virtually (8) through the Zoom meeting platform to discuss the measures and vote for recommendations. CMS and Battelle facilitators joined these members.

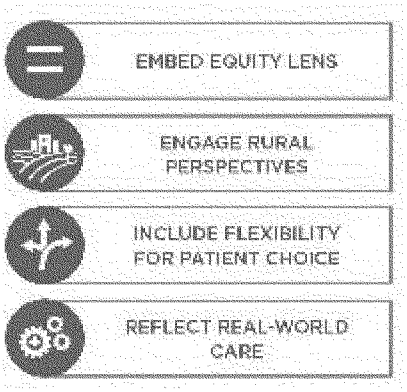
Specifications for each measure can be found in the online CMS Measure Inventory Tool (CMIT). A detailed review of the MSR discussion and results can be found in the "2023 Measure Set Review (MSR): End-Stage Renal Disease Quality Incentive Program (ESRD QIP)". An overview of the results can be found in Table 7.

Table 7. MSR Recommendation Group Vote Counts per Measure (ESRD QIP, October 2023)

CMIT ID	MEASURE TITLE	RETAIN	REMOVE	RECUSALS
00314-01C-ESRDQIP	Hemodialysis Vascular Access Type: Standardized Fistula Rate	2 (10%)	**19 (90%)**	0
00313-01-C-ESRDQIP	Hemodialysis Vascular Access: Long-term Catheter Rate	**18 (90%)**	2 (10%)	0
00698-01-C-ESRDQIP	Standardized Transfusion Ratio (STrR)	**14 (74%)**	5 (26%)	0
00407-01-C-ESRDQIP	Kt/V Dialysis Adequacy (Comprehensive)	**16 (84%)**	3 (16%)	1
00360-01-C-ESRDQIP	Hypercalcemia	**16 (89%)**	2 (11%)	0
00733-01-C-ESRDQIP	Ultrafiltration Rate (UFR)	1 (5%)	**20 (95%)**	0
00440-01-C-ESRDQIP	Medication Reconciliation for Patients Receiving Care at Dialysis Facilities (MedRec)	**16 (76%)**	5 (24%)	0
00461-02-C-ESRDQIP	National Healthcare Safety Network (NHSN) Dialysis Event	**16 (76%)**	5 (24%)	0
00672-03-C-ESRDQIP	Clinical Depression Screening and Follow-Up	**13 (65%)**	7 (35%)	0
00180-01-CESRDQIP	COVID-19 Vaccination Coverage Among Healthcare Personnel	**13 (65%)**	7 (35%)	0
00697-01-CESRDQIP	Standardized Readmission Ratio (SRR) for dialysis facilities	**13 (68%)**	6 (32%)	0
00695-01-C-ESRDQIP	Standardized Hospitalization Ratio (SHR)	**14 (74%)**	5 (26%)	0
00546-01-C-ESRDQIP	Percentage of Prevalent Patients Waitlisted (PPPW)	**12 (63%)**	7 (37%)	0
00381-02-C-ESRDQIP	CAHPS In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) Survey	**14 (78%)**	4 (22%)	0
00458-01-C-ESRDQIP	National Healthcare Safety Network (NHSN) Bloodstream Infection (BSI) in Hemodialysis Patients	**17 (100%)**	0	0

5.5 MSR Gaps Identified

During the course of the day's discussions, Recommendation Group members voiced interest in seeing progress made in the areas of equity across multiple social determinants of health, flexibility in measure specifications to account for patient choice and personalized medicine, risk adjustment and measure exclusions that reflect real-world care scenarios, consideration of the unique needs of rural communities, and exploration of ways to increase measure utility to patients and measured entities. The MSR Committee's strategic recommendations are detailed in Section 2.0, and they informed Battelle's strategy for carrying out the CBE activities on this contract.



6.0 Core Quality Measures Collaborative (CQMC)

The CQMC is a broad-based coalition of health care leaders working to facilitate cross-payer measure alignment through the development of core sets of measures to assess the quality of health care in the United States. "Core measure sets" are defined as measures organized around a specific condition or topic; they can either be implemented together, or users in the field can decide which measure(s) to use.

Founded in 2015, the CQMC is a public-private partnership between America's Health Insurance Plans (AHIP) and CMS. Over 70 member organizations, such as health insurance organizations, primary care and specialty societies, consumer and employer groups, and other quality collaboratives, constitute the membership. CQMC is a membership-driven and -funded effort, with additional funding provided by CMS and AHIP. The CQMC is convened by Battelle in its role as the CBE.

Members of the "Full Collaborative" populate various workgroups based on medical or health care condition and/or care setting. Workgroups prepare initial recommendations, which then move forward to a meeting of the Full Collaborative. The CQMC aims to:

- Identify high-value, high-impact, evidence-based measures promoting better health outcomes, and providing useful information for improvement, decision-making, and payment
- Align measures across public and private payers to achieve congruence in the use of measures for quality improvement, transparency, and payment purposes
- Reduce the burden of measurement by eliminating low-value metrics, redundancies, and inconsistencies in measure specifications and quality measure reporting requirements across payers.

CQMC is a public-private partnership between America's Health Insurance Plans and the Centers for Medicare & Medicaid Services that includes over 20 member organizations.

The CQMC seeks to continue its work through ongoing maintenance of the existing core measure sets to reflect the shifting measurement landscape, including changes in clinical practice guidelines, data sources, and risk adjustment. It further strives to expand into new clinical areas. In addition, the CQMC identifies gaps in measurement and challenges in implementation to advance adoption of the core sets.

The ten current core measure sets are listed below. In August 2023, CQMC announced updates to eight core measure sets, indicated by asterisk (*) symbols:

- Accountable Care Organizations/ Patient Centered Medical Homes/ Primary Care*
- Behavioral Health*
- Cardiology*
- Gastroenterology*
- HIV & Hepatitis C*
- Medical Oncology
- Neurology
- Obstetrics & Gynecology*
- Orthopedics*
- Pediatrics.*

Battelle convened the CQMC Full Collaborative in late 2023 to set priorities for the upcoming year. The goal of the meeting was to explore the CQMC's role in three key areas:

- Health equity measurement
- Movement to digital measures
- Alignment around measurement models.

In addition, the CQMC discussed the leading barriers to adoption of measures within the core sets, achieving the desired impact of the core sets, and how these can be overcome. The CQMC also began to develop a vision and strategy for the next phases of work.

7.0 Ad Hoc Projects

The primary objective of Battelle in serving as the CBE in 2023 was the transition of the NCDC and launch of the new E&M, PRMR, and MSR processes. Battelle has also begun the process of developing a CBE Quality Measurement Strategy to guide the continued evolution of quality measurement science over the next five years (see Section 2.0).

8.0 Financial Information for Fiscal Year 2023

Pursuant to §1890(b)(5)(A)(ii)(I) and (II), the CBE must present "an itemization of financial information for the fiscal year ending September 30 of the preceding year, including—(I) annual revenues of the entity (including any government funding, private sector contributions, grants, membership revenues, and investment revenue) and (II) annual expenses of the entity (including grants paid, benefits paid, salaries or other compensation, fundraising expenses, and overhead costs)."

8.1 Battelle Finances

As shown in Table 8, Battelle's revenues for FY 2023 were about $12.4 billion, including federal funds or government revenue authorized under §1890(d) of the SSA, private-sector contributions, and investment revenue. The former CBE contractor levied fees on their members, whereas Battelle has opted to make PQM membership free of charge, removing barriers and enhancing transparency and inclusivity for all stakeholders. PQM members contribute in-kind resources through the time and expertise they provide in reviewing measures and participating in committee work.

Battelle's expenses for FY 2023 were about $12.3 billion. These expenses include grants and benefits paid, salaries and other compensations, purchased services such as subcontracting, and overhead costs.

Table 8. Battelle's Unaudited Financial Statement of Revenues and Expenses, for FY2023

Operating Highlights	Amount ($)
Government Revenue	12,503,969,602
Commercial Revenue	760,267,758
Other Revenue	8,479,740
Total Revenue	12,448,414,100
Investment Income	30,666,232
Salaries and Benefits	6,798,807,020
Purchased Services and Materials	4,889,069,532
Other Expense	678,035,890
Total Expense	12,365,911,942

8.2 NCDC Finances

Pursuant to §1890(b)(5)(A)(ii)(III), the CBE must provide "a breakdown of the amount awarded per contracted task order and the specific projects funded in each task order assigned to the entity." Table 9 lists the tasks with award amounts and funded amounts in the base period of the contract (February 2023 to February 2024).

Table 9. Federally Funded Tasks Awarded and Funded in FY 2023 under IDIQ Contract 75FCMC23C0010

ID # (SLIN)*	Description	Awarded, $	Funded,$
0001	Transition Period	$295,709	$295,709
0002AA	Measures Reviewed: Endorsement and Maintenance	$3,694,320	$3,694,320
0002AB	(OPTIONAL) Measures Reviewed: Endorsement and Maintenance	$553,440	$0
0002AC	Measures Reviewed: Pre-Rulemaking	$1,102,390	$1,102,390
0002AD	(OPTIONAL) Measures Reviewed: Pre-Rulemaking	$330,505	$330,505
0002AE	(OPTIONAL) Measures Reviewed: Pre-Rulemaking	$330,505	$0
0002AF	Measures Reviewed: Measure Set Review	$351,015	$351,015
0002AG	(OPTIONAL) Measures Reviewed: Measure Set Review	$150,220	$0
0002AH	(Deliverable 2-3) Final Project Management Plan	$1,088,078	$1,088,078
0002AJ	(Deliverable 2-13) Final Annual Report	$339,914	$339,914
0002AK	(Deliverable 2-17) Health Care Ad Hoc Tasks: Level of Effort Units	$1,200,000	$1,200,000
0002AL	(Deliverable 4-27) Measure Selection and Removal-Related Ad Hoc Tasks	$201,270	$201,270
0002AM	(Deliverable 5-1) Core Quality Measures Collaborative (CQMC) Activities Implementation Proposal	$500,688	$500,688
0002AN	(Deliverable 6-1) Transition Plan	$71,079	$71,079
Total		**$10,369,290**	**$9,314,355**

9.0 Updates to Policies and Procedures

Pursuant to §1830(b)(5)(A)(ii) the CBE must report "any updates or modifications of internal policies and procedures of the entity as they relate to the duties of the entity . . . including—(I) specifically identifying any modifications to the disclosure of interests and conflicts of interests for committees, workgroups, task forces, and advisory panels of the entity. Additionally, the CBE must report relevant interests and any conflicts of interest for members of all committees, workgroups, task forces, and advisory panels, and the total percentage by health care sector of all convened committees, workgroups, task forces, and advisory panels."

In 2023, Battelle developed and posted appropriate forms to use in nominating interested parties, subject matter experts, and other stakeholders as candidates for committees and workgroups. Battelle also developed forms for collecting information on actual, apparent, or potential conflicts of interest (COIs) from nominees for committees and workgroups, including both personal financial interests and interests related to one or more specific measures under discussion. Battelle did not change any of its policies or procedures concerning for stakeholder (interested party) participation or for its COI disclosures during 2023.

In accordance with the Battelle (PQM) Conflict of Interest Policy for Committees, all nominees are asked to complete a general disclosure of interest (DOI) form for each committee to which they have applied prior to being seated on the committee. The DOI form for each nominee is reviewed holistically and in the context of the topic area in which the committee will be reviewing measures, if applicable. Nominees must complete this general DOI form annually through the PQM website in order to participate in a committee.

Specific to E&M Standing Committees, once nominees have been selected to serve on a committee, Battelle provides nominees with a measure-specific DOI form near the beginning of each evaluation cycle. Battelle uses this measure specific DOI form to determine whether any members will be required to recuse themselves from the discussion of one or more measures under review based on prior involvement or relationships to entities relevant to the topic area. Because Standing Committee members are asked to review various types of measures throughout their term of service, Battelle asks members to complete the measure-specific DOI form for all measures being evaluated in each cycle, as well as any measures that are related to, or competing with, measures being evaluated to identify any potential conflicts or biases. Committee members who fail to return a completed measure-specific DOI form prior to the measure evaluation meetings will not be allowed to participate in the discussion or submit votes on the measures being evaluated.

Battelle reviewed the disclosures as noted above. In the E&M committees, eight members disclosed relevant interests or potential conflicts, which resulted in the following recusals:

Fall 2022 Cycle:

- Renal Committee:
  - Five standing committee members disclosed a conflict with two renal measures: CBE #3722 and CBE #3725, which led to their recusal from the discussion and voting on those measures. Those five Standing Committee members were recused due to their collaboration with the measure developer on the development of those measures.

Spring 2023 Cycle:

- Prevention and Population Health Committee:
  - One standing committee member disclosed a conflict with CBE #3751, which captures the risk-adjusted post-ambulance provider triage emergency department visit rate. The committee member was recused as they served as the director of the measure development team. This conflict led to his recusal from discussing and voting on CBE #3751.
- Primary Care and Chronic Illness Committee:
  - One standing committee member disclosed a conflict with CBE #3210e, #3752e, and #3755e, which focused on HIV care and screening, because they served on a technical expert panel (TEP) for these three measures, which led to their recusal from the discussion and voting on those measures.
  - One standing committee member was recused from a renal measure, CBE #3742, due to their involvement on a patient-reported outcome TEP that provided guidance on the conceptual framework for the measure.

In the PRMR committees, recusals were determined as members were seated, and continued to cover the committees' activities into early 2024. The PRMR committees had five recusals as outlined below.

- Clinician Committee:
  - One member recused for measure MUC 137, "Initial Opioid Prescribing for Long Duration (IOP-LD)," due to employment with the developer organization.
- Hospital Committee:
  - One member was recused from MUC 049, "Thirty-day Risk Standardized Death Rate among Surgical Inpatients with Complications (Failure-to-Rescue)," due to membership on the technical expert panel.
  - Two members were recused from MUC 188, "Patient Safety Structural Measure," due to membership on the technical expert panel.
  - One member was recused for MUC 72, "Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery, Patient Reported Outcome-Based Performance Measure," due to membership on the technical expert panel.
- PAC/LTC Committee:
  - No recusals.

In the MSR committees, one recommendation group member had a conflict with CBE #00407-01-C-ESRDQIP, "Kt/V Dialysis Adequacy (Comprehensive)," as they had assisted in early measure development. This conflict led to this member's recusal from voting on this measure.

In the CQMC committees, the partner entities, and not the CBE, manage the members' disclosures of interest and any conflicts, mitigations, or recusals.

Also in 2023, Battelle convened approximately 430 volunteer individuals or organizations across ten multistakeholder groups (see Appendix). Figure 7 shows the percentage of committee members who represented various health care sectors. The figure gives an idea of the proportional representation of each sector across all current CBE committees hosted by Battelle.

One additional multistakeholder group, the CQMC Full Collaborative, is represented in this figure through counts of unique organization members and not individual persons.

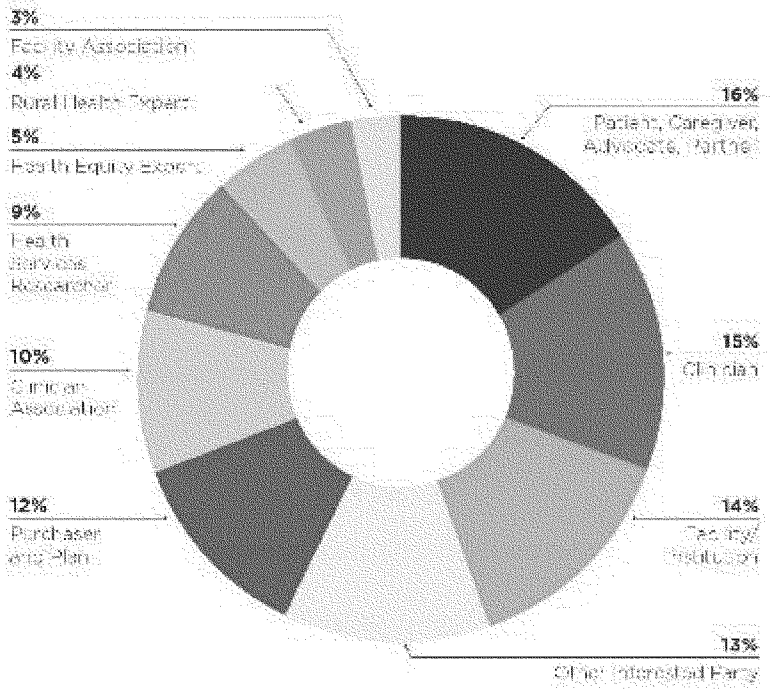
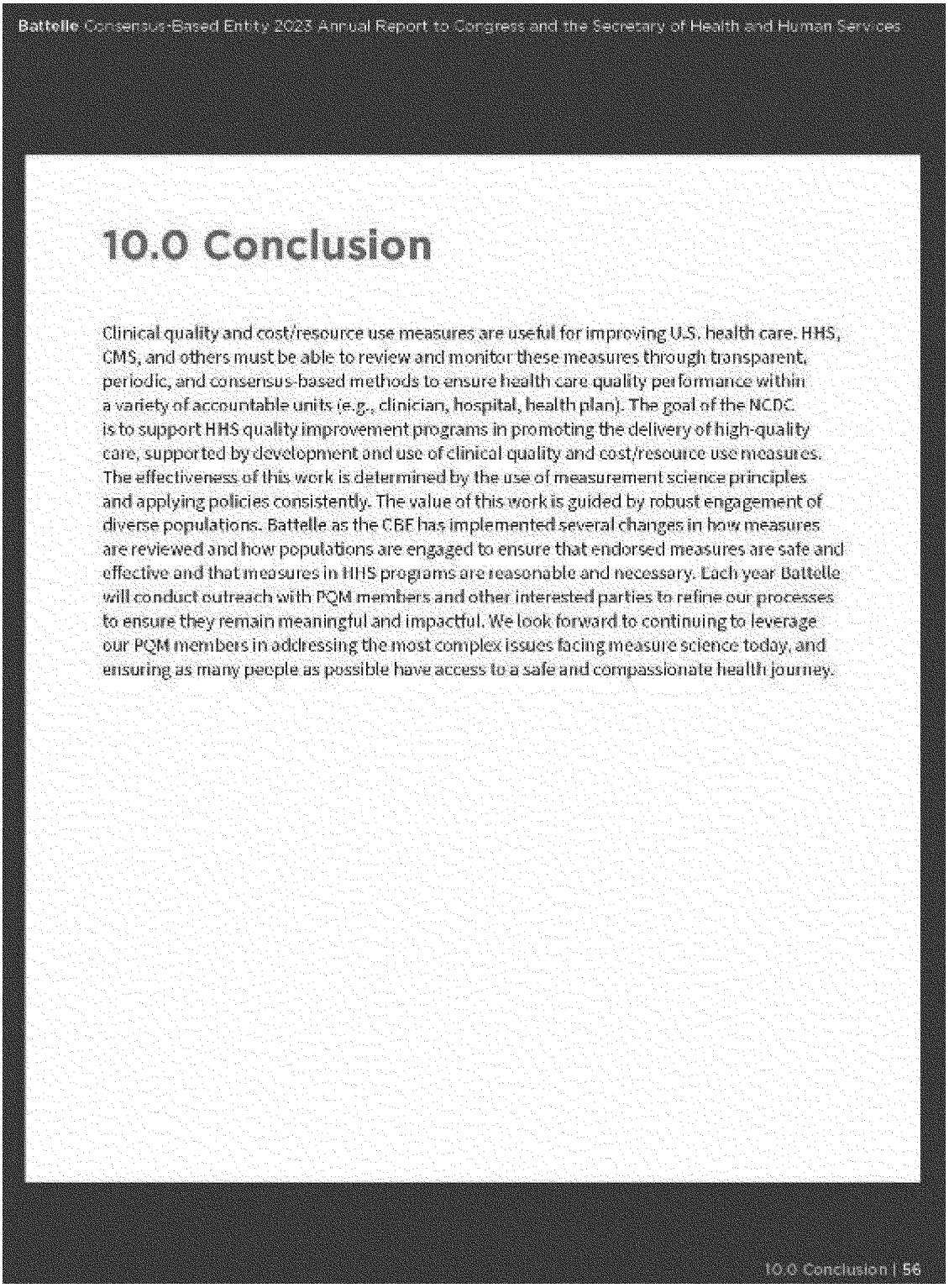


Figure 7. Proportional Representation of Health Care Sectors in PQM Committees and Other Groups in 2023

Complete rosters for all committees, workgroups, task forces, and advisory panels funded through NCDC are provided in the appendix.


Battelle Consensus-Based Entity 2023 Annual Report to Congress and the Secretary of Health and Human Services
10.0 Conclusion
Clinical quality and cost/resource use measures are useful for improving U.S. health care. HHS, CMS, and others must be able to review and monitor these measures through transparent, periodic, and consensus-based methods to ensure health care quality performance within a variety of accountable units (e.g., clinician, hospital, health plan). The goal of the NCDC is to support HHS quality improvement programs in promoting the delivery of high-quality care, supported by development and use of clinical quality and cost/resource use measures. The effectiveness of this work is determined by the use of measurement science principles and applying policies consistently. The value of this work is guided by robust engagement of diverse populations. Battelle as the CBE has implemented several changes in how measures are reviewed and how populations are engaged to ensure that endorsed measures are safe and effective and that measures in HHS programs are reasonable and necessary. Each year Battelle will conduct outreach with PQM members and other interested parties to refine our processes to ensure they remain meaningful and impactful. We look forward to continuing to leverage our PQM members in addressing the most complex issues facing measure science today, and ensuring as many people as possible have access to a safe and compassionate health journey.
10.0 Conclusion | 56

11.0 References

CMS National Quality Strategy. Centers for Medicare & Medicaid Services web site, accessed November 2023. https://www.cms.gov/medicare/quality/meaningful-measures-initiative/cms-quality-strategy

Consolidated Appropriations Act, 2021. Public Law 116–260, 116th Congress, H.R. 133, December 27, 2020. https://www.congress.gov/116/plaws/publ260/PLAW-116publ260.pdf

Contract with a Consensus-Based Entity Regarding Performance Measurement. In: Medicare Improvement Act for Patients and Providers Act (MIPPA) of 2008, §1890 [42 U.S.C. 1395aaa]. Public Law 110–275, 122 STAT. 2494 et seq., 110th Congress, H.R. 6331. July 15, 2008. https://www.ssa.gov/OP_Home/comp2/F110-275.html

Davies S., Romano P.S., Schmidt E.M., Schultz E., Geppert J.J., McDonald K.M. Assessment of a novel hybrid Delphi and nominal groups technique to evaluate quality indicators. Health Services Research. 2011 Dec; 46 (6pt1): 2005-18. https://doi.org/10.1111/j.1475-6773.2011.01297.x

National Strategy for Quality Improvement in Health Care, Part S–Health Care Quality Programs, §399HH. 42 U.S.C. 280j. Public Law 78–410, 58 Stat. 682. Approved July 1, 1944. https://www.ssa.gov/OP_Home/comp2/F078-410.html

Patient Protection and Affordable Care Act of 2010, Public Law 111–148, 124 STAT. 119 et seq, 111th Congress, H.R. 3590, March 23, 2010. https://www.congress.gov/111/plaws/publ148/PLAW-111publ148.pdf

Quality and Efficiency Measurement, Social Security Act, §1890(a) [42 U.S.C. 1395aaa-1] (a) Multi-Stakeholder Group Input Into Selection of Quality Measures. https://www.ssa.gov/OP_Home/ssact/title18/1890.htm

U.S. DHHS. 2024 Guidance for explaining the laws and regulations as they pertain to the ESRD Quality Incentive Program. ESRD Quality Incentive Program - Laws & Regulations | Guidance Portal (hhs.gov).

12.0 Abbreviations

AAB	Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis
AAMC	American Academy of Medical Colleges
ACA	Patient Protection and Affordable Care Act
AHA	American Hospital Association or American Heart Association
AHIP	American Health Insurance Partnership
CBE	Consensus-Based Entity
CBE	Strategy Consensus-Based Entity Quality Measurement Strategy
CBE ID	Consensus-Based Entity Identifier
CMIT	CMS Measure Inventory Tool
CMS	Centers for Medicare & Medicaid Services
CQMC	Core Quality Measures Collaborative
CSAC	Consensus Standards Approval Committee
E&M	Endorsement and Maintenance
ERSD QIP	End-Stage Renal Disease Quality Incentives Program
FAQ	Frequently Asked Questions
HHS	Department of Health and Human Services
Kt/V	Parameter to measure efficacy of hemodialysis (removal of a solute (K) resulting from a given treatment (t) per volume of distribution (V))
MAP	Measure Applications Partnership
MedRec	Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
MMS Hub	Measures Management System website
MIPPA	Medicare Improvement for Patients and Providers Act
MSPB	Medicare Spending Per Beneficiary
MSR	Measure Set Review
MUC	Measures under Consideration
NCDC	National Consensus Development and Strategic Planning for Health Care Quality Measurement Contract
NHDNG	Novel Hybrid Delphi and Nominal Groups
NQF	National Quality Forum
NQS	National Quality Strategy
PAC/LTC	Post-Acute Care/Long-Term Care
PQM	Partnership for Quality Measurement
PRMR	Pre-Rulemaking Measure Review
SMP	Scientific Methods Panel
SSA	Social Security Act
STAR	Submission Tool and Repository
STrR	Standardized Transfusion Ratio (STrR)
TEP	Technical Expert Panel
UFR	Ultrafiltration Rate

Appendix: PQM Multistakeholder Group Rosters

This appendix presents the current rosters for all consensus-based committees hosted and managed by PQM. Further information on each committee, including member biographies, is available on the PQM website, under the respective task areas.

Fall 2023 and Spring 2024 E&M Primary Prevention Committee Roster

NAME	ROSTER CATEGORY/PERSPECTIVE	ORGANIZATION
Abdallah, Ramsey	Facility/Institutional	Northwell Health
Angove, Rebekah	Patient Partner; Health Services Researcher; Health Equity Expert	Patient Advocate Foundation
Bowman, Kevin	Purchaser and Plan; Clinician	Elevance
Brady, Jeff	Purchaser and Plan; Clinician; Health Services Researcher; Other Interested Parties	Enterprise Research & Innovation, Highmark Health
Burdick, Jon	Clinician; Facility/Institutional	St Joseph Hospital
Campione, Joanne	Health Services Researcher; Other Interested Parties	Westat
Eggen, Melissa	Purchaser and Plan; Rural Health Expert; Health Services Researcher; Other Interested Parties	University of Louisville School of Public Health and Information Sciences
Farrell, Paula	Other Interested Parties; Clinician	Lantana Consulting Group
Herrera, Peter	Patient Partner	--
Hill, Jessica	Patient Partner	--
Ho, Michael	Health Services Researcher; Purchaser and Plan; Clinician; Facility/Institutional; Rural Health Expert	VA Eastern Colorado Health Care System and University of Colorado School of Medicine and American Heart Association
Hussein, Mahir	Health Equity Expert; Patient Partner	--
Kelley, Daniel	Patient Partner	Wellframe

Fall 2023 and Spring 2024 E&M Primary Prevention Committee Roster
(continued)

NAME	ROSTER CATEGORY/PERSPECTIVE	ORGANIZATION
Kothari, Pooja	Patient Partner; Other Interested Parties	X4 Health
Kraft, Lawrence (Larry)	Rural Health Expert	Edgar May Health and Recreation Center
Krueger, John	Rural Health Expert; Clinician; Facility/Institutional; Purchaser and Plan; Health Equity Expert; Other Interested Parties	The Chickasaw Nation Department of Health
Laios, Tim	Other Interested Parties	Health Services Advisory Group, Inc.
Levy, Shoshana	Purchaser and Plan; Clinician	CVS/Aetna
Marius, Lucy	Patient Partner	Federal Highway Administration
Mayo, Robert R.	Clinician; Facility/Institutional	Rochester Regional Health
Morris, Jean	Facility/Institutional	Maricopa Integrated Health System
Mumford, Quinyatta	Patient Partner; Health Equity Expert; Other Interested Parties	Mumford and Associates
Napier, Heather	Facility/Institutional; Clinician	Baptist Health Corbin
Patel, Padmaja	Clinician; Facility/Institutional	American College of Lifestyle Medicine; World Lifestyle Medicine Organization; Wellvana
Perez-Hudgins, Adeliza	Other Interested Parties; Clinician	New Jersey Health Care Quality Institute
Petersen, Barbara	Facility/Institutional; Patient Partner; Clinician	Great Plains Health
Pryor, David	Facility/Institutional; Clinician; Health Equity Expert	Intermountain Health
Qaseem, Amir	Clinician; Other Interested Parties	American College of Physicians
Rodgers, Kimberly	Patient Partner	--
Rozenich, Jennifer	Rural Health Expert; Facility/Institutional	Cook County Health System
Sartin, Pamela L.	Health Equity Expert; Clinician; Facility/Institutional	Chota Community Health Services
Starkey, Christa	Clinician; Patient Partner	S.W. Zimostrad and Associates P.C.

Fall 2023 and Spring 2024 E&M Primary Prevention Committee Roster
(continued)

NAME	ROSTER CATEGORY/PERSPECTIVE	ORGANIZATION
Stump, Terra	Other Interested Parties; Clinician	Quality Insights; Mathematica
Switaj, Timothy	Facility/Institutional; Clinician	West Region, WellSpan Health
Vijan, Sandeep	Facility/Institutional; Clinician; Other Interested Parties	University of Michigan Health
Williams-Bader, Jenna	Other Interested Parties	National Quality Forum

Fall 2023 and Spring 2024 E&M Initial Recognition and Management Committee Roster

NAME	ROSTER CATEGORY/PERSPECTIVE	ORGANIZATION
Ajayi, Kobi	Patient Partner; Health Equity Expert; Health Services Researcher; Other Interested Parties	Texas Department of State Health Services
Anderson, Kory	Facility/Institutional; Clinician	Intermountain Physician Advisor Services; McKay-Dee Hospital, Intermountain Health
Austin, Matt	Health Services Researcher	Johns Hopkins Armstrong Institute for Patient Safety and Quality
Ballit, Jennifer	Clinician	Case Western Reserve University
Bailly, Edward	Facility/Institutional	Mount Sinai Health Partners
Barker, Danny	Clinician; Facility/Institutional	Intermountain Health
Bartsch, Juliet	Patient Partner; Clinician; Facility/Institutional	TNAA/INOVA Health System
Bhu, Sherly	Other Interested Parties; Clinician; Facility/Institutional	REL Group Inc
Blazier, Jill	Rural Health Expert; Clinician; Facility/Institutional	Intermountain Health
Bosci, Gregary	Facility/Institutional; Clinician	Department of Pathology, University of Colorado Anschutz Medical Campus
Brasel, Tracey H.	Rural Health Expert; Facility/Institutional	Pinckneyville Community Hospital
Bream, Kent	Clinician; Facility/Institutional; Health Equity Expert; Health Services Researcher	University of Pennsylvania; Spectrum Health Services, Inc.
Caceres, Billy A.	Health Equity Expert; Clinician; Health Services Researcher	Columbia University
Campbell, Kyle	Other Interested Parties; Clinician; Health Services Researcher	Health Services Advisory Group, Inc.
Comiskey, Ashley	Clinician; Facility/Institutional	Baptist Health Paducah
Dantes, Raymond	Clinician; Facility/Institutional; Other Interested Parties	Emory University School of Medicine; Centers for Disease Control and Prevention
Ellison, Mark	Purchaser and Plan	Elevance Health
Fernandes, Karen M.	Patient Partner; Clinician	AYR Consulting Group
Guttman, Oren	Facility/Institutional; Clinician	Jefferson Abington Health; Sidney Kimmel Medical College

Fall 2023 and Spring 2024 E&M Initial Recognition and Management Committee Roster *(continued)*

NAME	ROSTER CATEGORY/PERSPECTIVE	ORGANIZATION
Haskell, Helen	Patient Partner	Mothers Against Medical Error
Hemmelgarn, Carole	Patient Partner; Other Interested Parties	MedStar Institute for Quality and Safety; Self and Patients for Patient Safety US
Hurley, Janet	Facility/Institutional; Clinician	CHRISTUS Health
Ingber, Hannah	Other Interested Parties	National Quality Forum
Jacob, Abraham	Clinician; Facility/Institutional	University of Minnesota; M Health Fairview
Jah, Zainab	Patient Partner; Health Equity Expert; Other Interested Parties	Reproductive Health Impact: The Collaborative for Equity and Justice
Johnson, Karen	Other Interested Parties; Health Services Researcher	American Urological Association
Klyowitz, Barbara	Patient Partner; Health Equity Expert	--
Kraemer, Marianne	Health Equity Expert; Clinician	Sepsis Alliance
Leckrone, Lisa	Rural Health Expert; Facility/Institutional	St. Mary Medical Center
Llewellyn, Anne	Patient Partner; Clinician	--
Love, Tammy	Other Interested Parties; Clinician	Oracle Health
McCord, Selena	Rural Health Expert; Health Equity Expert; Other Interested Parties	National Rural Health Resource Center
Merryweather-Arges, Patricia	Patient Partner	Project Patient Care
Ojeda-Avila, Tamaire	Other Interested Parties	Commission of Dietetic Registration
Owens-Collins, Sheila	Clinician; Other Interested Parties	Lexington-Fayette County Health Department
Purcell, Cecilia	Patient Partner	--
Sakala, Carol	Health Services Researcher; Other Interested Parties	National Partnership for Women & Families
Sasson, Talia	Clinician; Facility/Institutional; Other Interested Parties	University of Rochester School of Medicine and Dentistry
Sood, Geeta	Health Services Researcher; Clinician; Facility/Institutional; Other Interested Parties	Johns Hopkins Medical Center

Fall 2023 and Spring 2024 E&M Initial Recognition and Management Committee Roster *(continued)*

NAME	ROSTER CATEGORY/PERSPECTIVE	ORGANIZATION
Spiegel, Thomas	Facility/Institutional; Clinician; Other Interested Parties	The University of Chicago Medicine
Tilly, Jean-Luc	Purchaser and Plan; Other Interested Parties	The Leapfrog Group
Trivedi, Pranali	Health Equity Expert; Facility/Institutional; Other Interested Parties	Ascension
Venkatesh, Arjun	Health Services Researcher; Clinician; Other Interested Parties	Yale University School of Medicine; Yale New Haven Hospital
Venugopal, Usha	Health Equity Expert; Clinician; Facility/Institutional	NYC Health
Wilding, Karen	Facility/Institutional; Other Interested Parties	Nemours Children's Health
Young, Janice	Facility/Institutional; Clinician; Other Interested Parties	HCA Florida Ocala Health

Fall 2023 and Spring 2024 E&M Management of Acute Events and Chronic Disease Committee Roster

NAME	ROSTER CATEGORY/PERSPECTIVE	ORGANIZATION
Albers, Lisa	Purchaser and Plan	CalPERS
Albert-Hultz, Kyle	Clinician; Facility/Institutional	Memorial Healthcare System- Memorial Regional Hospital
Ardise, Joshua	Purchaser and Plan; Clinician; Other Interested Parties	Medicare - East Region, Elevance Health
Ayers, Sharon	Patient Partner	--
Bartel, Rosie	Patient Partner	--
Bowman-Zatzkin, Whitney	Patient Partner; Rural Health Expert; Health Equity Expert; Other Interested Parties	Rare Dots Consulting
Clayman, David	Other Interested Parties; Clinician	Mathematica
Commodore-Mensah, Yvonne	Health Equity Expert; Clinician; Health Services Researcher; Other Interested Parties	American Heart Association, Johns Hopkins School of Nursing
Doubeni, Anna	Health Equity Expert; Clinician; Facility/Institutional	Ohio State University Wexner Medical Center
Duggan-Goldstein, Sarah	Other Interested Parties	Phreesia
Everson, Marjorie	Rural Health Expert; Clinician; Facility/Institutional	American Association of Nurse Anesthesiology
Farquhar, Marybeth	Health Services Researcher; Other Interested Parties	American Urological Association
Fergus-Rowe, Kilma	Facility/Institutional; Clinician; Health Equity Expert; Health Services Researcher	Icahn School of Medicine at Mount Sinai
Gale-Suter, Lisa	Clinician; Facility/Institutional; Health Services Researcher; Other Interested Parties	Yale University School of Medicine; YNHHSC Center for Outcomes Research & Evaluation (CORE)
Gans, Mika	Purchaser and Plan; Health Equity Expert; Other Interested Parties	Colorado Access
Glance, Laurent G.	Facility and Institutional; Clinician; Health Services Researcher; Other Interested Parties	University of Rochester Medical Center; RAND Corporation
Harrak, Michael	Facility/Institutional; Clinician; Other Interested Parties	Rush University Medical Center

Fall 2023 and Spring 2024 E&M Management of Acute Events and Chronic Disease Committee Roster *(continued)*

NAME	ROSTER CATEGORY/PERSPECTIVE	ORGANIZATION
Jenkins, Wiley D.	Rural Health Expert; Health Services Researcher	Southern Illinois University School of Medicine
Joseph, Vilma	Facility/Institutional; Clinician; Health Services Researcher; Other Interested Parties	Albert Einstein College of Medicine/Montefiore medical Center
Kavan, Amber	Other Interested Parties; Clinician	Nebraska Hospital Association
Khan, Nasir	Other Interested Parties; Facility/Institutional	Loyola Medicine; Trinity Health
Little, Vilma	Rural Health Expert; Facility/Institutional; Other Interested Parties	Zero Overdose; Concert Health
Mahan, Charles	Clinician; Facility/Institutional	University of New Mexico (UNM)
Mamma, Abate	Other Interested Parties	New Jersey Hospital Association
May, David P.	Facility/Institutional; Clinician; Other Interested Parties	Jefferson Health
Mayne, Raquel	Facility/Institutional; Clinician	Phelps Hospital Northwell Health
Nagel, Jill	Facility/Institutional	Mayo Clinic
Pugh, Ashley	Patient Partner	National Committee for Quality Assurance
Sartor, Monique	Patient Partner	Oakland Home Care
Schast, Aileen P.	Health Equity Expert; Clinician; Facility/ Institutional; Other Interested Parties	Jefferson Einstein Hospital
Schoenthaler, Antoinette	Health Equity Expert	NYU Langone Health
Shahian, David M.	Health Services Researcher; Clinician; Facility/ Institutional; Health Equity Expert; Other Interested Parties	Dept. of Surgery and Division of Cardiac Surgery, Massachusetts General Hospital; Harvard Medical School
Shirley, Benjamin	Other Interested Parties	Pharmacy Quality Alliance
Slocum, Chloe	Clinician; Patient Partner; Facility/Institutional	Harvard Medical School, Spaulding Rehabilitation Network at Mass General Brigham, Harvard Medical School Department of Physical Medicine and Rehabilitation
Tait-Dinger, Ashley	Purchaser and Plan; Other Interested Parties	Florida Alliance for Healthcare Value
Theodoropoulos, Eleni	Other Interested Parties	URAC

Fall 2023 and Spring 2024 E&M Management of Acute Events and Chronic Disease Committee Roster *(continued)*

NAME	ROSTER CATEGORY/PERSPECTIVE	ORGANIZATION
Thicklin, Florence	Patient Partner	--
Tierney, Samantha	Other Interested Parties	American College of Physicians
Tignanelli, Christopher	Health Services Researcher; Clinician; Facility/Institutional; Other Interested Parties	University of Minnesota Medical School
Tucker, Vandolynn	Patient Partner	--
Valdes, Marisa	Clinician; Facility/Institutional; Other Interested Parties	Baylor Scott and White Health
Vik-Shah, Vikram	Purchaser and Plan; Clinician; Other Interested Parties	Cigna
Votaw, Misty	Patient Partner	FH Foundation Advocate
Wagner, John	Facility/Institutional; Clinician; Health Equity Expert	NYC Health + Hospitals/Kings County
Wasfy, Jason H.	Clinician; Facility/Institutional; Health Services Researcher	Massachusetts General Hospital; Harvard Medical School
Wilcox, Jamieson	Clinician; Facility/Institutional; Other Interested Parties	University of Southern California; Keck Medicine of USC
Young, Bianca	Patient Partner	--
Youngstrom, Eric A.	Other Interested Parties	University of North Carolina Chapel Hill; Helping Give Away Psychological Science
Yuce, Tarik	Health Services Researcher; Clinician; Facility/Institutional; Health Equity Expert; Other Interested Parties	Indiana University School of Medicine
Zima, Bonnie T.	Clinician; Facility/Institutional; Health Services Researcher	UCLA Semel Institute for Neuroscience and Human Behavior; Mental Health Informatics and Data Science (MINDS) Hub

Fall 2023 and Spring 2024 E&M Advanced Illness and Post-Acute Care Committee Roster

NAME	ROSTER CATEGORY/PERSPECTIVE	ORGANIZATION
Ayeni, Ginette	Facility/Institutional; Clinician	Aspire Health
Clark, Sheila	Health Equity Expert; Patient Partner; Other Interested Parties	California Hospice and Palliative Care Association (CHAPCA)
Crum, Erin	Other Interested Parties	McKesson
DeMarzo, Brigette	Facility/Institutional; Other Interested Parties	Northwestern Medicine
Dooley, Lea	Patient Partner	Nationwide Children's Hospital
Fugate, Karie	Patient Partner	Retired, The Boeing Company
Gainhutt, Paul	Patient Partner	M Health Fairview | University of Minnesota Medical Center
Groves, Brenda	Patient Partner	KFMC Health Improvement Partner
Hamilton, Morris	Other Interested Parties; Health Services Researcher	Abt Associates
Josberger, Raina	Purchaser and Plan; Health Services Researcher; Other Interested Parties	Center for Applied Research and Evaluation, New York State Department of Health
Jun, Soojin	Patient Partner; Clinician	Patients for Patient Safety US
Keane, Nicole	Other Interested Parties; Clinician	Abt Associates
Kohler, Andrew	Rural Health Expert; Clinician; Facility/ Institutional	Rappahannock Health, Atlantic Telehealth
Labson, Margherita	Clinician; Other Interested Parties	MC Labson Consultation and Education Services
Lamb, Geri	Clinician; Other Interested Parties	Arizona State University
Latif, Omar	Purchaser and Plan; Clinician; Other Interested Parties	Elevance Health
Liss, Yaakov	Clinician; Facility/Institutional	Optum Tristate
Martin, Emily	Clinician; Facility/Institutional	University of California, Los Angeles
Matthews, Kyle	Patient Partner	National Kidney Foundation & Nevada Kidney Disease Prevention and Education Taskforce
Moore, Shelby	Facility/Institutional	HeartLinks
Nicolla, Jonathan	Other Interested Parties	Palliative Care Quality Collaborative

***Fall 2023 and Spring 2024 E&M Advanced Illness and Post-Acute Care Committee Roster** (continued)*

NAME	ROSTER CATEGORY/PERSPECTIVE	ORGANIZATION
Outwater-Wright, Sassy	Patient Partner	Massachusetts Association for the Blind and Visually Impaired (MABVI)
Raskolnikov, Dima	Facility/Institutional; Clinician	Montefiore/Albert Einstein College of Medicine
Regnier, Marla	Rural Health Expert; Facility/Institutional	Sanford Health
Rice, Kristin	Patient Partner	Allegis Group
Seidl, Kristin	Clinician; Facility/Institutional	University of Maryland Medical Center & University of Maryland School of Nursing
Siebert, Carol	Health Equity Expert; Clinician; Other Interested Parties	The Home Remedy
Smith, Cardinale	Health Equity Expert; Clinician; Facility/Institutional; Health Services Researcher; Other Interested Parties	Division of Hematology/ Medical Oncology and Brookdale Department of Geriatrics and Palliative Medicine; Tisch Cancer Hospital, The Mount Sinai Hospital; The Mount Sinai Health System
Staley, Alicia	Patient Partner	Medidata
Sternberg, Donna M.	Clinician; Facility/Institutional	Hampton University Proton Therapy Institute
Swain-Eng, Rebecca	Other Interested Parties	SEA Healthcare & The Quality Collaborative
Tatum, Paul	Clinician; Patient Partner; Facility/Institutional; Rural Health Expert; Health Services Researcher	Washington University in St. Louis; Veterans Affairs St. Louis Health Care System
Thirlwall, Sarah	Facility/Institutional; Patient Partner; Clinician	Chapters Health System
Thomas, Cher	Patient Partner; Clinician	Renal Support Network
Thompson, Heather	Facility/Institutional	LHC Group/Optum
Wood, Stephen	Patient Partner	Ventura Unified School District
West, Milli	Facility/Institutional; Other Interested Parties	Intermountain Health/Clinical Excellence
Winters-Todd, Barbara	Facility/Institutional; Clinician	Encompass Health
Wladkowski, Stephanie	Health Services Researcher	Bowling Green State University
Woods, Donna	Health Services Researcher	Centers for Healthcare Studies and Education in the Health Sciences, Feinberg School of Medicine, Northwestern University
Zein, Lama El	Purchaser and Plan; Clinician; Other Interested Parties	EmblemHealth

Fall 2023 and Spring 2024 E&M Cost and Efficiency Committee Roster

NAME	ROSTER CATEGORY/PERSPECTIVE	ORGANIZATION
Andrews, David	Patient Partner	--
Andronaco, Sapida	Clinician; Facility/Institutional	Hoag Orthopedic Institute
Bell, Alice	Clinician; Other Interested Parties	American Physical Therapy Association
Bhansali, Henish	Facility/Institutional; Clinician	--
Dipl. ABOM	Duly Health and Care	--
Borah, Bijan	Health Services Researcher; Facility/Institutional	Mayo Clinic College of Medicine and Science
Campbell, Lauren	Other Interested Parties; Health Equity Expert; Health Services Researcher	NORC at the University of Chicago
Chin, Amy	Health Services Researcher; Facility/Institutional	HSS Center for the Advancement of Value in Musculoskeletal Care & Value Management Office at HSS
Das, Sandeep	Health Equity Expert; Clinician; Facility/Institutional; Health Services Researcher	University of Texas Southwestern Medical Center
Dezii, Christopher M.	Other Interested Parties; Patient Partner; Clinician	Healthcare Quality Advocacy & Strategy Consultants, LLP
Elliott, Marisa	Facility/Institutional; Health Equity Expert	Ascension Medical Group
Ferguson, Lynn	Patient Partner	Patient and Family Advisory Council, Vanderbilt University
Geoffrey, Kimberly	Patient Partner	--
Godsey, Beth	Other Interested Parties	Wizent, Inc.
Golden, William	Purchaser and Plan; Clinician; Rural Health Expert; Health Equity Expert	University of AR for Medical Science, Arkansas Medicaid
Guinn, Megan	Facility/Institutional; Clinician; Other Interested Parties	BJC Healthcare ACO and BJC Medical Group
Halevy, Daniel	Purchaser and Plan; Clinician	Healthfirst
Hammer, Michelle	Purchaser and Plan	Elevance Health
Heidtbrink, Tera	Rural Health Expert; Facility/Institutional	Bryan Health Connect
Hoo, Emma	Purchaser and Plan	Purchaser Business Group on Health
Jhamnani, Sunny	Clinician; Facility/Institutional	TriCity Cardiology
Kallaur, Paul	Other Interested Parties	Center for the Study of Services

Fall 2023 and Spring 2024 E&M Cost and Efficiency Committee Roster (continued)

NAME	ROSTER CATEGORY/PERSPECTIVE	ORGANIZATION
Mabry, Tad	Clinician; Facility/Institutional	Mayo Clinic
Martin, John	Other Interested Parties; Health Services Researcher	Premier, Inc.
McCord, Hal	Rural Health Expert; Clinician	Spencer Fane, LLP
Miller, Harold D.	Health Services Researcher; Other Interested Parties	Center for Healthcare Quality and Payment Reform
Morrison, Seth	Patient Partner	Patient Centered Outcomes Research Institute
Needleman, Jack	Health Services Researcher	University of California, Los Angeles, Fielding School of Public Health
Plasencia, Rosa	Health Equity Expert; Other Interested Parties; Rural Health Expert	National Core Indicators, Aging and Disabilities (NCI-AD); Advancing State
Poznyak, Dmitriy	Other Interested Parties; Health Services Researcher	Mathematica
Probst, Louise Y.	Purchaser and Plan; Other Interested Plans	St. Louis Area Business Health Coalition
Roberts, Pamela	Clinician; Facility/Institutional; Health Services Researcher	Cedars-Sinai Medical Center & Physical Medicine and Rehabilitation, Cedars-Sinai Medical Center
Ruder, Shawn	Patient Partner	--
Schleich, Benjamin	Facility/Institutional	Hackensack Meridian Health; Hackensack Meridian School of Medicine
Schramke, Mary	Patient Partner	--
Schultz, David	Clinician	Evansville Primary Care
Scott, Joan Gleason	Other Interested Parties; Clinician	New Jersey Hospital Association
Senathirajah, Mahil	Other Interested Parties	Merative
Sreeramoju, Pranavi	Facility/Institutional; Clinician; Health Equity Expert; Health Services Researcher	Thomas Jefferson University Hospital, Inc., Jefferson Health
Tyree, Kim	Rural Health Expert; Facility/Institutional; Health Equity Expert; Other Interested Parties	Evergreen Family Medicine
Van Leeuwen, Danny	Patient Partner; Clinician	Health Hats
Woeppel, Margaret	Rural Health Expert; Clinician; Facility/Institutional; Other Interested Parties	Nebraska Hospital Association

2023–2024 Pre-Rulemaking Measure Review (PRMR) Clinician Committee Roster

NAME	ROSTER CATEGORY/PERSPECTIVE	ORGANIZATION
Bajaj, Puneet	Clinician; Facility/institution	University of Texas Southwestern
Barnes, Reginald	Patient, caregiver, patient advocate	Autoimmune Registry
Beffa, Lucas	Facility/institution	Cleveland Clinic
Bernis-Dougherty, Anita	Clinician association	American Physical Therapy Association
Brockman, Jennifer	Other interested party	Iowa Healthcare Collaborative
Brown, Tamara	Patient, caregiver, patient advocate	Self
Butt, Zeeshan	Clinician association	American Psychological Association
Byron, Sepheen	Other interested party	National Committee for Quality Assurance
Cerasale, Matthew	Clinician association	Society of Hospital Medicine
Cowan, Scott	Clinician; Health services researcher	Thomas Jefferson University
Dardis, Michelle	Other interested party	The Joint Commission
Drummond, Jean	Health equity	HealthCare Dynamics International
Eakin, Sarah	Clinician association; Clinician	College of American Pathologists
Fields, Robert	Facility/institution	Self
Francis, Shani	Clinician	Self
French, Jonathan	Other interested party	Healthcare and Information Management Systems Society
Friedland, Richard	Clinician; Other interested party	Hudson Valley Radiologists, P.C.
Geoghegan, Eileen	Patient, caregiver, patient advocate	Self
Griffin, Shawn	Other interested party	Utilization Review Accreditation Commission
Hawkins, Brandon	Other interested party	Stockdale Podiatry Group
Heller, Richard	Facility/institution; Health services researcher	Radiology Partners
Hines, Lisa	Clinician; Other interested party	Pharmacy Quality Alliance
Holness, Wendy	Purchaser/Plan	Pragmedic Health Solutions
Jhamnani, Sunny	Clinician; Rural health	TriCity Cardiology

***2023–2024 Pre-Rulemaking Measure Review (PRMR) Clinician Committee Roster** (continued)*

NAME	ROSTER CATEGORY/PERSPECTIVE	ORGANIZATION
Kertai, Miklos	Clinician association; Clinician; Facility/ Institution	Vanderbilt University Medical Center
Lardieri, Michael	Other interested party	Core EHR Solutions
Lubowski, Teresa	Health services researcher	IPRO
Ma, Sai	Purchaser/plan; Health services researcher	Elevance Health
MacMillan, Carlene	Clinician; Other interested party	Osmind
Moore, Gwendolyn	Patient, caregiver, patient advocate	Self
Morgan, Eileen	Patient, caregiver, patient advocate	Self
Mylod, Deirdre	Health equity	Press Ganey
Nosamiefan, Chisa	Patient, caregiver, patient advocate	Self
Ojji, Valarie	Rural health; Other interested party	MedCentre PLLC
Puri, Tipu	Clinician	Self
Qaseem, Amir	Clinician Association	American College of Physicians
Rauner, Robert	Facility/Institution; Rural health	HealthyLincoln.org (NE)
Reyna, Megan	Facility association	National Association of Accountable Care Organizations
Rivera-Edwards, Angelic	Patient, caregiver, patient advocate	Montefiore
Roman, Sheila	Clinician	Johns Hopkins University School of Medicine
Rose, Geoffrey	Clinician association; Clinician	American College of Cardiology
Rubin, Koryn	Clinician association	American Medical Association
Seidenwurm, David	Clinician association	American College of Radiology
Shames, Cary B	Purchaser/plan	AHIP
Shuemaker, Jill	Health services researcher	American Board of Family Medicine
Sonier, Julie	Other interested party	MN Measurement Collaborative
Thompson, Peggy	Patient, caregiver, patient advocate	Self
Tinloy, Bradford	Clinician; Other interested party	Vituity

***2023–2024 Pre-Rulemaking Measure Review (PRMR) Clinician Committee Roster** (continued)*

NAME	ROSTER CATEGORY/PERSPECTIVE	ORGANIZATION
Wheat, Deidre	Purchaser/plan; Rural health	Independent Health
Woodward, Jennifer	Clinician; Clinician association	American Academy of Family Physicians

* For the list of roster categories, reference the Guidebook of Policies and Procedures for Pre-Rulemaking Measure Review (PRMR) and Measure Set Review (MSR).

CLINICIAN COMMITTEE MEMBERS
FEDERAL AGENCIES
• Administration for Community Living (ACL) • Agency for Healthcare Research and Quality (AHRQ) • Centers for Disease Control and Prevention (CDC) • Department of Veterans Affairs (VA) • Health Resources and Services Administration (HRSA) • Indian Health Service (IHS) • National Institutes of Health (NIH) • Office of the National Coordinator for Health Information Technology (ONC) • Substance Abuse and Mental Health Services Administration (SAMHSA)

2023–2024 Pre-Rulemaking Measure Review (PRMR) Hospital Committee Roster

NAME	ROSTER CATEGORY/PERSPECTIVE	ORGANIZATION
Anand, Nishant	Clinician	Altais
Baker, David	Health services researcher	The Joint Commission
Bartel, Rosie	Patient, caregiver, patient advocate	Self
Basel, David	Facility/institution; Rural health	Avera Health
Bott, John	Health services researcher	Independent Consultant
Brodie, Rachel	Purchaser/plan	Purchaser Business Group on Health
Buck, Jeffrey	Health services researcher	Self
Butt, Zahid	Other interested party	HIMSS
Carvalho, Marissa	Clinician association	Duke University Health System; American Physical Therapy Association
Danforth, Melissa	Clinician association	The Leapfrog Group
Demehin, Akinluwa	Facility association	American Hospital Association
Devkaran, Subashnie	Clinician	Mayo Clinic
Dianka, Coumba	Patient, caregiver, patient advocate	Self
Dickson, Virgil	Facility association	America's Essential Hospitals
Doll, Michelle	Clinician; Health services researcher	VCU Health System
Fitts, Wendy	Clinician	University of Pennsylvania Health System (Penn Medicine) - Lancaster General Health
Frederickson, Thomas	Facility/institution; Rural health	Society of Hospital Medicine
Gandhi, Tejal	Health equity	Press Ganey
Gasperini, Jennifer	Facility association	National Association of ACOs
Gruner, Marc	Clinician association	Aligned Orthopedic & Sports Therapy at OrthoBethesda; American Academy of Physical Medicine and Rehabilitation
Harding, Ivory	Other interested party	National Kidney Foundation
Hatle, Martin	Patient, caregiver, patient advocate	Self
Hyde, Sandi	Facility/institution; Rural health	Lifepoint Health

***2023–2024 Pre-Rulemaking Measure Review (PRMR) Hospital Committee Roster** (continued)*

NAME	ROSTER CATEGORY/PERSPECTIVE	ORGANIZATION
Irwin-Scott, Virginia	Facility/institution	ChenMed
Kadom, Nadja	Clinician association	Emory University School of Medicine; American College of Radiology
Kalantar-Zadeh, Kamyar	Clinician; Health equity	Harbor-UCLA Medical Center; National Forum of ESRD Networks
Krol, David	Clinician; Other interested party	Brigham and Women's Hospital; American Psychiatric Association
Lane, Michael	Other interested party	Parkland Health
Legreid Dopp, Anna	Clinician	American Society of Health-System Pharmacists
Luu, Allison	Clinician	Los Angeles County
Lynch, Michael	Clinician; Other interested party	UPMC Health Plan
Marchnek, Julie	Clinician association	OhioHealth; American Academy of Family Physicians
Matthes, Nikolas	Health services researcher	IPRO
McBride, Tilithia	Facility association	Federation of American Hospitals
McCard, Hal	Rural health	Spencer Fane
McGaugh, Ben	Patient, caregiver, patient advocate	Mountain Pacific Quality Health
McGiffert, Lisa	Patient, caregiver, patient advocate	Self
McKnight, Elizabeth	Facility/institution	Intermountain Healthcare
Michl, Sheri	Patient, caregiver, patient advocate	Fillmore County Hospital
Minnich, Amy	Purchaser/plan	Geisinger
Moore, James	Clinician association; Facility/institution	UCLA Health; American Society of Anesthesiologists
Musser, Lara	Health equity	NYC Health + Hospitals/Jacobi/North Central Bronx
Parker, Mark	Clinician	MaineHealth
Pollak, Edward	Clinician; Other interested party	Henry Ford Health
Pollock, Benjamin	Health services researcher	Mayo Clinic

2023–2024 Pre-Rulemaking Measure Review (PRMR) Hospital Committee Roster (continued)

NAME	ROSTER CATEGORY/PERSPECTIVE	ORGANIZATION
Ramsey, Phoebe	Clinician association	Association of American Medical Colleges
Rauch, Kathleen	Facility association	Health Care Association of New York State
Runyan, Susan	Rural health; Other interested party	Runyan Health Care Quality Consulting
Silberzweig, Jeffrey	Clinician	The Rogosin Institute
Thompson, Kristine	Clinician	Mayo Clinic
Varnell, Holly	Health equity; Other interested party	Dream Big Health, cognAizant dx
Wilson, Kathy	Other interested party	ASC Quality Collaboration
Ying, Wei	Purchaser/plan	Blue Cross Blue Shield of Massachusetts
Zambrana, Isis	Facility/institution; Health equity	Jackson Health System

* For the list of roster categories, reference the Guidebook of Policies and Procedures for Pre- Rulemaking Measure Review (PRMR) and Measure Set Review (MSR).

HOSPITAL COMMITTEE MEMBERS
FEDERAL AGENCIES
• Administration for Community Living (ACL) • Agency for Healthcare Research and Quality (AHRQ) • Centers for Disease Control and Prevention (CDC) • Department of Veterans Affairs (VA) • Health Resources and Services Administration (HRSA) • Indian Health Service (IHS) • National Institutes of Health (NIH) • Office of the National Coordinator for Health Information Technology (ONC) • Substance Abuse and Mental Health Services Administration (SAMHSA)

2023–2024 Pre-Rulemaking Measure Review (PRMR) Post-Acute Care/Long-Term Care (PAC/LTC) Committee Roster

NAME	ROSTER CATEGORY/PERSPECTIVE	ORGANIZATION
Albertson, Maureen	Facility/institution	Millennium Home Care
Battaglia, Susan	Other interested party	Tara Cares
Bednarski, Donna	Clinician association	American Nephrology Nurses Association
Benton, Jeremy	Health services researcher	Indiana Family and Social Services Administration (Medicaid)
Black, Terrie	Clinician	University of Massachusetts
Blaum, Caroline	Health services researcher	National Committee for Quality Assurance
Burrows, Lara	Purchaser/plan	Aetna
Butler, Melissa	Patient, caregiver, patient advocate; Clinician	Amedisys Home Health
Coomes, J.	Facility/institution	Advent Health
Coxon, April	Facility/institution	Healing Hands Healthcare
DeBardeleben, Mary Ellen	Facility/institution	Encompass Health
DeMarzo, Brigette	Other interested party	Northwestern Medicine
Edelstein, Theresa	Facility association	New Jersey Hospital Association
Ehle, Heidi	Facility/institution; Purchaser/plan	Pro Medica
Eylgor, Jodi	Other interested party	LeadingAge
Getzer, Benjamin	Clinician	Compassus
Grotzky, Danielle	Rural health	Madonna Rehabilitation Hospitals
Haubner, Laura	Facility/institution	Tampa General Hospital
Haydon-Greatting, Starlin	Clinician; Health equity, Health services researcher	Illinois Pharmacists Association
Henwood, Patricia	Facility/institution	Thomas Jefferson University
Hofman, Laura	Clinician	LeadingAge Washington
Jakubik, Andrew	Facility/institution	Mary Free Bed Rehab
Jersey, Andrea	Clinician	Ethica Health
Jones, Warren	Health equity	Diabetes Foundation of Mississippi

2023–2024 Pre-Rulemaking Measure Review (PRMR) Post-Acute Care/Long-Term Care (PAC/LTC) Committee Roster *(continued)*

NAME	ROSTER CATEGORY/PERSPECTIVE	ORGANIZATION
Khan, Shabina	Patient, caregiver, patient advocate	Self
Kiser, Annette	Facility/institution	National Partnership for Healthcare & Hospice Innovations
Lally, Kate	Clinician association; Clinician	American Academy of Hospice and Palliative Medicine
Langham, Ronald	Clinician	Enhabit Home Health & Hospice
Leffler, Robert	Clinician	Synchrony Health Services
Lerza, Cathy	Purchaser/plan	State of Kentucky
Lillard-Green, Arion	Health equity	George Mason University
Littlehale, Steven	Other interested party	Zimmet Health Care Services Group
Logan, William	Other interested party	Care More
Luciano, Peggy	Facility/institution; Rural health	Accura Health Care
Pearlmutter, Lori	Clinician	American Physical Therapy Association
Perez, Rebecca	Other interested party	Parthenon Management
Plasencia, Rosa	Other interested party	Advancing States
Pue, Janet	Other interested party	Atrium Health
Rask, Kimberly	Facility/institution; Rural health; Other interested party	Alliant Health
Roberts, Pamela	Clinician association	American Occupational Therapy Association
Sanchez, Anthony	Patient, caregiver, patient advocate	Self
Sandin, Karl	Facility association	American Medical Rehabilitation Providers Association
Schmidt, Theresa	Health equity; Health services researcher	Real Chemistry
Schweon, Steven	Clinician	Self
Siebert, Carol	Clinician; Health equity	The Home Remedy
Sreenivas, Kiran	Facility association	American Health Care Association
Tufte, Janice	Patient, caregiver, patient advocate	Hassanah Consulting

2023–2024 Pre-Rulemaking Measure Review (PRMR) Post-Acute Care/Long-Term Care (PAC/LTC) Committee Roster *(continued)*

NAME	ROSTER CATEGORY/PERSPECTIVE	ORGANIZATION
Ukaegbu, Crystal	Patient, caregiver, patient advocate	Self
Von Raesfeld, Christine	Patient, caregiver, patient advocate	People with Empathy
Winters-Todd, Barbara	Facility/institution	Encompass Health
Yanamadala, Mamata	Clinician association	American Geriatric Society

* For the list of roster categories, reference the Guidebook of Policies and Procedures for Pre-Rulemaking Measure Review (PRMR) and Measure Set Review (MSR).

PAC/LTC COMMITTEE MEMBERS
FEDERAL AGENCIES
• Administration for Community Living (ACL) • Agency for Healthcare Research and Quality (AHRQ) • Centers for Disease Control and Prevention (CDC) • Department of Veterans Affairs (VA) • Health Resources and Services Administration (HRSA) • Indian Health Service (IHS) • National Institutes of Health (NIH) • Office of the National Coordinator for Health Information Technology (ONC) • Substance Abuse and Mental Health Services Administration (SAMHSA)

2023–2024 Pre-Rulemaking Measure Review (PRMR) / Measure Set Review (MSR) Recommendation Group Roster

NAME	ROSTER CATEGORY/PERSPECTIVE	ORGANIZATION
Barnes, Reginald	Patient, caregiver, patient advocate	Autoimmune Registry
Bednarski, Donna	Clinician association	American Nephrology Nurses Association
Cerasale, Matthew	Clinician association	University of Chicago, Society of Hospital Medicine
DeBardeleben, Mary Ellen	Facility/institution	Encompass Health
Demehin, Akinluwa	Facility association	American Hospital Association
Dickson, Virgil	Facility association	America's Essential Hospitals
Doll, Michelle	Clinician; Health services researcher	VCU Health System
Drummond, Jean	Health equity	HealthCare Dynamics International
Fitts, Wendy	Clinician	University of Pennsylvania Health System (Penn Medicine) - Lancaster General Health
Geoghegan, Eileen	Patients, caregiver, patient advocate	Self
Haydon-Greatting, Starlin	Clinician; Health equity; Health services researcher	SHG Clinical Consulting and Population Health
Irwin-Scott, Virginia	Facility/institution	CherMed
Jones, Warren	Health equity	University of Mississippi Medical Center
Kalantar-Zadeh, Kamyar	Clinician; Health equity	Harbor-UCLA Medical Center; National Forum of ESRD Networks
Langham, Ronald	Clinician	Enhabit Home Health and Hospice
McBride, Tilithia	Facility association	Federation of American Hospitals
McGaugh, Ben	Patient, caregiver, patient advocate	Mountain-Pacific Quality Health Foundation
Qaseem, Amir	Clinician association	American College of Physicians
Rubin, Koryn	Clinician association	American Medical Association
Runyan, Susan	Rural health; Other interested party	Runyan Health Care Quality Consulting
Schmidt, Theresa	Health equity; Health services researcher	Real Chemistry
Shames, Cary B.	Purchaser/plan	Sharp Health Plan; AHIP

2023–2024 Pre-Rulemaking Measure Review (PRMR) / Measure Set Review (MSR) Recommendation Group Roster *(continued)*

NAME	ROSTER CATEGORY/PERSPECTIVE	ORGANIZATION
Tufte, Janice	Patient, caregiver, patient advocate	Hassanah Consulting
Ying, Wei	Purchaser/plan	Blue Cross Blue Shield of Massachusetts

* For the list of roster categories, reference the Guidebook of Policies and Procedures for Pre-Rulemaking Measure Review (PRMR) and Measure Set Review (MSR).

MSR RECOMMENDATION GROUP MEMBERS
FEDERAL AGENCIES
• Administration for Community Living (ACL) • Agency for Healthcare Research and Quality (AHRQ) • Centers for Disease Control and Prevention (CDC) • Department of Veterans Affairs (VA) • Health Resources and Services Administration (HRSA) • Indian Health Service (IHS) • National Institutes of Health (NIH) • Office of the National Coordinator for Health Information Technology (ONC) • Substance Abuse and Mental Health Services Administration (SAMHSA)

CQMC

CQMC Full Collaborative Voting Member Organizations

- Aetna
- American Academy of Family Physicians (AAFP)
- American Academy of Hospice and Palliative Medicine (AAHPM)
- American Academy of Orthopaedic Surgeons (AAOS)
- American Academy of Pediatrics (AAP)
- American Association on Health and Disability (AAHD)
- American Benefits Council
- American Board of Family Medicine Foundation (ABFM Foundation)
- American College of Cardiology (ACC)
- American College of Emergency Physicians (ACEP)
- American College of Obstetricians and Gynecologists (ACOG)
- American College of Physicians (ACP)
- American Gastroenterological Association (AGA)
- American Geriatrics Society (AGS)
- American Heart Association
- American Medical Association (AMA)
- American Occupational Therapy Association
- American Psychiatric Association
- American Specialty Health (ASH)
- America's Health Insurance Plans (AHIP)
- AmeriHealth Caritas
- Arkansas Blue Cross Blue Shield
- Blue Cross and Blue Shield of North Carolina (BCBSNC)
- Blue Cross Blue Shield Association
- Blue Cross Blue Shield of Michigan
- Bone Health and Osteoporosis Foundation
- Business Group on Health
- CareFirst Blue Cross Blue Shield
- Centene
- Centers For Medicare & Medicaid Services (CMS)
- Cigna Healthcare
- College of American Pathologists (CAP)
- Consumers' Checkbook/Center for the Study of Services
- Council of Medical Specialty Societies (CMSS)
- Defense Health Agency (DHA)
- Elevance Health
- Health Care Service Corporation (HCSC)
- Health Resources and Services Administration (HRSA)
- HealthCareTN
- HealthPartners
- HIV Medicine Association of the Infectious Diseases Society of America
- Humana
- Independent Health
- Integrated Healthcare Association (IHA)
- Kaiser Permanente
- Kentuckiana Health Collaborative
- Minnesota Community Measurement
- National Association of ACOs (NAACOS)
- National Patient Advocate Foundation (NPAF)
- Purchaser Business Group on Health (PBGH)
- Shatterproof
- Society for Maternal-Fetal Medicine (SMFM)
- The Leapfrog Group
- U.S. Department of Veterans Affairs (VA)
- UnitedHealth Group
- Wisconsin Collaborative for Healthcare Quality (WCHQ)

CQMC Full Collaborative Non-Voting Member Organizations

- Ambulatory Surgery Center (ASC) Quality Collaboration
- American College of Lifestyle Medicine
- American Hospital Association (AHA)
- American Institute for Research (AIR)
- Children's Hospital Association (CHA)
- Civitas Network for Health
- Contexture
- GIQuIC
- Health Care Transformation Task Force (HCTTF)
- Hematology Oncology Pharmacy Association
- National Committee for Quality Assurance (NCQA)
- Oracle Cerner
- Pharmacy Quality Alliance (PQA)
- Rise, Inc.
- Texas Medical Association (TMA)
- Vizient

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Submission for Office of Management and Budget Review; Office of Community Services Affordable Housing and Supportive Services Demonstration Data Collection (Office of Management and Budget #: 0970–0628)

AGENCY: Office of Community Services, Administration for Children and Families, U.S. Department of Health and Human Services.

ACTION: Request for public comments.

SUMMARY: The Office of Community Services (OCS), Administration for Children and Families (ACF), U.S. Department of Health and Human Services, is requesting an extension of approval for a recently approved information collection: OCS Affordable Housing and Supportive Services Demonstration (Office of Management and Budget (OMB) #: 0970–0628, Expiration Date: September 30, 2024). This information collection was originally approved for 6 months as an emergency approval. In addition to extending the approval, OCS seeks to update the burden estimates to accommodate an anticipated increase in the number of grant recipients, as well as to collect additional responses to several of the instruments. OCS also seeks to make updates to approved forms.

DATES: *Comments due October 3, 2024.* OMB must make a decision about the collection of information between 30 and 60 days after publication of this document in the **Federal Register**. Therefore, a comment is best assured of having its full effect if OMB receives it within 30 days of publication.

ADDRESSES: Written comments and recommendations for the proposed information collection should be sent within 30 days of publication of this notice to *www.reginfo.gov/public/do/PRAMain.* Find this particular information collection by selecting ''Currently under 30-day Review—Open for Public Comments'' or by using the search function. You can also obtain copies of the proposed collection of information by emailing *infocollection@acf.hhs.gov.* Identify all emailed requests by the title of the information collection.

SUPPLEMENTARY INFORMATION: OCS is seeking to continue collecting the information requested from grant recipients under OMB #: 0970–0628. In order to determine best practices in the implementation of supportive services in the affordable housing context and describe how supportive services help residents to improve well-being and economic mobility, OCS will engage in the following activities:

- Conducting interviews with program directors and caseworkers to understand program implementation.
- Conducting focus groups with residents to understand their needs and how the services funded by this grant impacted their lives.
- Administering a self-sufficiency matrix to residents receiving intensive services to understand the impact of the program on various domains of well-being.
- Conducting a questionnaire with residents, to see if they were able to access more services due to the funding.
- Collecting information from program officers about the number and types of services/events provided, aggregate demographics of residents served, partner organizations and referrals, and how the housing community was impacted by the grant funding.
- Collecting narrative reports from program officers about the progress of implementation of the program.

This request is to extend the approved collection period to 3 years, which will permit OCS to complete the collection with current grant recipients as well as future grant recipients. With an extended timeline, OCS will request additional responses for several approved instruments to observe activities over the course of the full project period for grant recipients. The self-sufficiency matrix and service receipt questionnaires will be administered every 6 months during the project period. The semi-annual quantitative report mandatory and optional forms will be required every 6 months, with a final cumulative report. The quarterly narrative PPR will be requested every quarter of the project period.

OCS has developed substantially revised 2024 versions of the semi-annual quantitative report forms for the mandatory and optional reports to broaden the measures of service delivery and outcomes to better accommodate the universe of potential services offered by future cohorts of grant recipients. The new mandatory form combines the direct services and referrals tabs of the original form into a single tab where grant recipients will report the number of individuals receiving services through AHSSD funding and through the organization's other funding sources, alongside the information reported about referrals. The new optional form broadens the list of outcome measures that grant recipients can choose to report for the individuals they serve. In consideration of the overall reporting burden for grant recipients, the 2024 version of the forms continue draw upon the service and outcome categories that grant recipients already use to report their Community Services Block Grant-related activities (OMB# 0970–0492). Additionally, the 2024 version of the forms request cumulative counts across the grant period, negating the need for a separate final report.

Current grant recipients will be able to choose between using the current 2023 version of the forms and the revised 2024 version of the forms through the completion of their current project. New grant recipients will be required to use the 2024 version of the forms.

Respondents: There will be three types of respondents to the proposed instruments. First, the direct beneficiaries, the clients receiving supportive services, will participate in the service receipt questionnaire, self-sufficiency matrix, and focus groups, and they will also provide information about their characteristics, needs, and outcomes for the grant recipients' semi-annual quantitative reporting. Second, the program directors and social services staff will respond to interview instruments tailored to their roles. Grant recipients will also be asked to complete quarterly narrative PPRs and semi-annual quantitative reports to describe their service delivery activities, and outcomes.

Annual Burden Estimates

Burden estimates show the total number of responses per respondent over the next 3 years. The current grant recipients (9 total) will be able to choose between using the 2023 version of the semi-annual quantitative report forms and the 2024 version of those forms through the completion of their current project. New grant recipients (9 new recipients estimated) will be required to use the 2024 version of the forms.