Partnership for Quality Measurement
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National Consensus Development and Strategic Planning for Health Care Quality Measurement

2025-2026 Pre-Rulemaking Measure Review Final Recommendations Report

FEBRUARY 2026

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Executive Summary

Battelle, as the consensus-based entity (CBE) holding the national consensus development contract, managed the Pre-Rulemaking Measure Review (PRMR) process for the 2025-2026 cycle. We convened the Partnership for Quality Measurement (PQM) committee members to review measures submitted to the Centers for Medicare & Medicaid Services (CMS) as part of the pre-rulemaking process.

These committee members considered the critical question: Is the measure reasonable and necessary for use in the intended CMS quality reporting and value-based program(s)? Sponsored and overseen by CMS, the PRMR process provides recommendations to the Department of Health and Human Services (HHS) on selecting quality and efficiency measures under consideration (MUC) for use by HHS.

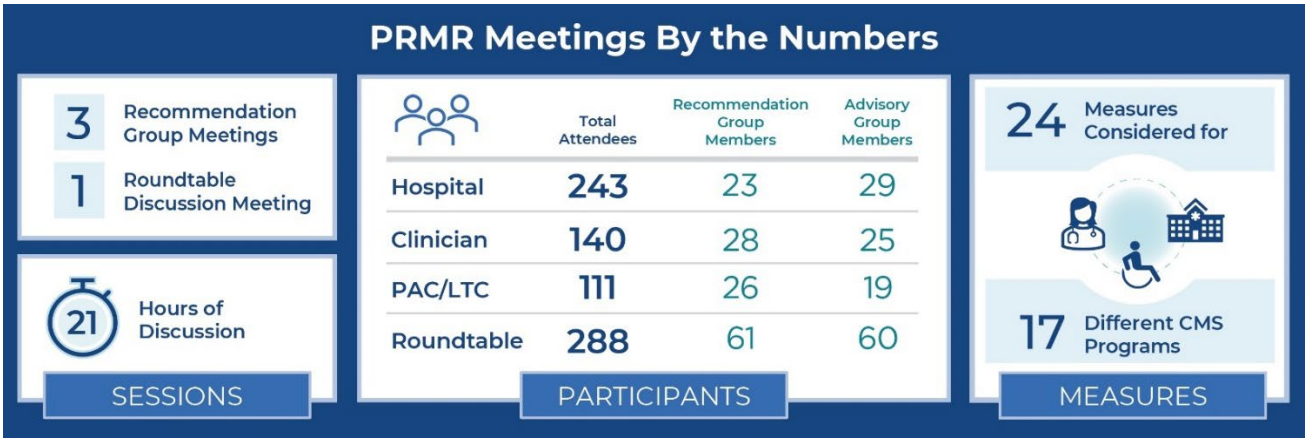

Figure 1. PRMR 2025 Meetings by the Numbers

Across three setting-specific committees, committee members reviewed 24 measures spanning 17 CMS programs, as shown in Figure 2. Of the 52 measure-to-program votes scheduled, the committees:

- Reached consensus agreement and recommended 21 measures.
- Did not reach consensus but showed majority support for 7 measures.
- Did not reach consensus and expressed majority concern for 4 measures.

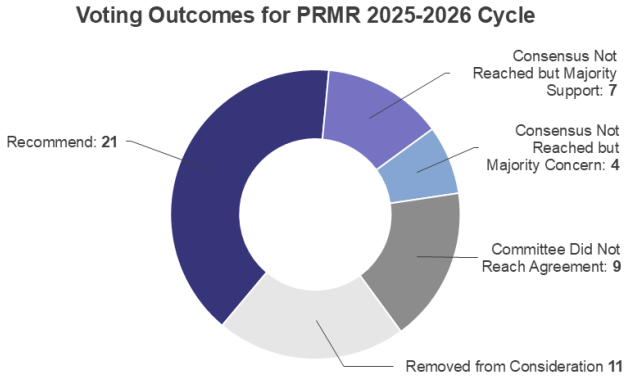

Figure 2. Voting Outcomes by the Numbers

- Did not reach agreement on 9 measures.[1]

Section 1.5 includes an explanation of the voting guidelines.

This report summarizes the PRMR process, encompassing the following overarching steps:

Public Engagement: Battelle held a written public comment period from December 16, 2025-January 6, 2026. Battelle also hosted three setting-specific listening sessions where members of the public provided spoken feedback on measures under consideration.

Preliminary Measure Assessment: Battelle staff conducted a preliminary assessment (PA) on PRMR evaluation criteria for each measure to inform and support committee members' reviews of the MUC List measures assigned to their committee.

Committee Discussion: In three meetings spanning 3 days, Battelle convened the Advisory and Recommendation Group members of the Clinician, Hospital, and Post-Acute Care/Long-Term Care (PAC/LTC) committees together with CMS leadership and measure developers to evaluate the 24 measures under consideration for 17 CMS programs.

PRMR Votes and Outcomes: Table 1 outlines the final program-specific votes of the Recommendation Groups for each CMS program. Section 1 describes the PRMR activities, voting guidelines, and special considerations for the PRMR cycle this year due to the government shutdown in October 2025. Section 2 presents detailed discussions for each measure and voting outcomes. Section 3 outlines common themes across the measure discussions as well as considerations for areas of further development and interest for CMS to explore based on the input of interested parties during this PRMR cycle.

[1] CMS removed MUC2025-020 Advance Care Planning from consideration for 11 programs, so committees did not vote on the measure's use in those programs. These programs included: Ambulatory Surgical Center Quality Reporting Program; End-Stage Renal Disease Quality Incentive Program; Home Health Quality Reporting Program; Hospital Outpatient Quality Reporting Program; Inpatient Psychiatric Facility Quality Reporting Program; Inpatient Rehabilitation Facility Quality Reporting Program; Long-Term Care Hospital Quality Reporting Program; Merit-based Incentive Payment System; Rural Emergency Hospital Quality Reporting Program; Skilled Nursing Facility Quality Reporting Program; and Skilled Nursing Facility Value-Based Purchasing Program.

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Table 1. PRMR Recommendations for 2025 Measures Under Consideration[2]

MUC ID	Measure Title	CMS Program	Vote Outcome	Vote Count[3]
MUC2025-011	Dialysis Facility Discussion of Patient Life Goals	End-Stage Renal Disease Quality Incentive Program	Although **consensus was not reached, the majority of the committee expressed some concern** about use of the measure in the End-Stage Renal Disease Quality Incentive Program.	7 (33%) Recommend, 14 (67%) Do Not Recommend
MUC2025-016	Excess Antibiotic Duration for Adult Hospitalized Patients with Uncomplicated Community-Acquired Pneumonia	Hospital Inpatient Quality Reporting Program	The committee **did not reach agreement** on use of the measure in the Hospital Inpatient Quality Reporting Program.	10 (50%) Recommend, 10 (50%) Do Not Recommend
MUC2025-016	Excess Antibiotic Duration for Adult Hospitalized Patients with Uncomplicated Community-Acquired Pneumonia	Medicare Promoting Interoperability Program	The committee **did not reach agreement** on use of the measure in the Medicare Promoting Interoperability Program.	11 (55%) Recommend, 9 (45%) Do Not Recommend
MUC2025-019	Inappropriately Broad Empiric Antibiotic Selection for Adult Hospitalized Patients with Uncomplicated Community-Acquired Pneumonia	Hospital Inpatient Quality Reporting Program	The committee **did not reach agreement** on use of the measure in the Hospital Inpatient Quality Reporting Program.	10 (48%) Recommend, 11 (52%) Do Not Recommend
MUC2025-019	Inappropriately Broad Empiric Antibiotic Selection for Adult Hospitalized Patients with Uncomplicated Community-Acquired Pneumonia	Medicare Promoting Interoperability Program	The committee **did not reach agreement** on use of the measure in the Medicare Promoting Interoperability Program.	10 (50%) Recommend, 10 (50%) Do Not Recommend

[2] Due to rounding, percentages may not always add up to 100%.
[3] No committee members disclosed conflicts of interests that would recuse them from voting

MUC ID	Measure Title	CMS Program	Vote Outcome	Vote Count[3]
MUC2025-020	Advance Care Planning (ACP)	Ambulatory Surgical Center Quality Reporting Program	N/A	CMS removed MUC2025-020 from consideration for this program.[4]
MUC2025-020	Advance Care Planning (ACP)	End-Stage Renal Disease Quality Incentive Program	N/A	CMS removed MUC2025-020 from consideration for this program.[4]
MUC2025-020	Advance Care Planning (ACP)	Home Health Quality Reporting Program	N/A	CMS removed MUC2025-020 from consideration for this program.[4]
MUC2025-020	Advance Care Planning (ACP)	Hospital Inpatient Quality Reporting Program	The committee **reached consensus agreement to recommend** the measure for use in the Hospital Inpatient Quality Reporting Program.	19 (90%) Recommend, 2 (10%) Do Not Recommend
MUC2025-020	Advance Care Planning (ACP)	Hospital Outpatient Quality Reporting Program	N/A	CMS removed MUC2025-020 from consideration for this program.[4]
MUC2025-020	Advance Care Planning (ACP)	Hospital Value-Based Purchasing Program	Although **consensus was not reached, the majority of the committee expressed some support** for use of the measure in the Hospital Value-Based Purchasing Program.	14 (67%) Recommend, 7 (33%) Do Not Recommend
MUC2025-020	Advance Care Planning (ACP)	Inpatient Psychiatric Facility Quality Reporting Program	N/A	CMS removed MUC2025-020 from consideration for this program.[4]

[4] Because MUC2025-020 is specified and was tested at the hospital inpatient level, CMS leadership removed this measure from voting consideration for all non-relevant programs. The Recommendation Group still discussed the following programs but did not vote on them: Ambulatory Surgical Center Quality Reporting Program; End-Stage Renal Disease Quality Incentive Program; Home Health Quality Reporting Program; Hospital Outpatient Quality Reporting Program; Inpatient Psychiatric Facility Quality Reporting Program; Inpatient Rehabilitation Facility Quality Reporting Program; Long-Term Care Hospital Quality Reporting Program; Merit-based Incentive Payment System; Rural Emergency Hospital Quality Reporting Program; Skilled Nursing Facility Quality Reporting Program; and Skilled Nursing Facility Value-Based Purchasing Program.

MUC ID	Measure Title	CMS Program	Vote Outcome	Vote Count[3]
MUC2025-020	Advance Care Planning (ACP)	Inpatient Rehabilitation Facility Quality Reporting Program	N/A	CMS removed MUC2025-020 from consideration for this program.[4]
MUC2025-020	Advance Care Planning (ACP)	Long-Term Care Hospital Quality Reporting Program	N/A	CMS removed MUC2025-020 from consideration for this program.[4]
MUC2025-020	Advance Care Planning (ACP)	Medicare Promoting Interoperability Program	The committee reached **consensus agreement to recommend** the measure for use in the Medicare Promoting Interoperability Program.	16 (76%) Recommend, 5 (24%) Do Not Recommend
MUC2025-020	Advance Care Planning (ACP)	Merit-based Incentive Payment System	N/A	CMS removed MUC2025-020 from consideration for this program.[4]
MUC2025-020	Advance Care Planning (ACP)	Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program	The committee reached **consensus agreement to recommend** the measure for use in the Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program.	20 (95%) Recommend, 1 (5%) Do Not Recommend
MUC2025-020	Advance Care Planning (ACP)	Rural Emergency Hospital Quality Reporting Program	N/A	CMS removed MUC2025-020 from consideration for this program.[4]
MUC2025-020	Advance Care Planning (ACP)	Skilled Nursing Facility Quality Reporting Program	N/A	CMS removed MUC2025-020 from consideration for this program.[4]

MUC ID	Measure Title	CMS Program	Vote Outcome	Vote Count[3]
MUC2025-020	Advance Care Planning (ACP)	Skilled Nursing Facility Value-Based Purchasing Program	N/A	CMS removed MUC2025-020 from consideration for this program.[4]
MUC2025-023	CollaboRATE Shared Decision-Making Tool for Ambulatory or Outpatient Surgery Patients (Surgical CollaboRATE OAS-PM)	Ambulatory Surgical Center Quality Reporting Program	The committee **did not reach agreement** on use of the measure in the Ambulatory Surgical Center Quality Reporting Program.	12 (57%) Recommend, 9 (43%) Do Not Recommend
MUC2025-023	CollaboRATE Shared Decision-Making Tool for Ambulatory or Outpatient Surgery Patients (Surgical CollaboRATE OAS-PM)	Hospital Outpatient Quality Reporting Program	The committee **did not reach agreement** on use of the measure in the Hospital Outpatient Quality Reporting Program.	11 (52%) Recommend, 10 (48%) Do Not Recommend
MUC2025-030	Excess Days in Acute Care (EDAC) after Hospitalization for Acute Myocardial Infarction (AMI)	Hospital Inpatient Quality Reporting Program	The committee reached **consensus agreement to recommend** the measure for use in the Hospital Inpatient Quality Reporting Program.	18 (86%) Recommend, 3 (14%) Do Not Recommend
MUC2025-031	Excess Days in Acute Care (EDAC) after Hospitalization for Heart Failure (HF)	Hospital Inpatient Quality Reporting Program	The committee reached **consensus agreement to recommend** the measure for use in the Hospital Inpatient Quality Reporting Program.	19 (90%) Recommend, 2 (10%) Do Not Recommend
MUC2025-034	Low Density Lipoprotein Cholesterol (LDL-C) Monitoring and Management	Merit-based Incentive Payment System	The committee reached **consensus agreement to recommend** the measure for use in the Merit-based Incentive Payment System.	21 (78%) Recommend, 6 (22%) Do Not Recommend

MUC ID	Measure Title	CMS Program	Vote Outcome	Vote Count[3]
MUC2025-036	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction (AMI) Hospitalization	Hospital Inpatient Quality Reporting Program	The committee reached **consensus agreement to recommend** the measure for use in the Hospital Inpatient Quality Program.	17 (81%) Recommend, 4 (19%) Do Not Recommend
MUC2025-036	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction (AMI) Hospitalization	Hospital Value-Based Purchasing Program	The committee reached **consensus agreement to recommend** the measure for use in the Hospital Value-Based Purchasing Program.	16 (76%) Recommend, 5 (24%) Do Not Recommend
MUC2025-037	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Heart Failure (HF) Hospitalization	Hospital Inpatient Quality Reporting Program	The committee reached **consensus agreement to recommend** the measure for use in the Hospital Inpatient Quality Reporting Program.	17 (81%) Recommend, 4 (19%) Do Not Recommend
MUC2025-037	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Heart Failure (HF) Hospitalization	Hospital Value-Based Purchasing Program	The committee reached **consensus agreement to recommend** the measure for use in the Hospital Value-Based Purchasing Program.	15 (75%) Recommend, 5 (25%) Do Not Recommend
MUC2025-039	Excess Days in Acute Care (EDAC) after Hospitalization for Pneumonia	Hospital Inpatient Quality Reporting Program	The committee reached **consensus agreement to recommend** the measure for use in the Hospital Inpatient Quality Reporting Program.	19 (90%) Recommend, 2 (10%) Do Not Recommend
MUC2025-040	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	Hospital Inpatient Quality Reporting Program	The committee reached **consensus agreement to recommend** the measure for use in the Hospital Inpatient Quality Reporting Program.	16 (80%) Recommend, 4 (20%) Do Not Recommend

MUC ID	Measure Title	CMS Program	Vote Outcome	Vote Count[3]
MUC2025-040	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	Hospital Value-Based Purchasing Program	The committee reached **consensus agreement to recommend** the measure for use in the Hospital Value-Based Purchasing Program.	15 (75%) Recommend, 5 (25%) Do Not Recommend
MUC2025-042	Rate of Timely Follow-up on Abnormal Screening Mammograms for Breast Cancer Detection	Merit-based Incentive Payment System	Although **consensus was not reached, the majority of the committee expressed some support** for use of the measure in the Merit-based Incentive Payment System.	20 (71%) Recommend, 8 (29%) Do Not Recommend
MUC2025-043	Rate of Timely Follow-up on Positive Stool-based Tests for Colorectal Cancer Detection	Merit-based Incentive Payment System	The committee **did not reach agreement** on use of the measure in the Merit-based Incentive Payment System.	16 (57%) Recommend, 12 (43%) Do Not Recommend
MUC2025-044	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Pneumonia (PN) Hospitalization	Hospital Inpatient Quality Reporting Program	The committee reached **consensus agreement to recommend** the measure for use in the Hospital Inpatient Quality Reporting Program.	16 (80%) Recommend, 4 (20%) Do Not Recommend
MUC2025-044	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Pneumonia (PN) Hospitalization	Hospital Value-Based Purchasing Program	The committee reached **consensus agreement to recommend** the measure for use in the Hospital Value-Based Purchasing Program	15 (75%) Recommend, 5 (25%) Do Not Recommend
MUC2025-045	Adult Community-Onset (CO) Sepsis Standardized Mortality Ratio (SMR)	Hospital Inpatient Quality Reporting Program	The committee reached **consensus agreement to recommend** the measure for use in the Hospital Inpatient Quality Reporting Program.	17 (81%) Recommend, 4 (19%) Do Not Recommend

MUC ID	Measure Title	CMS Program	Vote Outcome	Vote Count[3]
MUC2025-045	Adult Community-Onset (CO) Sepsis Standardized Mortality Ratio (SMR)	Hospital Value-Based Purchasing Program	The committee **did not reach agreement** on use of the measure in the Hospital Value-Based Purchasing Program.	12 (57%) Recommend, 9 (43%) Do Not Recommend
MUC2025-046	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) Surgery	Hospital Inpatient Quality Reporting Program	The committee reached **consensus agreement to recommend** the measure for use in the Hospital Inpatient Quality Reporting Program.	17 (85%) Recommend, 3 (15%) Do Not Recommend
MUC2025-046	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) Surgery	Hospital Value-Based Purchasing Program	Although **consensus was not reached, the majority of the committee expressed some support** for use of the measure in the Hospital Value-Based Purchasing Program.	15 (71%) Recommend, 6 (29%) Do Not Recommend
MUC2025-047	Hospital Sepsis Program Core Elements Score	Hospital Inpatient Quality Reporting Program	The committee reached **consensus agreement to recommend** the measure for use in the Hospital Inpatient Quality Reporting Program.	20 (95%) Recommend, 1 (5%) Do Not Recommend
MUC2025-053	Excess Days in Acute Care (EDAC) After Hospitalization for Diabetes	Hospital Inpatient Quality Reporting Program	Although **consensus was not reached, the majority of the committee expressed some support** for use of the measure in the Hospital Inpatient Quality Reporting Program.	15 (68%) Recommend, 7 (32%) Do Not Recommend

MUC ID	Measure Title	CMS Program	Vote Outcome	Vote Count[3]
MUC2025-055	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Sepsis Hospitalization	Hospital Inpatient Quality Reporting Program	The committee reached **consensus agreement to recommend** the measure for use in the Hospital Inpatient Quality Reporting Program.	19 (95%) Recommend, 1 (5%) Do Not Recommend
MUC2025-055	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Sepsis Hospitalization	Hospital Readmissions Reduction Program	Although **consensus was not reached, the majority of the committee expressed some support** for use of the measure in the Hospital Readmissions Reduction Program.	13 (65%) Recommend, 7 (35%) Do Not Recommend
MUC2025-064	Facility Level Percentage of Chronic Hyperphosphatemia in Dialysis Patients	End-Stage Renal Disease Quality Incentive Program	The committee reached **consensus agreement to recommend** the measure for use in the End-Stage Renal Disease Quality Incentive Program.	16 (76%) Recommend, 5 (24%) Do Not Recommend
MUC2025-065	Malnutrition Care Score	Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program	The committee reached **consensus agreement to recommend** the measure for use in the Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program.	19 (95%) Recommend, 1 (5%) Do Not Recommend
MUC2025-067	Hospital Harm - Postoperative Venous Thromboembolism	Hospital Inpatient Quality Reporting Program	Although **consensus was not reached, the majority of the committee expressed some concern** about use of the measure in the Hospital Inpatient Quality Reporting Program.	7 (35%) Recommend, 13 (65%) Do Not Recommend

MUC ID	Measure Title	CMS Program	Vote Outcome	Vote Count[3]
MUC2025-067	Hospital Harm - Postoperative Venous Thromboembolism	Hospital-Acquired Condition Reduction Program	Although **consensus was not reached, the majority of the committee expressed some concern** about use of the measure in the Hospital-Acquired Condition Reduction Program.	6 (30%) Recommend, 14 (70%) Do Not Recommend
MUC2025-067	Hospital Harm - Postoperative Venous Thromboembolism	Medicare Promoting Interoperability Program	Although **consensus was not reached, the majority of the committee expressed some concern** about use of the measure in the Medicare Promoting Interoperability Program.	7 (35%) Recommend, 13 (65%) Do Not Recommend
MUC2025-072	Emergency Care Access & Timeliness (ECAT)	Hospital Inpatient Quality Reporting Program	Although **consensus was not reached, the majority of the committee expressed some support** for use of the measure in the Hospital Inpatient Quality Reporting Program.	14 (70%) Recommend, 6 (30%) Do Not Recommend
MUC2025-072	Emergency Care Access & Timeliness (ECAT)	Hospital Value-Based Purchasing Program	The committee **did not reach agreement** on use of the measure in the Hospital Value-Based Purchasing Program.	11 (52%) Recommend, 10 (48%) Do Not Recommend
MUC2025-072	Emergency Care Access & Timeliness (ECAT)	Medicare Promoting Interoperability Program	Although **consensus was not reached, the majority of the committee expressed some support** for use of the measure in the Medicare Promoting Interoperability Program.	13 (65%) Recommend, 7 (35%) Do Not Recommend

1.0 Pre-Rulemaking Measure Review (PRMR) Overview

1.1 PRMR Overview

The goal of the PRMR process is to inform the selection of health care quality and efficiency measures for use in CMS Medicare quality programs. Per statute,[5] each December HHS publishes a list of measures under consideration (MUC) for future federal rulemaking. The PRMR process provides consensus recommendations regarding measures under consideration for inclusion in CMS quality reporting and value-based programs. It focuses on evaluating a measure's appropriateness for a specific program and assessing whether the measure is meaningful, tailored to the program's unique needs, balanced, and scaled to meet program-specific goals. Additionally, the process examines if the measure demonstrates a clear vision of both near- and long-term program impacts.

The cornerstone of a transparent and meaningful consensus-based process is effective engagement of interested parties. This ensures that CMS has access to meaningful feedback on all measures proposed for inclusion in CMS quality programs. Battelle convenes and engages interested parties throughout the PRMR cycle. The interested parties include those who are impacted or affected by quality and efficiency measures. Interested parties come from a variety of groups (Figure 3) and provide a balance of perspectives.

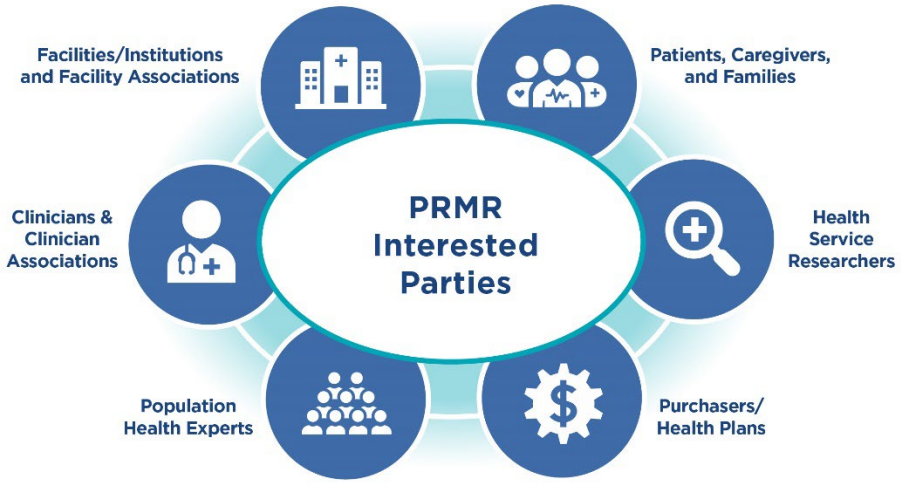

Figure 3. PRMR Interested Parties

1.2 Committee Membership & Process

Battelle staff conducted a public call for nominations and targeted outreach to solicit nominees for PRMR committees (Figure 4) in spring 2025. Battelle prioritizes individuals who 1) have previously participated in similar panels/committees or have demonstrated knowledge of these

[5] Section 3014 of the Patient Protection and Affordable Care Act of 2010 (ACA) (P.L. 111-148) created section 1890A of the Social Security Act (the Act), which required HHS to establish a federal pre-rulemaking process for the selection of quality and efficiency measures for use by HHS.

processes, 2) fit into more than one roster category, and 3) possess lived experience interacting with the health care system.

Figure 4. PRMR Committees

To ensure many perspectives are represented, Battelle includes individuals from traditionally underrepresented groups such as patients/recipients of care and caregivers, people who belong to racial/ethnic minority groups, and rural health providers as well as experts in population health in the committees.

Full committee rosters and biographies are on the PQM website.

At the start of the PRMR review process, all committee members attest to a measure disclosure of interest (DOI) form. For this cycle, no committee members were recused from voting on measures due to a potential conflict of interest (COI).

Each committee is supported by both a patient and technical co-chair. Battelle selects co-chairs based on their subject matter expertise, past contributions and engagement in the process, and ability to support discussions as needed during Recommendation Group facilitation.

Each committee includes two groups of reviewers—a Delphi group (hereafter referred to as an Advisory Group) and a nominal group (hereafter referred to as a Recommendation Group)—consistent with the principles of the Novel Hybrid Delphi and Nominal Group (NHDNG) Technique.[6] 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 advice and recommendations. Advisory Group input guides the Recommendation Groups' final consensus recommendations to CMS. Both groups work in tandem to provide meaningful impact on measures at different points of the PRMR process. The PRMR & Measure Set Review (MSR) Guidebook outlines this process in detail.

Impact of the 2025 Government Shutdown: The 2025 federal government shutdown created several disruptions that directly affected the timing and workflow of this year's PRMR cycle. The shutdown delayed CMS's publication of the MUC List, which significantly compressed the time

[6] 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

frame available for committee review and preparation. As a result, Battelle made the Pre-Meeting Initial Evaluation (PIE) Forms optional this year. Committee members complete PIE Forms as part of their measure review to prepare feedback in a structured way.

To support a thorough evaluation within these constraints, Battelle further adapted the process by combining the Advisory Group and Recommendation Group meetings, allowing the Advisory Group to directly share measure feedback with their Recommendation Group peers. This combined format provided a more comprehensive discussion, additional time for clarification, and improved continuity in the review process. These adjustments helped ensure that the committees could complete their responsibilities effectively despite the condensed timeline and external delays.

1.3 Public Engagement

Each PRMR cycle begins with the publication of the MUC List. The PRMR process engages a diverse group of interested parties across the health care and quality measurement landscape to provide perspectives on these measures (Figure 5). Interested parties provide feedback on the measures through written and spoken public comment opportunities. Battelle held a written public comment period from December 16, 2025-January 6, 2026. Battelle also hosted a series of three setting-specific listening sessions where members of the public provided spoken feedback on measures under consideration.

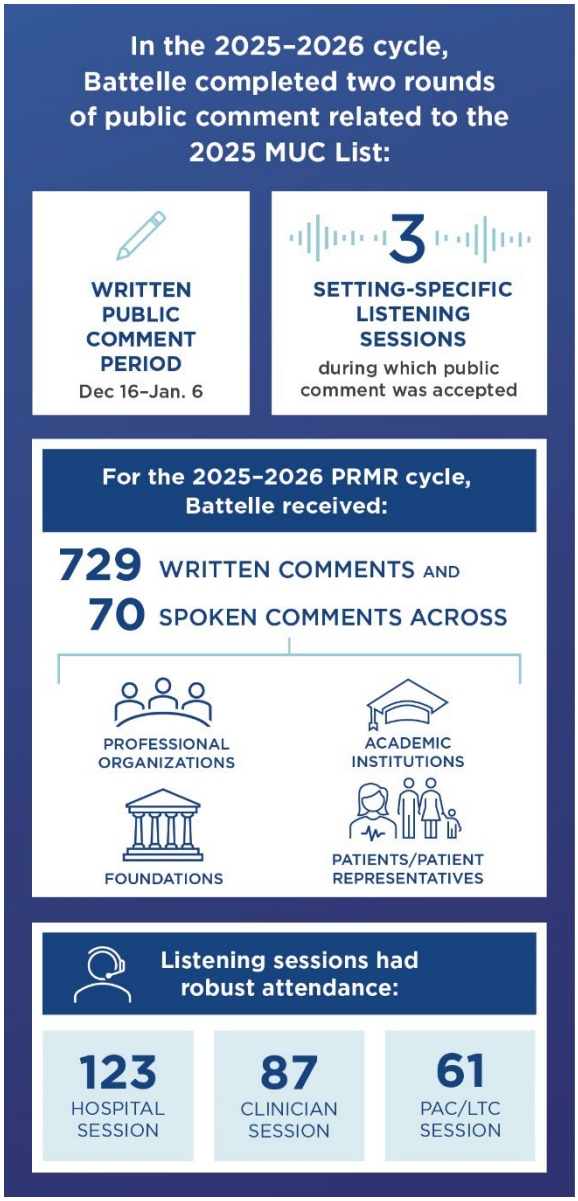

Figure 5. PRMR Public Engagement

Battelle received a total of 729 written comments and 70 spoken comments from 28 individuals and 166 organizations. A compiled list of public comments is available on the PQM website. Insights from public comments help identify areas of non-consensus to focus on during the Recommendation Group meetings. This approach ensures that the PRMR processes adequately represents the voices of many interested parties.

1.4 PRMR Preliminary Assessments & MUC List Materials

To inform and guide committee members in reviewing the MUC List, Battelle staff create a Preliminary Assessment (PA) for each measure. These PAs provide committee members with a comprehensive and standardized baseline evaluation of the measures under consideration. The PAs serve as a tool to support members as they examine and discuss the suitability of measures for the proposed CMS program, both before and during the Recommendation Group meetings.

To develop the PAs, a team of experienced measure evaluators review submission documentation in the MUC Entry/Review Information Tool (CMS MERIT) system including information provided in the submission form as well as any supplemental materials, which may include Measure Information Forms, peer-reviewed literature, clinical practice guidelines, validity and reliability testing methods and results, and electronic clinical quality measure (eCQM) feasibility testing information, as needed. The measure evaluators compare this information against the evaluation criteria outlined in the PRMR Guidebook with an emphasis on measure importance, conformance, feasibility, reliability, validity, and usability (i.e., meaningfulness), as well as the measure's appropriateness of scale and time-to-value realization for the selected CMS program.

Battelle summarizes each measure's performance on these evaluation criteria and discusses specific considerations for use of the measure within the CMS program. Each criterion is rated as "Met," "Not Met but Addressable," or "Not Met." Measures with prior CBE endorsement receive "Met" for the Meaningfulness criteria, with added discussion on merits and concerns as well as questions for committees to consider when evaluating. Relevant CMS staff and measure developers review the summaries, and Battelle staff make revisions based on collaboration with these key informants. PRMR committee members and the public have access to these PAs through the Battelle website following the MUC List publication.

While reviewing the PAs, the committees also have full access to materials submitted by measure developers in CMS MERIT. Battelle makes these available for download on the tabbed measure display pages for each of the MUC List measures.

1.5 Recommendation Group Meetings

In three meetings spanning 3 days, Battelle virtually convened both the Advisory Group and the Recommendation Group members of the Clinician, Hospital, and Post-Acute Care/Long-Term Care (PAC/LTC) committees together with CMS leadership and measure developers to evaluate the 24 MUC for 17 CMS programs. Meeting summaries with detailed discussion notes and recordings for Hospital, Clinician, and PAC/LTC Recommendation Group Meetings are available on the PQM website.

Battelle collected spoken disclosures of potential COIs during roll call at the start of each meeting. No committee members reported any conflicts.

Following opening remarks, Battelle facilitators outlined the procedures for discussing and voting on measures. At the start of each measure discussion, Battelle provided a brief measure overview and presented a summary of public comments. Battelle facilitators also provided evidence from literature reviews assessing gaps in care related to age, geography (urban vs. rural), insurance status, dual Medicare and Medicaid eligibility, and language/literacy relevant to the measure topic. CMS medical officers then provided a concise rationale for the measure from a programmatic perspective. Battelle then invited members of the Advisory Group to highlight areas of concern or support that they wanted the Recommendation Group to consider in voting. Then, patient members of both the Advisory and Recommendation Groups highlighted their perspectives, Finally, the broader Recommendation Group discussed the measure, considering all the feedback. Battelle facilitators summarized the key points of the discussion and consulted with patient and technical co-chairs on the Recommendation Group's readiness to vote. Recommendation Group members cast their votes at the conclusion of discussion for each measure.

The discussion quorum requires at least 60% of the Recommendation Group members in attendance during roll call. The voting quorum requires the presence of at least 80% of active Recommendation Group members who were not recused from the vote due to a COI. During the 3 meeting days, some members stepped away temporarily, so Battelle collected voting counts for each measure to ensure quorum was retained. When asynchronous voting occurred, Battelle followed up via email with impacted committee members and shared results at the end of the Recommendation Group meeting or via email, as necessary.

The Recommendation Group uses a structured, transparent voting process to determine whether a measure should be recommended for use in CMS programs. Committee members cast votes through Poll Everywhere, selecting one of the following options: Recommend or Do Not Recommend. When voting to recommend, members could provide optional considerations; when voting do not recommend, members had to provide a rationale.

After voting concluded, the percentage of votes cast for each option determined the committee's level of agreement, with consensus defined as at least 75% agreement. Figure 6 outlines the voting procedures.

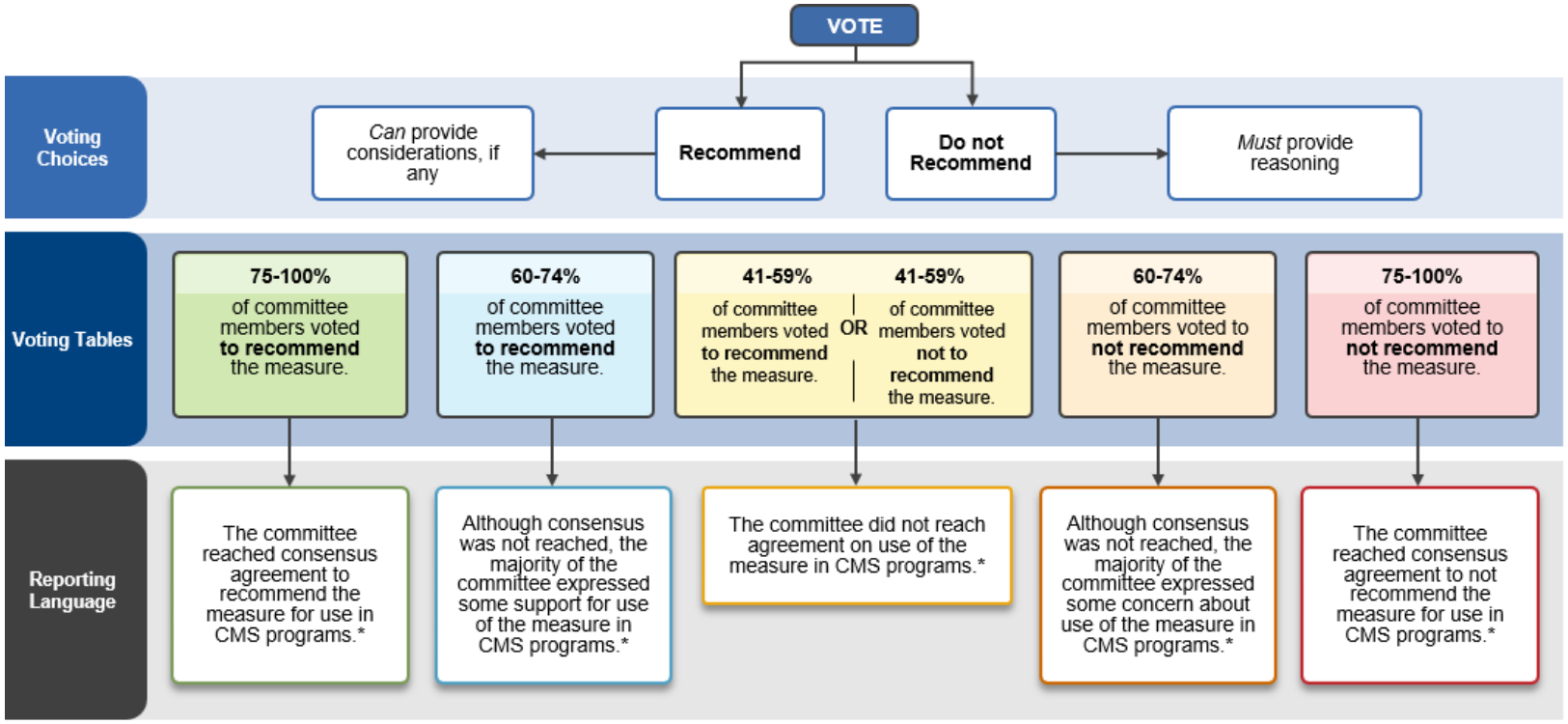

Figure 6. PRMR Voting Procedures

2.0 PRMR Recommendations

2.1 Hospital Committee Measures

2.1.1 MUC2025-036 Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction (AMI) Hospitalization [CMS]

Description: The measure estimates a hospital-level 30-day risk-standardized mortality rate (RSMR) for Medicare patients (Fee-For-Service [FFS] and Medicare Advantage [MA]) aged 65 and older discharged from the hospital with a principal diagnosis of AMI. The outcome is all-cause 30-day mortality, defined as death from any cause within 30 days of the index admission date, including in-hospital death.

Public Comment Summary: Battelle received 12 written public comments and one spoken public comment on the five RSMR measures under consideration (MUC2025-036, MUC2025-037, MUC2025-040, MUC2025-044, and MUC2025-046). Public commenters strongly supported adding MA beneficiaries and endorsed moving to a 2-year performance period to produce more timely results. Many, however, raised concerns about the reliability of combining MA and fee-for-service data and questioned the transition from HCCN categories to ICD-10 coding due to potential bias and increased variability. Commenters also cautioned that excluding social and economic risk factors could disadvantage hospitals serving vulnerable populations. Several highlighted challenges related to MA utilization practices and recommended a phased implementation to limit potential impacts on Hospital Value Based-Payments payments. Commenters further urged safeguards—such as minimum case thresholds—to manage variability, and AMI-specific feedback recommended excluding patients with palliative goals or limited life expectancy.

Closing Gaps of Care Considerations: Battelle presented the considerations for Closing Gaps of Care as a group for the RSMR measures. Battelle's literature review found that older patients face higher risks of complications and mortality due to comorbidities and frailty. Heart failure and pneumonia patients experience higher hospitalization and mortality rates than people without these conditions. Rural hospitals show gaps in care, with limited access to specialists and higher pneumonia mortality. Dual Medicare-Medicaid eligibility correlates with higher mortality from AMI. Insurance status also affects outcomes: uninsured patients face higher mortality and lower use of guideline-based therapies, while MA enrollees are more often discharged home with less post-acute care. Language and literacy barriers worsen outcomes: low health literacy among HF patients and limited English proficiency lead to poor post-discharge understanding, medication access issues, and worse outcomes after coronary procedures.[7]

Measure Review Final Vote:

Hospital Inpatient Quality Reporting Program: The committee reached consensus agreement to recommend the measure for use in the Hospital Inpatient Quality Program.

- **Vote Count:** Recommend 17 (81%), Do Not Recommend 4 (19%), No Recusals.

Hospital Value-Based Purchasing Program: The committee reached consensus agreement to recommend the measure for use in the Hospital Value-Based Purchasing Program.

[7] For complete information on the Closing Gaps of Care literature review for this measure, including references cited, please refer to the Hospital Recommendation Group Meeting slide deck.

- **Vote Count:** Recommend 16 (76%), Do Not Recommend 5 (24%), No Recusals.

Note: The following table includes RSMR measures discussed as a group, including MUC2025-036, MUC2025-037, MUC2025-040, MUC2025-044, and MUC2025-046.

Discussion Themes	Committee Member Discussion
Methodological Changes	• Committee members stated that fundamental methodological changes (reducing the reporting window, adding MA beneficiaries, and shifting to ICD-10 code–level modeling) effectively create a new metric that requires formal endorsement and rigorous technical testing. • The developer acknowledged the substantial redesign and reported that internal testing supports validity and reliability, and CMS clarified that MA data inclusion does not add burden because CMS conducts all calculations.
Impact on Rural and Low-Volume Hospitals	• Committee members cautioned that shortening the reporting window could reduce case counts for rural and low-volume hospitals and urged evaluation of potential unintended consequences. • The developer responded that adding MA beneficiaries expands the eligible cohort and offsets the reduced time frame, preserving reliability for smaller facilities.
Mortality Window Length	• Committee members questioned whether the 30-day mortality window remains appropriate and suggested testing a 15-day alternative because many deaths after day 14 appear unrelated to the index hospitalization.
Risk Adjustment	• Committee members emphasized the need to protect hospitals honoring patient preferences and requested stronger risk-adjustment markers for palliative care and do-not-resuscitate (DNR) status. • The developer affirmed that hospice patients are excluded, while palliative care patients remain included with explicit risk-adjustment indicators for DNR and palliative status to safeguard goal-concordant care. • Committee members asked whether social risk factors should be included in the model. The developer explained that social risk factors exert minimal influence on model performance and could obscure care gaps by lowering expected mortality for vulnerable populations.
MA Data Inclusion and Model Performance	• Committee members and patient representatives strongly supported adding MA beneficiaries to improve completeness, transparency, and representativeness. They also discussed that the broader diversity of the MA patient population may impact performance on these measures. • The developer confirmed that extensive testing demonstrated stable or improved model performance, and the updated risk adjustment incorporates MA status, individual ICD-10 codes, frailty markers, and palliative indicators to enhance accuracy.

Discussion Themes	Committee Member Discussion
Denominator Exclusions, Attribution Rules, and Handling of Special Populations	• Committee members sought clarity on denominator exclusions and requested safeguards for rare-disease cases across broad age ranges. • The developer responded that the measure excludes patients with prior hospice enrollment (including Veterans Affairs [VA] hospice), discharges against medical advice (AMA), cases with unreliable demographic data, same-day or next-day non-transfer discharges, and applies a one-per-year heart-failure selection rule • Committee members requested clarity on mortality and readmission attribution. The developer confirmed that mortality is attributed to the admitting hospital, while readmissions are attributed to the receiving hospital.

Areas for Future Consideration: The committee recommended reevaluating the 30-day mortality window and testing a 15-day alternative. Members supported transitioning to individual ICD-10 codes to improve accuracy. One member urged the developer to reconsider excluding sparsely coded ICD-10 variables, noting that infrequently used codes may represent critical conditions in specialized units such as cardiac surgery intensive care unit (ICU), cardiac ICU, and medical respiratory ICU. The developer acknowledged this input and stated that the team performs annual model reevaluations to ensure validity and reliability.

2.1.2 MUC2025-037 Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Heart Failure (HF) Hospitalization [CMS]

Description: The measure estimates a hospital-level 30-day risk-standardized mortality rate (RSMR) for Medicare patients (Fee-For-Service [FFS] and Medicare Advantage [MA]) aged 65 and older discharged from the hospital with a principal diagnosis of HF. The outcome is all-cause 30-day mortality, defined as death from any cause within 30 days of the index admission date, including in-hospital death.

Public Comment Summary: Battelle received 12 written public comments and one spoken public comment across all risk-standardized mortality measures. See MUC2025-036 for a summary of the comments across this group of measures. For HF specifically, public commenters suggested excluding left ventricular assist device (LVAD) and transplant cases and adjusting for disease severity.

Closing Gaps of Care Considerations: See MUC20205-036.

Measure Review Final Vote:

Hospital Inpatient Quality Reporting Program: The committee reached consensus agreement to recommend the measure for use in the Hospital Inpatient Quality Reporting Program.

- **Vote Count:** Recommend 17 (81%), Do Not Recommend 4 (19%), No Recusals.

Hospital Value-Based Purchasing Program: The committee reached consensus agreement to recommend the measure for use in the Hospital Value-Based Purchasing Program.

- **Vote Count:** Recommend 15 (75%), Do Not Recommend 5 (25%), No Recusals.

Measure Group Discussion: The committee discussed this measure as a group with other measures (MUC2025-036, MUC2025-037, MUC2025-040, MUC2025-044, and MUC2025-046). See MUC2025-036 for discussion and conditions.

Areas for Future Consideration: See MUC2025-036.

2.1.3 MUC2025-040 Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization [CMS]

Description: The measure estimates a hospital-level 30-day risk-standardized mortality rate (RSMR) for Medicare patients (Fee-For-Service [FFS] and Medicare Advantage [MA]) aged 65 and older discharged from the hospital with a principal diagnosis of COPD. The outcome is all-cause 30-day mortality, defined as death from any cause within 30 days of the index admission date, including in-hospital death.

Public Comment Summary: Battelle received 12 written public comments and one spoken public comment across all risk-standardized mortality measures. See MUC2025-036.

Closing Gaps of Care Considerations: See MUC2025-036.

Measure Review Final Vote:

Hospital Inpatient Quality Reporting Program: The committee reached consensus agreement to recommend the measure for use in the Hospital Inpatient Quality Reporting Program.

- **Vote Count:** Recommend 16 (80%), Do Not Recommend 4 (20%), No Recusals.

Hospital Value-Based Purchasing Program: The committee reached consensus agreement to recommend the measure for use in the Hospital Value-Based Purchasing Program.

- **Vote Count:** Recommend 15 (75%), Do Not Recommend 5 (25%), No Recusals.

Measure Group Discussion: The committee discussed this measure as a group with other measures (MUC2025-036, MUC2025-037, MUC2025-040, MUC2025-044, and MUC2025-046). See MUC2025-036 for discussion and conditions.

Areas for Future Consideration: See MUC2025-036.

2.1.4 MUC2025-044 Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Pneumonia (PN) Hospitalization [CMS]

Description: The measure estimates a hospital-level 30-day risk-standardized mortality rate (RSMR) for Medicare patients (Fee-For-Service [FFS] and Medicare Advantage [MA]) aged 65 and older discharged from the hospital with a principal diagnosis of Pneumonia. The outcome is all-cause 30-day mortality, defined as death from any cause within 30 days of the index admission date, including in-hospital death.

Public Comment Summary: Battelle received 12 written public comments and one spoken public comment across all risk-standardized mortality measures. See MUC2025-036.

Closing Gaps of Care Considerations: See MUC20205-036.

Measure Review Final Vote:

Hospital Inpatient Quality Reporting Program: The committee reached consensus agreement to recommend the measure for use in the Hospital Inpatient Quality Reporting Program.

- **Vote Count:** Recommend 16 (80%), Do Not Recommend 4 (20%), No Recusals.

Hospital Value-Based Purchasing Program: The committee reached consensus agreement to recommend the measure for use in the Hospital Value-Based Purchasing Program.

- **Vote Count:** Recommend 15 (75%), Do Not Recommend 5 (25%), No Recusals.

Measure Group Discussion: The committee discussed this measure as a group with other measures (MUC2025-036, MUC2025-037, MUC2025-040, MUC2025-044, and MUC2025-046). See MUC2025-036 for discussion and conditions.

Areas for Future Consideration: See MUC2025-036.

2.1.5 MUC2025-046 Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) Surgery [CMS]

Description: The measure estimates a hospital-level 30-day risk-standardized mortality rate (RSMR) for Medicare patients (Fee-For-Service [FFS] and Medicare Advantage [MA]) aged 65 and older discharged from the hospital with a principal diagnosis of CABG. The outcome is all-cause 30-day mortality, defined as death from any cause within 30 days of the index admission date, including in-hospital death.

Public Comment Summary: Battelle received 12 written public comments and one spoken public comment across all risk-standardized mortality measures. See MUC2025-036

Closing Gaps of Care Considerations: See MUC2025-036.

Measure Review Final Vote:

Hospital Inpatient Quality Reporting Program: The committee reached consensus agreement to recommend the measure for use in the Hospital Inpatient Quality Reporting Program.

- **Vote Count:** Recommend 17 (85%), Do Not Recommend 3 (15%), No Recusals.

Hospital Value-Based Purchasing Program: Although consensus was not reached, the majority of the committee expressed some support for use of the measure in the Hospital Value-Based Purchasing Program.

- **Vote Count:** Recommend 15 (71%), Do Not Recommend 6 (29%), No Recusals.

Measure Group Discussion: The committee discussed this measure as a group with other measures (MUC2025-036, MUC2025-037, MUC2025-040, MUC2025-044, and MUC2025-046). See MUC2025-036 for discussion and conditions.

Areas for Future Consideration: See MUC2025-036.

2.1.6 MUC2025-016 Excess Antibiotic Duration for Adult Hospitalized Patients with Uncomplicated Community-Acquired Pneumonia [University of Utah]

Description: Percentage of adult non-ICU hospitalized patients with uncomplicated pneumonia that qualify for 5-day duration according to national guidelines who received excess antibiotic

duration, defined as >/= 7 days of total antibiotic therapy including inpatient and discharge antibiotics. Measure is reported annually at the hospital level.

Public Comment Summary: Battelle received 16 written public comments and no spoken public comments on this measure. Supporters emphasized the measure's potential to improve patient outcomes, noting that community-acquired pneumonia is a leading cause of antibiotic use and mortality. They highlighted evidence that shorter antibiotic courses are effective and reduce adverse events, and that the measure aligns with stewardship programs and complements National Healthcare Safety Network (NHSN) reporting. Several commenters agreed that the measure is feasible, as data elements are routinely collected. Several commenters expressed concerns about the recent update to American Thoracic Society (ATS) guidelines recommending less than 5 days of antibiotics, with a minimum of 3 days for stable patients. The developer maintained the 5-day cutoff, citing current practice and the fact that most patients do not stabilize within 3 days. Commenters raised concerns around the definition of clinical stability, exclusion criteria additions (e.g., immunocompromised patients), potential duplication with Centers for Disease Control and Prevention (CDC) initiatives, overlap with Severe Sepsis and Septic Shock Early Management Bundle (SEP-1), and reporting burden. Commenters also questioned feasibility for smaller hospitals and asked for clarification on denominator criteria and chest imaging requirements.

Closing Gaps of Care Considerations: Closing Gaps of Care considerations included age (older adults often require longer treatment and have more comorbidities), and geography (rural patients tend to receive longer courses).[8]

Measure Review Final Vote:

Hospital Inpatient Quality Reporting Program: The committee did not reach agreement on use of the measure in the Hospital Inpatient Quality Reporting Program.

- **Vote Count:** Recommend 10 (50%), Do Not Recommend 10 (50%), No Recusals.

Medicare Promoting Interoperability Program: The committee did not reach agreement on use of the measure in the Promoting Interoperability Program.

- **Vote Count:** Recommend 11 (55%), Do Not Recommend 9 (45%), No Recusals.

Discussion Themes	Committee Member Discussion
Clinical Importance	• The committee broadly agreed that the measure is clinically important, citing variability in antibiotic prescribing and risks such as antibiotic resistance and C. difficile infections. • Patient representatives shared experiences of harm from prolonged antibiotic courses, reinforcing the measure's potential to improve outcomes.
Scope and Relation to Existing Metrics	• The developer presented evidence demonstrating wide variation in excess antibiotic duration across hospitals (~11.9% to ~80%), indicating a need for intervention on this topic. The developer clarified the measure targets antibiotics prescribed during hospitalization and at discharge, excluding post-discharge prescribing by outpatient providers.

[8] For complete information on the Closing Gaps of Care literature review for this measure, including references cited, please refer to the Hospital Recommendation Group Meeting slide deck.

Discussion Themes	Committee Member Discussion
	• The developer emphasized that the measure complements CDC's NHSN Antibiotic Use (AU) reporting by addressing appropriateness and discharge prescribing, which AU does not capture.
Feasibility and Data Burden	• Committee members expressed concerns about feasibility and complexity, noting reliance on multiple data elements (labs, diagnoses, clinical stability indicators) that may be difficult to capture accurately, particularly for smaller/rural hospitals. • While the developer tested in Epic and VA systems, members called for broader testing across diverse electronic health record (EHR) platforms. • The committee had concerns that hospitals could be penalized for documentation gaps rather than true clinical performance, and that unintended consequences could occur if complex patients receive insufficient treatment due to rigid specifications. • CMS acknowledged the need for collaboration with EHR vendors to ensure technical feasibility and suggested leveraging existing NHSN infrastructure to ease implementation.
Alignment with Guidelines and Exclusions	• Some members felt the measure's "clinical stability" definition is not aligned with ATS/IDSA guidelines. • Several members recommended additional exclusions (e.g., pregnancy, certain severe infections). • The committee raised questions about alignment with guidelines that favor shorter courses but are based on limited evidence.

Areas for Future Consideration: Members emphasized the importance of expanding feasibility testing to include a broader range of EHR systems and smaller hospitals to ensure the measure's scalability and accuracy. They highlighted the need for ongoing collaboration with EHR vendors to standardize data capture and automate reporting, reducing the burden on hospitals and leveraging Promoting Interoperability requirements. Several participants suggested refining the measure's specifications, such as simplifying clinical stability definitions and clarifying inclusion and exclusion criteria, to improve feasibility and reduce complexity. Committee members proposed integrating the measure with existing programs, such as NHSN AU reporting, to minimize duplication and capitalize on established infrastructure. They recommended that the measure developers incorporate this feedback into future maintenance and updates, including exploring partnerships with additional vendors and facilities. Patient advocates reinforced the urgency of these efforts, stressing that timely implementation is critical to curb antibiotic resistance and improve patient safety.

2.1.7 MUC2025-019 Inappropriately Broad Empiric Antibiotic Selection for Adult Hospitalized Patients with Uncomplicated Community-Acquired Pneumonia [University of Utah]

Description: Percentage of adult non-ICU hospitalized patients with uncomplicated pneumonia who: a) did not have risk factors for methicillin-resistant Staphylococcus aureus (MRSA) or Pseudomonas aeruginosa, and b) received empiric (within first 48 hours of emergency

department arrival) antibiotics targeting MRSA or Pseudomonas aeruginosa. Percentage reported annually at the hospital level.

Public Comment Summary: Battelle received 14 written public comments and no spoken public comments on the measure. Supportive comments emphasized that the measure aligns with efforts to reduce hospital-acquired infections, antimicrobial resistance, and federal initiatives such as CDC's NHSN AU option. Commenters noted that inappropriate broad-spectrum empiric antibiotic use is linked to higher readmissions, ICU transfers, adverse events, and longer hospital stays, and that this measure could help address these issues. They also highlighted the challenge of assessing antibiotic prescribing quality and viewed the measure as a first step toward improvement. Commenters recognized that community-acquired pneumonia is common and often treated with unnecessarily broad antibiotics.

Several commenters had concerns that the exclusions do not match current clinical guidelines. They recommended adjustments for MRSA and pseudomonas risk factors, immunocompromised patients, and those receiving antibiotics in the emergency department (ED). Other commenter concerns included difficulty capturing pre-hospital antibiotic and imaging data, overlap with SEP-1, reporting burden, and feasibility for rural hospitals with limited IT infrastructure. Commenters requested clarification on specifications such as the 48-hour window (defined as ED arrival or hospital admission) and chest imaging within 3 days prior to hospitalization.

Closing Gaps of Care Considerations: Closing Gaps of Care considerations included age (older adults have the highest rates of inappropriate prescriptions), geographic variation (highest use in the South), and language barriers (patients with limited English proficiency may not understand the risks of broad-spectrum antibiotic use).[9]

Measure Review Final Vote:

Hospital Inpatient Quality Reporting Program: The committee did not reach agreement on use of the measure in the Hospital Inpatient Quality Reporting Program.

- **Vote Count:** Recommend 10 (48%), Do Not Recommend 11 (52%), No Recusals.

Medicare Promoting Interoperability Program: The committee did not reach agreement on use of the measure in the Promoting Interoperability Program.

- **Vote Count:** Recommend 10 (50%), Do Not Recommend 10 (50%), No Recusals.

Discussion Themes	Committee Member Discussion
Measure Complexity	• Committee members supported the measure's intent to advance antimicrobial stewardship yet expressed concern that its complexity could result in unintended consequences in clinical settings.

[9] For complete information on the Closing Gaps of Care literature review for this measure, including references cited, please refer to the Hospital Recommendation Group Meeting slide deck.

Discussion Themes	Committee Member Discussion
Guideline Alignment and Clinical Logic	• Several members questioned whether the exclusion criteria fully align with ATS/IDSA guidelines, noting omissions such as extended-spectrum beta-lactamases (ESBLs)-producing organisms. • The committee raised concerns about including illness severity as a risk factor for multidrug-resistant pathogens, as some members noted the lack of supporting evidence. • The developer stated that the measure logic closely follows ATS guidelines and shared testing results showing very low MDR pathogen rates when exclusions were applied.
Data Capture and Technical Feasibility	• Committee members highlighted challenges in electronically capturing prior hospitalizations and IV antibiotic exposure, particularly for hospitals with limited EHR capabilities. • The committee viewed these data requirements as a significant feasibility barrier, especially for smaller, rural hospitals and those lacking advanced health IT infrastructure. • Members noted that effective implementation would require additional time, resources, and system enhancements.
Timing of Measurement and Unintended Consequences	• The committee expressed strong concerns about triggering the measure at the first antibiotic dose, with fears that clinicians might delay treatment for septic patients when diagnostic information is limited. • Several members suggested focusing the measure on de-escalation at 48 hours, rather than restricting initial empiric therapy. • While the developer emphasized the intent to function as a balancing measure to SEP-1, some members remained concerned about encouraging potential risk-averse behavior in emergent cases.
Patient Safety	• Patient representatives shared experiences of harm from prolonged antibiotic use and adverse effects from agents such as vancomycin. • They expressed strong support for measures that prevent unnecessary exposure, reduce antibiotic resistance, and emphasize getting antibiotic selection correct early, reinforcing the measure's overall importance.

Areas for Future Consideration: Committee members suggested several additional considerations and future directions for the measure. Participants emphasized the need for further feasibility testing across diverse EHR systems to ensure accurate data capture and reduced implementation burden, particularly for smaller or rural hospitals. The committee demonstrated strong interest in engaging EHR vendors through PI programs to support automated reporting and minimize manual validation. Clinicians recommended exploring alternative measure timing, such as starting assessment at the second antibiotic dose rather than the first, to avoid unintended delays in care for septic patients. Others called for refinements to exclusion criteria, including clearer alignment with ATS guidelines, consideration of immunocompromised patients on active chemotherapy, and potential inclusion of rapid

molecular diagnostics. Finally, members highlighted the importance of ongoing evaluation of risk factors and measure complexity, suggesting that future iterations balance clinical accuracy with practical implementation while maintaining patient safety and stewardship goals.

2.1.8 MUC2025-053 Excess Days in Acute Care (EDAC) After Hospitalization for Diabetes [CMS]

Description: Excess Days in Acute Care (EDAC) After Hospitalization for Diabetes ("Diabetes EDAC measure") measure assesses days spent in acute care within 30 days of discharge from an inpatient hospitalization for diabetes. This measure is intended to improve the quality of care (with a focus on care transitions) provided to discharged patients who had a diabetes hospitalization by collectively measuring a set of adverse acute care outcomes that can occur post-discharge: emergency department (ED) visits, observation stays, and unplanned readmissions at any time during the 30 days post-discharge. To aggregate all three events, we measure each in terms of days. The outcome is adjusted to account for age and patient comorbidities and incorporates exposure time to account for survival times shorter than 30 days (for patients who die within 30 days of discharge). The measure is calculated for admissions for patients who are 65 years or older, are enrolled in Medicare Fee-For-Service (FFS) or Medicare Advantage (MA) and are hospitalized in non-federal short-term acute care hospitals. The final risk-adjusted measure score is calculated as the difference ("excess") between a hospital's "predicted days" and "expected days," per 100 discharges.

Public Comment Summary: Battelle received 12 written comments and four spoken comments from the listening session across all EDAC measures. Several comments expressed support for the measures and the inclusion of MA data, noting that this addition improves reporting accuracy, highlights outcome gaps by coverage type, and promotes accountability for MA plans. One commenter described the measures as a significant step toward improving care transitions and outcomes for diabetic patients. Commenters expressed several concerns, including questions about the reliability of diabetes diagnosis coding, the complexity of risk adjustment, and the feasibility of accurate data capture. Others raised issues about potential overlap with existing measures and unintended consequences, such as increased mortality due to negative incentives tied to readmission-related measures. Commenters requested further analysis of risk-adjusted versus unadjusted rates, timing of readmissions, and appropriateness of the 30-day post-discharge period. Additional concerns included the absence of sociodemographic factors in risk adjustment, challenges posed by MA plan utilization policies, and the impact of counting ED visits and observation stays as full days, which may overstate utilization and penalize hospitals for appropriate care. One commenter suggested the measures may be better suited for an accountable care organization (ACO) environment, given its reliance on post-discharge resources, while others noted rural hospitals face disadvantages due to limited community resources.

Closing Gaps of Care Considerations: The measure incorporates risk adjustment by age because most hospitalized patients with diabetes are older than 65, frail, and have multiple comorbidities. Geographic gaps persist, as rural patients experience worse quality outcomes than urban patients, even within integrated health systems and after adjusting for other factors. Insurance status also influences care quality, as insured adults with diabetes are more likely to have a regular source of care and receive recommended services such as A1C testing, eye exams, and daily glucose monitoring compared to uninsured individuals. Language barriers further contribute to gaps in care, as patients who speak neither English nor Spanish are less

likely to successfully control risk factors for diabetes and cardiovascular disease when compared to English-speaking patients.[10]

Measure Review Final Vote:

Hospital Inpatient Quality Reporting Program: Although consensus was not reached, the majority of the committee expressed some support for use of the measure in the Hospital Inpatient Quality Reporting Program.

- **Vote Count:** Recommend 15 (68%), Do Not Recommend 7 (32%), No Recusals.

Discussion Themes	Committee Member Discussion
Patient Perspective	• One patient committee member stated this measure would help increase hospital accountability for outcomes after hospitalization.
Medicare Advantage	• Committee members raised concerns about hospitals bearing financial losses when MA plans merge index and readmission encounters, resulting in non-payment for secondary admissions. They questioned how CMS would ensure accurate documentation of MA readmissions and suggested revisiting MA payment guidelines to prevent hospitals from being penalized twice. • The developer clarified that MA claims data are sourced from both hospitals and MA organizations, and extensive validation has been conducted. Related measures using MA data have already received endorsement. CMS stated that as they receive more performance data, they will continue to look at the impact of MA data.
Volume Thresholds and Impact on Low-Volume Facilities	• Committee members questioned whether small rural hospitals would meet minimum volume thresholds, given that diabetes is rarely a principal diagnosis. They also noted challenges in replicating EDAC measures for quality improvement, due to data complexity. • The developer confirmed that approximately 4,000 hospitals have at least one qualifying admission. For public reporting, hospitals must meet a minimum of 25 admissions per year for reliability, which still covers 96% of patients. Hospitals below the threshold would still receive all applicable data for internal quality improvement. The developer also noted that recent methodological changes (i.e., switching to a binomial model) have simplified calculation.
CBE Endorsement Process	• Committee members expressed their preferences that measures obtain CBE endorsement before being added to programs to help validate technical specifications. • CMS confirmed the measure will be submitted for endorsement in the Spring 2026 cycle. The developer emphasized that the measure is supported by extensive analysis and aligns with previously endorsed methodologies.

[10] For complete information on the Closing Gaps of Care literature review for this measure, including references cited, please refer to the Hospital Recommendation Group Meeting slide deck.

Discussion Themes	Committee Member Discussion
30-Day Window for Readmissions	• Committee members questioned whether hospitals should be held accountable for outcomes within a 30-day window, given that many readmissions are influenced by community-level factors and outpatient care availability. Some suggested shortening the accountability window to 7 days, arguing that hospitals have limited influence beyond the immediate post-discharge period. • The developer acknowledged the complexity of readmissions but stressed that hospitals exert significant influence over care transitions and community coordination. The measure aims to provide hospitals with detailed reports to drive improvement, not penalize performance. • CMS clarified that the measure is currently intended for pay-for-reporting, not pay-for-performance. The developer responded that the 30-day time frame is consistent with existing CMS measures and supported by evidence, while noting that shorter time frames rely on older data.
Diabetes-Specific Considerations	• Committee members discussed whether EDAC is the right metric for diabetes care, given that long-term management typically occurs in outpatient settings. However, some acknowledged that hospitals could improve discharge planning and medication management for diabetic patients, which often falls short. • The developer explained that the measure targets patients hospitalized for severe diabetes-related complications (e.g., diabetic ketoacidosis, hypoglycemia), who benefit most from improved discharge planning and care coordination. They clarified that ED visits and observations stays are included in the outcome, not ambulatory clinic visits. • The developer explained that while ED visits at hospital outpatient departments count as outcome events, only inpatient hospitals are measured—not outpatient departments.

Areas for Future Consideration: CMS acknowledged that the measure has not yet completed the endorsement process but will be submitted for the Spring 2026 cycle. CMS also stated that as they receive more performance data, they will continue to look at the impact of MA. The committee encouraged developers and CMS to consider impacts of measures on low-volume facilities when determining thresholds and conducting testing during measure development.

2.1.9 MUC2025-030 Excess Days in Acute Care (EDAC) after Hospitalization for Acute Myocardial Infarction (AMI) [CMS]

Description: This measure estimates days spent in acute care within 30 days post discharge from an inpatient hospitalization for acute myocardial infarction (AMI). The acute care outcomes include 1) Emergency Department (ED) visits, 2) observation stays (OBSs), and 3) unplanned readmissions. Unplanned readmissions are defined using the planned readmission algorithm (PRA). ED visits are counted as 1 day and OBSs are counted by hours and rounded up to 1 day. CMS annually reports the measure for patients who are 65 years or older and enrolled in fee-for-service (FFS) Medicare or Medicare Advantage (MA) and hospitalized in non-federal hospitals or Veterans Health Administration (VA) facilities.

Public Comment Summary: Battelle received 12 written and four spoken comments across all EDAC measures. Committee members generally supported counting ED, and observation stays as 1 day, noting such an approach improves consistency and aids benchmarking. Commenters raised concerns about integrating MA data with FFS data and requested additional testing for reliability. They also questioned risk-adjustment methodology, the 30-day window, and whether an EDAC measure is appropriate for AMI given its low frequency. While supportive of more granular risk adjustment, some warned the measures could increase vulnerability to coding variation.

Closing Gaps of Care Considerations: Older patients with AMI face higher risks of complications and mortality due to frailty and comorbidities. Rural hospitals provide fewer key AMI procedures, while dual-eligible patients experience higher AMI mortality. Uninsured individuals have worse AMI outcomes and receive fewer guideline-based therapies. MA enrollees are more often discharged home rather than to skilled nursing or rehab compared to FFS beneficiaries.[11]

Measure Review Final Vote:

Hospital Inpatient Quality Reporting Program: The committee reached consensus agreement to recommend the measure for use in the Hospital Inpatient Quality Reporting Program.

- **Vote Count:** Recommend 18 (86%), Do Not Recommend 3 (14%), No Recusals.

Note: The committee discussed this measure as a group with other EDAC measures (MUC2025-030, MUC2025-031, MUC2025-39, MUC2025-053), and the discussion considerations outlined in MUC2025-053 apply, but additional themes discussed for this measure are outlined below.

Discussion Themes	Committee Member Discussion
Medicare Advantage	• Committee members supported the changes, including the addition of MA patients and reducing the performance period to 2 years. • One committee member was supportive of adding the MA population because it would be helpful for their organization. However, this committee member also noted that there is a low volume of MA patients at their facility, meaning one patient's care can make a difference in measure performance. • The measure developer acknowledged that the CBE asked them to investigate the impacts of including MA data more closely when the measure is up for maintenance endorsement in 5 years.
Risk Adjustment	• The measure developer described a recent change to the risk model: the measure now uses a binomial count model instead of a Cox model. This approach predicts the proportion of acute care days (including ED, observation, and inpatient) and multiplies by survival time (up to 30 days or until death). The change improved model performance and computational efficiency and is considered non-substantive.

[11] For complete information on the Closing Gaps of Care literature review for this measure, including references cited, please refer to the Hospital Recommendation Group Meeting slide deck.

Discussion Themes	Committee Member Discussion
	• The developer also clarified that the goal is not to maximize model performance but to ensure fairness in evaluating hospital quality. They noted that C-statistics vary by outcome and that lower values (e.g., ~0.665) are acceptable based on literature.
30-Day Window for Readmissions	• The committee repeated the same concerns around follow-up period described in MUC2025-053.
AMI-Specific Considerations	• A committee member raised concerns about coding accuracy (e.g., non-ST-elevation myocardial infarction [NSTEMI] versus STEMI) and whether risk adjustment accounts for diagnostic complexity. • The developer responded that measures were historically validated against medical records but have not been validated against records in the last few years. They do not believe this has significant influence over the measure but can investigate that in the future. The developer further clarified that that they do an annual re-evaluation process where they can incorporate this feedback.

Areas for Future Consideration: The committee encouraged CMS and measure developers to proceed with CBE maintenance by reviewing the impact of including MA population on the risk model performance.

2.1.10 MUC2025-031 Excess Days in Acute Care (EDAC) after Hospitalization for Heart Failure (HF) [CMS]

Description: This measure estimates days spent in acute care within 30 days post discharge from an inpatient hospitalization for heart failure (HF). The acute care outcomes include 1) Emergency Department (ED) visits, 2) observation stays (OBSs), and 3) unplanned readmissions. Unplanned readmissions are defined using the planned readmission algorithm (PRA). ED visits are counted as 1 day and OBSs are counted by hours and rounded up to 1 day. CMS annually reports the measure for patients who are 65 years or older and enrolled in fee-for-service (FFS) Medicare or Medicare Advantage (MA) and hospitalized in non-federal hospitals or Veterans Health Administration (VA) facilities.

Public Comment Summary: Battelle received 12 written and four spoken comments across all EDAC measures. Specific to this measure, one public comment supported adding MA data, acknowledged the high clinical importance, and stated that encouraging hospitals to have robust postoperative hospital care programs is clinically important. Committee members generally supported counting ED, and observation stays as 1 day, noting this approach improves consistency and aids benchmarking. Commenters raised concerns about integrating MA data with FFS data and requested additional testing for reliability. While supportive of more granular risk adjustment, some warned it could increase vulnerability to coding variation.

Closing Gaps of Care Considerations: Older HF patients who are frail and have multiple comorbidities have worse health outcomes than those who have fewer comorbidities. Rural facilities are more likely than urban facilities to refer patients elsewhere for HF expertise. Hospitals with a higher proportion of dual-eligible beneficiaries provide lower rates of key HF care processes and have higher 30-day readmission rates. Lastly, low health literacy is common

among HF patients and is linked to worse outcomes, including higher hospitalization and mortality rates.[12]

Measure Review Final Vote:

Hospital Inpatient Quality Reporting Program: The committee reached consensus agreement to recommend the measure for use in the Hospital Inpatient Quality Reporting Program.

- **Vote Count:** Recommend 19 (90%), Do Not Recommend 2 (10%), No Recusals.

Note: The committee discussed this measure as a group with other EDAC measures (MUC2025-030, MUC2025-031, MUC2025-39, MUC2025-053), and the discussion considerations outlined in MUC2025-053 and MUC2025-030 apply. Additional discussion unique to this measure is summarized below.

Discussion Themes	Committee Member Discussion
Observation Visits after Heart Failure	• One committee member highlighted a public comment noting that ambulatory care delivery models may encourage observation visits, particularly in communities lacking resources for post-discharge follow-up for HF. This practice could lead to patients being sent for observation unnecessarily, which impacts EDAC measures.

Areas for Future Consideration: None.

2.1.11 MUC2025-039 Excess Days in Acute Care (EDAC) after Hospitalization for Pneumonia [CMS]

Description: This measure estimates days spent in acute care within 30 days post discharge from an inpatient hospitalization for pneumonia. The acute care outcomes include 1) Emergency Department (ED) visits, 2) observation stays (OBSs), and 3) unplanned readmissions. Unplanned readmissions are defined using the planned readmission algorithm (PRA). ED visits are counted as 1 day and OBSs are counted by hours and rounded up to 1 day. CMS annually reports the measure for patients who are 65 years or older and enrolled in fee-for-service (FFS) Medicare or Medicare Advantage (MA) and hospitalized in non-federal hospitals or Veterans Health Administration (VA) facilities.

Public Comment Summary: Battelle received 12 written and four spoken comments across all EDAC measures. Please refer to MUC2025-053 and MUC2025-030.

Closing Gaps of Care Considerations: Older patients with pneumonia have a high prevalence of comorbidities and a high in-hospital mortality rate. The mortality rate from pneumonia is higher in rural areas compared to urban areas.[13]

Measure Review Final Vote:

Hospital Inpatient Quality Reporting Program: The committee reached consensus agreement to recommend the measure for use in the Hospital Inpatient Quality Reporting

[12] For complete information on the Closing Gaps of Care literature review for this measure, including references cited, please refer to the Hospital Recommendation Group Meeting slide deck.
[13] For complete information on the Closing Gaps of Care literature review for this measure, including references cited, please refer to the Hospital Recommendation Group Meeting slide deck.

Program.

- **Vote Count:** Recommend 19 (90%), Do Not Recommend 2 (10%), No Recusals.

Note: The committee discussed this measure as a group with other EDAC measures (MUC2025-030, MUC2025-031, MUC2025-39, MUC2025-053), and the discussion considerations outlined in MUC2025-053 and MUC2025-030 apply.

Areas for Future Consideration: None.

2.1.12 MUC2025-067 Hospital Harm - Postoperative Venous Thromboembolism [CMS]

Description: The proportion of inpatient encounters for patients age 18 and older, who have at least one surgical procedure performed inside the operating room during the encounter, and who suffer the harm of a postoperative venous thromboembolism (VTE) during the encounter or within 30 days after the first surgical procedure. This measure is adjusted by patient-level risk factors (bleeding disorders, cancer, respiratory operations, central venous catheter insertion, vascular surgeries, obesity, stroke, and history of VTE).

Public Comment Summary: Battelle received 14 written public comments and no spoken public comments on this measure. Public comments highlighted the importance of the measure, noting that the incidence of VTE shows the ongoing need to minimize risk and enhance patient safety. Commenters noted the strong evidence base that supports various preventive strategies. Some public comments expressed concern that the measure focuses on surgical patients, which represent only a fraction of hospital-associated VTE cases. Another commenter sought clarification on whether procedures performed in non-operating room settings such as interventional radiology or cardiac catheterization labs would be excluded. They also questioned the appropriateness of the 30-day monitoring window, given that hospitals do not manage patient care after discharge. Other comments suggested adding social risk factors to the risk-adjustment model to account for influences outside hospital control. Additional concerns involved potential gaps in data capture for VTEs diagnosed outside the reporting hospital system and risks of inconsistent patient identification impacting measure validity. Commenters also noted limited validity testing and cautioned that even optimal care cannot prevent all VTEs, suggesting greater emphasis on adherence to guidelines rather than unattainable outcome expectations. Finally, several commenters warned of possible unintended consequences, including overtreatment to avoid VTE events, which could increase bleeding risks.

Closing Gaps of Care Considerations: Although the measure includes age-based risk adjustment, evidence shows that individuals age 55 and older face substantially greater risk of developing serious or fatal VTE events. Second, geographic gaps remain evident: age-adjusted mortality rates from pulmonary embolism are notably higher in rural populations than in metropolitan areas, highlighting significant gaps in health care access and outcomes. Third, VTE presents a significant financial challenge, with average 1-year costs estimated at approximately $33,000. This economic burden can further complicate care for patients who lack health insurance. Finally, the literature shows that communication gaps between clinicians and patients with VTE can worsen distress. Providers may unintentionally convey information in ways that increase fear, create ambiguity, or leave patients uncertain about their condition, contributing to ongoing anxiety.[14]

[14] For complete information on the Closing Gaps of Care literature review for this measure, including references cited, please refer to the Hospital Recommendation Group Meeting slide deck.

Measure Review Final Vote:

Hospital Inpatient Quality Reporting Program: Although consensus was not reached, the majority of the committee expressed some concern about use of the measure in the Hospital Inpatient Quality Reporting Program.

- **Vote Count:** Recommend 7 (35%), Do Not Recommend 13 (65%), No Recusals.

Medicare Promoting Interoperability Program: Although consensus was not reached, the majority of the committee expressed some concern about use of the measure in the Medicare Promoting Interoperability Program.

- **Vote Count:** Recommend 7 (35%), Do Not Recommend 13 (65%), No Recusals.

Hospital-Acquired Condition Reduction Program: Although consensus was not reached, the majority of the committee expressed some concern about use of the measure in the Hospital-Acquired Condition Reduction Program.

- **Vote Count:** Recommend 6 (30%), Do Not Recommend 14 (70%), No Recusals.

Discussion Themes	Committee Member Discussion
Importance	• Committee members agreed with public commenters that postoperative VTE poses serious, life-threatening harm and that a measure addressing it is valuable. Members agreed that the incidence of VTE highlights the need for continued efforts to reduce preventable events. • Additionally, a committee member highlighted that large performance gaps remain, providing justification for moving the measure forward. • Patient representatives expressed strong support for prioritizing prevention of postoperative VTEs due to their severity and the high potential for catastrophic outcomes.
Data Elements	• One committee member stated that the measure requires an unusually large set of data elements and may lead to over-identification of patients. They raised concerns with the measure's reliance on anticoagulant orders, which may be prescribed for reasons unrelated to VTE prophylaxis and warned about inaccuracies stemming from EHR problem lists not being reconciled.
Related and Competing Measures	• Additionally, committee members expressed concerns about potential overlap with other measures, particularly Patient Safety Indicator (PSI)-12, a component of the PSI-90. One member noted that there seems to be a strategic shift from PSIs toward Hospital Harm measures. • The developer clarified that although the measure was built using PSI-12 as a foundation, this new measure applies to a broader clinical population, and, as an eCQM, draws on a richer set of clinical data, unlike PSI-12, which relies solely on claims. • Another committee member noted that this measure could be a valuable counterpart to The Joint Commission's (TJC) VTE1 and VTE2 but highlighted the need for caution regarding technical specification details. For instance, there were historical challenges with aligning diagnostic procedures and coding workflows with VTE6.

Discussion Themes	Committee Member Discussion
	Additionally, this measure only counts procedures performed in operating rooms.
Unintended Consequences	• One committee member listed potential unintended consequences, including over-treatment and bleeding risk, surveillance bias, excluding short-length-of-stay procedures (e.g., joint replacements), and the lack of a formal risk-stratified balancing measure. CMS stated they are developing a balancing measure to monitor overuse of anticoagulants.
Potential Bias & IT Infrastructure	• Committee members were concerned over potential bias related to hospital EHR systems. Hospitals with a single-enterprise EHR would capture more postoperative VTE events, increasing their numerator counts compared to hospital systems comprised of multiple EHR vendors. Additionally, the testing was heavily Epic-centered and could perform differently in other EHRs. • The developer noted that the signal-to-noise reliability scores were high (0.9998-0.9999), the measure was tested in two EHRs (Epic and Meditech), and case counts in testing hospitals were robust (smallest hospital >260 denominator cases).
30-Day Window	• Committee members questioned the appropriateness of holding hospitals accountable for events up to 30 days post-surgery, arguing that patient non-adherence or patients not receiving appropriate care post-discharge at other facilities (e.g., skilled nursing facilities [SNFs]) is out of the hospital's control. • Other committee members and the developer stated that the 30-day window was appropriate. Although hospitals cannot control post-discharge outcomes, they can influence outcomes via interventions such as education, planning, and coordination with community providers. • Additionally, the developer shared the results of a 2023 meta-analysis by Singh and colleagues15 which indicated that pooled evidence of moderate certainty showed that 47.1% of the VTE events occurred during the first week, 26.9% during the second week, 15.8% during the third week, and 10.1% during the fourth week after surgery, highlighting the importance of capturing events within the 30-day window.
Exclusions	• The committee questioned why atrial fibrillation (AFib) was not excluded, because it is a common clinical indication for anticoagulation and may confound VTE identification. • The developer explained that AFib cases should not be captured because the measure requires both diagnostic imaging and a therapeutic anticoagulant order within 24 hours, which AFib typically

[15] Singh T, Lavikainen LI, Halme ALE, Aaltonen R, Agarwal A, Blanker MH, Bolsunovskyi K, Cartwright R, García-Perdomo H, Gutschon R, Lee Y, Pourjamal N, Vernooij RWM, Violette PD, Haukka J, Guyatt GH, Tikkinen KAO. Timing of symptomatic venous thromboembolism after surgery: meta-analysis. Br J Surg. 2023 Apr 12;110(5):553-561. doi: 10.1093/bjs/znad035. PMID: 36912116; PMCID: PMC10364527.

Discussion Themes	Committee Member Discussion
	does not trigger in the same sequence. The committee member noted that there was still clinical imprecision around this concept. The developer also clarified that a VTE diagnosis is not required for the numerator of the measure and can be met using other clinical indicators. • The developer said that obstetric patients are also excluded, as they are measured separately via the Severe Obstetric Complications measure.
Program Implementation	• Committee members had several other concerns about the measure, including the risk of being penalized twice in payment programs due to overlap, disproportionate impact on small/low-volume hospitals, and the need for a longer pre-implementation period for complex eCQM adoption. • In response to a question from CMS about whether they were concerned about the use of the measure in Hospital IQR or HACRP, committee members asserted their concerns were specific to measure implementation in HACRP. • Committee members asserted that small, rural hospitals may need at least a year to implement this measure as an eCQM before the voluntary reporting period begins, as this measure will be complex to put in place.
CBE Endorsement	• Committee members shared their preference for measures to obtain CBE endorsement process before being added to programs List.
Expert Engagement	• Additionally, one committee member expressed concerns over the lack of participation by the American College of Surgeons (ACS) or American Academic of Orthopedic Surgeons (AAOS) and other organizations to standardize VTE risk assessment approaches, as VTE prevention depends heavily on patient risk assessment by a surgeon.

Areas for Future Consideration: Members noted that patients must appear in the same EHR system to be counted as a postoperative VTE event under Criteria C. The developer may explore options to address this, including requiring the diagnosis to be made at the same facility as the surgery or bifurcating the measure into measures for standalone facilities and integrated health systems.

2.1.13 MUC2025-072 Emergency Care Access & Timeliness (ECAT) [CMS]

Description: This measure captures the proportion of Emergency Department (ED) visits where patients (all ages, all payers) experienced any one of four quality gaps in access:

1. The patient waited longer than 60 minutes (1 hour) after arrival to the ED to be placed in a treatment room or dedicated treatment area that allows for audiovisual privacy during history-taking and physical examination, or
2. The patient left the ED without being evaluated, or

3. The patient boarded (time from Decision to Admit order to ED departure for admitted patients) in the ED for longer than 240 minutes (4 hours), or
4. The patient had an ED length of stay (LOS) (time from ED arrival to ED departure as defined by the ED departure timestamp indicating when the patient physically left the ED) of longer than 480 minutes (8 hours).

Public Comment Summary: Battelle received 11 written public comments and two spoken public comments. Public comments emphasized the importance of tracking wait times and LOS for health system planning and noted that the measure extends beyond traditional timeliness metrics. Commenters stated that the measure will promote innovation, improve patient experience, and reduce reporting burden with an eCQM. They also expressed support for expanding the measure across additional hospital programs and recognized its relevance for patients with rare or chronic conditions. Commenters raised several concerns. They identified implementation challenges related to accurately capturing key time points and requested clearer definitions to avoid inconsistent interpretation. They questioned the evidence base for the selected time thresholds and noted the absence of risk adjustment for acuity, severity, and regional factors, which could lead to misleading comparisons. Commenters expressed concern about the measure's attribution approach, arguing that many drivers of ED delays fall outside the control of the department or hospital. They cautioned against potential unintended consequences, such as unsafe workarounds, and recommended a voluntary reporting period to refine technical specifications and better understand the experiences of early adopters. They also urged CMS to consider the resource implications for rural and critical access hospitals.

Closing Gaps of Care Considerations: Older patients who spend the night in the ED while waiting to be admitted are at a higher risk for death or health complications during their hospital stay. Urban EDs often experience high patient volumes that contribute to overcrowding, prolonged wait times, increased boarding, and higher rates of patients leaving without being seen. In contrast, rural emergency departments frequently contend with staffing shortages, limited specialty coverage, and fewer treatment spaces, which also impede timely care. Patients with a non-English language preference experience longer wait times to be seen by an emergency department -provider.[16]

Measure Review Final Vote:

Hospital Inpatient Quality Reporting Program: Consensus was not reached, but the majority of the committee expressed some support for use of the measure in the Hospital Inpatient Quality Reporting Program.

- **Vote Count:** Recommend 14 (70%), Do Not Recommend 6 (30%), No Recusals

Hospital Value-Based Purchasing Program: Committee did not reach agreement on use of the measure in the Hospital Value-Based Purchasing Program.

- **Vote Count:** Recommend 11 (52%), Do Not Recommend 10 (48%), No Recusals.

Medicare Promoting Interoperability Program: Consensus was not reached, but the majority of the committee expressed some support for use of the measure in the Promoting Interoperability Program.

- **Vote Count:** Recommend 13 (65%), Do Not Recommend 7 (35%), No Recusals.

[16] For complete information on the Closing Gaps of Care literature review for this measure, including references cited, please refer to the Hospital Recommendation Group Meeting slide deck.

Discussion Themes	Committee Member Discussion
Importance	• Committee members repeatedly stated that emergency care delays, especially ED boarding, constitute a major patient safety concern. Several committee members emphasized that long delays harm vulnerable populations, including pediatric, rare disease, and chronic condition patients who have no alternative settings for urgent care. ED overcrowding impacts clinical staff and patient experience.
Accountability	• Committee members asserted that ED performance reflects hospital-wide functions, such as bed management, discharge efficiency, and surgical scheduling. Staffing patterns and inpatient bottlenecks strongly affect delays. Others stressed that many drivers of ED crowding stem from community capacity, payer practices, and post-acute care availability, which hospitals cannot directly control. • CMS reiterated that certain efficiency improvements do fall within hospital influence even amid external constraints.
Unintended Consequences	• Committee members questioned whether the measure could unintentionally penalize hospitals serving complex populations or high need communities. • The developer clarified that the measure uses volume standardization, not stratification, to compare like hospitals and that thresholds are based on guidance from The Joint Commission and the American College of Emergency Physicians (ACEP). • The developer and CMS also noted that CMS will conduct implementation monitoring, surveillance analyses, and assessments of unintended consequences, including for hospitals with specific characteristics, such as safety-net facilities or high transfer rural settings, to ensure the measure does not introduce systematic bias or encourage harmful workarounds.
Technical Considerations	• Committee members raised several technical considerations. The measure combines several historical emergency care indicators into a single performance signal, and one committee member appreciated the move away from continuous measures that are harder to interpret. However, the committee raised concerns over binary thresholds and adjusting payments over small time differences (e.g., 60 minutes versus 61 minutes).
Considerations for Psychiatric Services & Pediatric Populations	• Committee members highlighted the disproportionate impact of psychiatric boarding on emergency workflow and patient flow. The developer confirmed that mental health populations are separately reported but that substance use disorder is not currently included; future consideration is possible. • The developer also confirmed that pediatric patients are a stratified population. • Committee members asked whether Emergency Severity Index (ESI) was evaluated; CMS confirmed that it was considered but not included in risk adjustment.

Discussion Themes	Committee Member Discussion
Transfers	• The committee discussed the handling of transfers, with rural representatives emphasizing frequent interfacility transfers and asking whether these cases would be counted as discharges for purposes of the 8-hour departure window or treated differently based on decision-to-transfer time. • The developer confirmed that LOS is measured from ED arrival to ED departure, and that transfers are counted based on the moment the patient physically leaves the ED.
Potential Measure "Gaming"	• Several committee members asked for clarity on how the measure handles transfers, observation status, and potential gaming through registration workflows or lab ordering. They had concerns about how hospitals might attempt to influence measure performance through operational or documentation practices. • Several committee members questioned whether shifting patients into observation status could be used to avoid inclusion in the numerator, noting parallels to strategies seen in readmissions measures. Others raised the possibility of gaming through registration workflows, such as delaying electronic sign-in or using paper sign-in processes to shorten measured arrival-to-room times. • Additional comments noted that clinicians might order laboratory tests before a medical screening exam, allowing hospitals to appear compliant with timeliness metrics while patients remain unseen, potentially resulting in low value care. • In response, the measure developer provided clarifications to address these concerns, explaining that the measure incorporates multiple numerator components, which reduces incentives to manipulate any single element and makes it harder for gaming behaviors to meaningfully improve performance across all criteria. The developer stated that the technical expert panel explicitly discussed potential gaming during measure development and that the measure's design seeks to minimize opportunities for manipulation.
Program Placement	• Committee members discussed appropriate program placement. Although some participants supported use in quality reporting programs, many opposed starting use in the Hospital Value Based Purchasing Program until more experience with reporting is gained. • The measure was adopted in the Hospital OQR and the REHQR Program for voluntary reporting in 2027 and mandatory reporting in 2028. CMS clarified that the ECAT eCQM is being submitted for the Hospital IQR Program, not the Hospital OQR Program. The Hospital IQR Program has the statutory requirement that measures be publicly reported for at least 1 year before HVBP inclusion. • CMS confirmed it would not remove the measure from Hospital OQR if added to Hospital IQR.

Areas for Future Consideration: The committee encouraged CMS to leverage this measure

as a driver of improvement by initially incorporating it into pay-for-reporting programs prior to use in payment-based initiatives. As part of future implementation, CMS intends to conduct ongoing impact and surveillance analyses—stratified by hospital characteristics—to identify any systematic biases and to track for potential unintended consequences that may emerge over time. Committee members also noted the importance of addressing care beyond traditional inpatient pathways, recommending that CMS explore development of a complementary measure focused on timely and effective care for patients in observation status.

The developer highlighted that current time thresholds are grounded in available evidence and expert consensus (e.g., the 4-hour benchmark for boarding time, informed by JC and ACEP recommendations). However, both CMS and the developer emphasized the need for continued reassessment of these thresholds as additional data accumulate. The committee encouraged CMS and the measure developer to prioritize ongoing monitoring for potential gaming behaviors to ensure the measure functions as intended and promotes genuine improvements rather than unintended distortions in practice.

2.1.14 MUC2025-055 Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Sepsis Hospitalization [CMS]

Description: The measure estimates a hospital-level 30-day, all-cause, risk-standardized readmission rate (RSRR) for patients aged 65 and older discharged from the hospital with a principal diagnosis of sepsis including post-procedural sepsis. Readmission is defined as unplanned readmission for any cause within 30 days of the discharge date for the index admission. Readmissions are classified as planned and unplanned by applying the planned readmission algorithm. CMS will report the measure for patients who are 65 years or older and enrolled in fee-for-service (FFS) Medicare or Medicare Advantage (MA) and are hospitalized in non-federal short-term acute care hospitals.

Public Comment Summary: Battelle received 26 written public comments and two spoken public comments about this measure. The comments emphasized the importance of a sepsis measure. Commenters believed this measure holds organizational leadership accountable and empowers frontline staff and middle managers to prevent sepsis in conjunction with the SEP-1 measure. The ACEP and the Infectious Diseases Society of America expressed support for the measure. However, commenters expressed concerns about the addition of MA data, alignment with SEP-1, and questions related to administrative burden and reliance on claims-based data.

Closing Gaps of Care Considerations: As people age, immune function declines, increasing susceptibility to sepsis. As such, the proposed sepsis measures risk adjust for age. Patients readmitted to a different hospital within 30 days after hospitalization for sepsis, which is more common in rural facilities, may experience higher in-hospital mortality, longer LOS, and higher hospitalization costs. Compared to urban patients, rural patients have higher odds of in-hospital sepsis death. Sepsis survivors incur high health care costs that can persist for years after discharge from initial hospitalization, imposing greater financial burdens on uninsured patients. For patients hospitalized with sepsis, limited English proficiency increases the odds of sepsis mortality.[17]

Measure Review Final Vote:

[17] For complete information on the Closing Gaps of Care literature review for this measure, including references cited, please refer to the Hospital Recommendation Group Meeting slide deck.

Hospital Inpatient Quality Reporting Program: The committee reached consensus agreement to recommend the measure for use in the Hospital Inpatient Quality Reporting Program.

- **Vote Count:** Recommend 19 (95%), Do Not Recommend, 1 (5%), No Recusals.

Hospital Readmissions Reduction Program: Although consensus was not reached, the majority of the committee expressed some support for use of the measure in the Hospital Readmissions Reduction Program.

- **Vote Count:** Recommend 13 (65%), Do Not Recommend 7 (35%), No Recusals.

Discussion Themes	Committee Member Discussion
Importance to Patients	• A patient committee member shared their experience as a 15-time sepsis survivor as the result of a knee replacement. They attributed their survival to their infectious disease doctor identifying their sepsis early. • Other committee members also shared experiences of loved ones diagnosed with sepsis. The committee agreed that addressing sepsis mortality is important to providing high-quality care.
Defining Sepsis	• The committee discussed concerns about using different definitions of sepsis across measures. The measure developer noted the calibration and performance of the risk model for this measure are excellent.
Program Implementation	• Committee members indicated the measure should not be included in the HRRP until it has been in the Hospital IQR Program for several years. Phased roll-out would allow hospitals to be well positioned when the measure moves to HRRP and allow time for implementation before hospitals are reimbursed based on measure performance.

Areas for Future Consideration: Committee members believed the measure should be implemented in the Hospital IQR Program before it is implemented in a payment program. This will give hospitals time to address challenges with measure reporting.

Committee members would like CMS to provide a standardized definition for sepsis that can be used across measures. CMS stated that because there is no single widely accepted definition of sepsis, the definitions chosen for measures must balance concerns about sensitivity and specificity. Nevertheless, committee members voiced a desire for a consistent definition across sepsis measures.

2.1.15 MUC2025-047 Hospital Sepsis Program Core Elements Score [CMS]

Description: Annual, non-weighted score, assessing acute care hospitals on their leadership support, personnel resources, implementation of quality improvement tools and practices to improve the recognition and care of patients with sepsis. Measure score = Sum of Hospital Sepsis Program Priority Examples in use by hospital.

Public Comment Summary: Battelle received 72 written public comments and two spoken public comments about this measure. Commenters expressed support for this measure as a

complement to SEP-1, while others opposed this measure's potential replacement of SEP-1. Commenters argued that process measures remain essential for ensuring real-time action at the bedside when delays of minutes or hours can determine outcomes. SEP-1 is repeatedly cited as the only nationally standardized mechanism holding hospitals accountable for timely recognition, treatment, and escalation of care. While some commenters acknowledge the burden of SEP-1 and support refinement or modernization, commenters believed that eliminating process accountability would risk increased missed sepsis and preventable harm.

However, commenters indicated this measure could be specified more clearly. They noted that interpreting metrics outside the NHSN survey responses can be challenging. Commenters would like more information on how the measure is tested and specified. There was also some concern that the measure requires changes without providing a payment pathway. Commenters also emphasized that structural and outcome measures alone are insufficient for a time-sensitive medical emergency.

Although commenters generally supported the Hospital Sepsis Program Core Elements Score framework, many raised concerns about implementing an attestation-based structural measure tied to reimbursement. Key issues included administrative burden, risk of box-checking, inconsistent interpretation, limited verification, and lack of validated linkages between structural attestations and outcomes across diverse hospital settings. Commenters had pronounced concerns for small, rural, and safety-net hospitals, where rigid staffing or documentation expectations may be infeasible and could inadvertently widen care gaps.

Closing Gaps of Care Considerations: See MUC2025-055.

Measure Review Final Vote:

Hospital Inpatient Quality Reporting Program: The committee reached consensus agreement to recommend the measure for use in the Hospital Inpatient Quality Reporting Program.

- **Vote Count:** Recommend 20 (95%), Do Not Recommend 1 (5%), No Recusals.

Discussion Themes	Committee Member Discussion
Importance	• A patient participant shared that this structure measure could signal to facility leadership that sepsis care is of importance and should be prioritized. • The committee discussed that performing well on structural measures is easier for hospitals compared to outcome measures. One member encouraged CMS to explicitly explain in future rulemaking how this structural measure should be used in concert with measures of morbidity and mortality to ensure it is impactful. In their opinion, CMS would need to ensure that sepsis-related morbidity and mortality decrease after this measure is implemented.
Usability Challenges	• Some committee members questioned the utility of a structural measure for this topic. • The committee expressed concern about the number of items that ask the respondent to determine whether "sufficient" resources are provided. They stated this seems open to interpretation and gaming and asked if there was any consideration given to framing these

Discussion Themes	Committee Member Discussion
	questions around full-time employees (FTEs) or other resources in a way that could be empirically audited. • The developer did not want to define "enough support," encouraging hospitals to have flexibility in defining what "enough" is for their establishment. An audit tool will be available on the CDC side to support this measure.

Areas for Future Consideration: CMS should explicitly explain in future rulemaking how this structural measure should be used in concert with measures of morbidity and mortality to ensure it is impactful. Committee members encouraged CMS to ensure that sepsis-related morbidity and mortality decrease after this measure is implemented.

2.1.16 MUC2025-045 Adult Community-Onset (CO) Sepsis Standardized Mortality Ratio (SMR) [CMS]

Description: Annual risk-adjusted standardized mortality ratio (SMR) of adult inpatients with community-onset sepsis who died during their hospitalization or were discharged to hospice. SMR is reported annually and is calculated by dividing the number of observed community-onset sepsis deaths by the number of predicted community-onset sepsis deaths.

Public Comment Summary: Battelle received 44 written public comments and three spoken public comments about this measure. Commenters broadly supported the goal of establishing a nationally benchmarked outcome measure for sepsis, while emphasizing the need for careful specification and implementation. Commenters agreed that a risk-adjusted mortality measure fills an important gap in existing quality measurement by allowing hospitals to assess whether sepsis care efforts translate into fewer deaths.

Commenters appreciated that the measure is based on CDC's Adult Sepsis Event definition and objective EHR-derived data rather than claims or documentation-driven approaches. Interested parties viewed this as a meaningful methodological advance that could support fairer comparisons, identify unwarranted variation, and guide system-level improvement. However, commenters consistently noted that mortality is an imperfect outcome influenced by factors beyond inpatient care, including delays in presentation, access to care, transfer patterns, and community-level characteristics.

Commenters were hesitant about the measure's use in the Hospital Value-Based Purchasing Program. Many urged robust risk adjustment, transparency in methodology, appropriate exclusions such as hospice discharges and early transfers, and phased implementation with public reporting prior to financial application. Comments highlighted rural hospitals and referral centers as potentially vulnerable to misattribution if pre-hospital factors are not adequately addressed. Commenters emphasized that outcome measurement alone is insufficient for a time-sensitive condition such as sepsis.

Closing Gaps of Care Considerations: See MUC2025-055.

Measure Review Final Vote:

Hospital Inpatient Quality Reporting Program: The committee reached consensus agreement to recommend the measure for use in the Hospital Inpatient Quality Reporting Program.

- **Vote Count:** Recommend 17 (81%), Do Not Recommend 4 (19%), No Recusals.

Hospital Value-Based Purchasing Program: The committee did not reach agreement on use of the measure in the Hospital Value-Based Purchasing Program.

- **Vote Count:** Recommend 12 (57%), Do Not Recommend 9 (43%), No Recusals.

Discussion Themes	Committee Member Discussion
Inclusion of Transfer and Community-Onset Sepsis Patients	• A committee member expressed support for the measure but was concerned about patients transferred to the hospital with sepsis. They stated that by the time patients reach the hospital, too much time may have passed for the receiving hospital to perform well on the measure. The committee member stated that this measure could penalize hospitals for the behavior of other hospitals. • CMS felt strongly that transfer patients should be included and noted that there is a separate stratification for transfer patients. Other committee members indicated they believed including transfer patients and community-onset patients in these measures is important.
Defining Mortality	• A committee member expressed support for the measure but noted that it assesses in-hospital mortality, not 30-day mortality, and that discharge to hospice counts as mortality. The measure developer commented that complex disease processes can lead to patient decompensation. It is not possible to exclude discharge to hospice for reasons other than sepsis in a measure. • CMS noted they included "discharged to hospice" as a mortality outcome because transferring patients to hospice right before they die may be one way hospitals avoid being penalized by mortality measures.
Validity	• A committee member expressed concern about the lack of validity for the measure and wondered why SEP-1 was used for validation. The measure developer responded that the core bundle of SEP-1 is controversial. When risk adjusted, the correlation between care and mortality is weak. • The committee discussed that this measure correlates poorly with SEP-1, meaning it may have low validity for use.
Implementation Timeline	• A committee member noted there is a lot of desire to do this measure "the right way." The measure is in testing to ensure the electronic pipeline works as expected. There is pressure to get rid of SEP-1; however, promising alternatives need to be sufficiently tested. CMS is looking at a longer time frame for implementation and will continue testing this measure. • A committee member acknowledged that while this measure is important and there is pressure to remove SEP-1, ensuring that the measure is sufficiently tested is vital.

Areas for Future Consideration: While the committee supported implementation in the Hospital IQR Program, committee members indicated through discussion and voting that they

feel the measure needs additional time to mature before implemented in a payment program such as HVBP. Several committee members also emphasized that the measure would benefit from obtaining CBE endorsement, which would ensure an in-depth examination of the measure's validity, including how mortality is defined and the lack of exclusions.

2.1.17 MUC2025-011 Dialysis Facility Discussion of Patient Life Goals [CMS]

Description: Dialysis Facility Discussion of Patient Life Goals is a patient reported outcome performance measure (the D-PaLS PRO-PM). The D-PaLS PRO-PM is a patient-specific measure that can be used to generate a t-score that is indicative of patient satisfaction with their care team about life goals discussions during the treatment planning and ongoing treatment process. The D-PaLS PRO-PM uses the patient specific scores to generate a performance-based facility level score. The performance-based measure is the percentage of adult chronic dialysis patients at a given ESRD facility that have a t-score of greater than 40.

Public Comment Summary: Battelle received 30 written public comments and one spoken public comment on this measure. Many patient organizations supported the measure and appreciated that the measure addresses mismatch between facility goals and patient needs.

However, commenters noted the measure could be strengthened by including transplant goals as a core part of the discussion. Many patient participants explained the challenges of being on dialysis. Patients and patient advocates were concerned this measure will not add to quality of life and imposes survey burden for dialysis patients. They noted there may be overlap between this measure and the In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) survey. Some patient participants wanted more actionability; asking to share goals should be paired with a way to achieve them.

Closing Gaps of Care Considerations: Older adults are more likely to have multiple comorbidities and frailty, so dialysis care should be tailored to these needs. Rural patients may have fewer dialysis centers, longer travel distances, and less frequent access to nephrologists. Treatment plans for those who are uninsured may differ due to increased cost of care. Patients with limited English proficiency reported poorer communication with the dialysis care team.[18]

Measure Review Final Vote:

End-Stage Renal Disease Quality Incentive Program: Although consensus was not reached, the majority of the committee expressed some concern about use of the measure in the End-Stage Renal Disease Quality Incentive Program.

- **Vote Count:** Recommend 7 (33%), Do Not Recommend 14 (67%), No Recusals.

Discussion Themes	Committee Member Discussion
Survey Burden & Patient Experience	• Patient committee members expressed that while discussing life goals with providers is important, dialysis patients may lack the energy to respond to more survey measures. Committee members discussed the large number of survey measures dialysis patients already complete. One committee member noted that 75% of dialysis centers that piloted the measure had response rates of less than 25% for this measure, indicating a lack of patient interest in the measure.

[18] For complete information on the Closing Gaps of Care literature review for this measure, including references cited, please refer to the Hospital Recommendation Group Meeting slide deck.

Discussion Themes	Committee Member Discussion
Relevance to Patient Outcomes	• One committee member noted that while the survey has strong psychometric properties, the measure is not linked to patient outcomes. Another committee member agreed with the assessment that there is no clear benefit for administering this survey. • However, one committee member pointed out that this measure addresses patient experience rather than patient clinical outcomes; these are two different goals. They countered that a patient experience measure may be just as valuable if it improves quality of life.

Areas for Future Consideration: The committee recommended CMS consider ways to reduce the annual survey burden for dialysis patients across all programs, models, and requirements, noting Patient Activation Measure twice a year, Patient Health Questionnaire-9 (PQH-9), Kidney Disease Quality of Life Instrument (KDQOL), ICH CAHPS twice a year, and now the D-PaLS. They recommended elements of this measure be combined with elements of other required survey measures and streamlined to reduce patient survey burden. Of the above, the ESRD QIP only currently utilizes the ICH CAHPS which assesses the experiences of people receiving in-center hemodialysis care.

2.1.18 MUC2025-064 Facility Level Percentage of Chronic Hyperphosphatemia in Dialysis Patients [CMS]

Description: Percentage of adult dialysis patients with a 6-month rolling average phosphorus value greater than or equal to 6.5 mg/dL.

Public Comment Summary: Battelle received 10 written public comments and no spoken public comments on this measure. Several commenters expressed strong support for the measure, noting the broad and skilled perspectives on the measure's technical expert panel (TEP). Commenters noted poor clinical outcomes associated with hyperphosphatemia include increased mortality, hospitalization, vascular calcification, cardiovascular events, and bone fracture. Many commenters said that hyperphosphatemia is a common complication and that appropriate phosphorous levels can be an indicator of health outcomes from dialysis patients.

A commenter expressed concerns that the measure would hold facilities accountable for factors beyond their control. Additionally, there were concerns about patient adherence to phosphate binders, tolerance of the binders, and dietary timing/choices. Another commenter noted the proposed metric relies on observational data and expert opinion with regards to serum phosphorus level thresholds rather than robust clinical trial evidence.

Closing Gaps of Care Considerations: See MUC2025-011.

Measure Review Final Vote:

End-Stage Renal Disease Quality Incentive Program: The committee reached consensus agreement to recommend the measure for use in the End-Stage Renal Disease Quality Incentive Program.

- **Vote Count:** Recommend 16 (76%), Do Not Recommend 5 (24%), No Recusals.

Discussion Themes	Committee Member Discussion
Phosphorus Threshold	• One committee member asked how the phosphorus threshold in the endorsed measure was justified, given the lack of consensus on ideal phosphorus levels for dialysis patients. The measure developer explained that while facilities typically aim for phosphorus below 5.5, evidence shows that a 6-month average above 6.5 is associated with the highest cardiovascular risk. The TEP agreed with this evidence-supported cutoff.
Usability	• A committee member explained that they understood the need for a bone and mineral management measure. However, they disagreed with a phosphorus measure because controlling phosphorus levels in dialysis is difficult and highly dependent on patient factors. Another committee member cited that patients must take two to four pills with each meal and snack to control phosphorus, which is why patient buy-in is challenging. • The measure developer explained that it takes many clinical team members to control phosphorus: the prescribing physician, the dietitian, the whole team working together to help patients lower their phosphorus values and make the best food choices.

Areas for Future Consideration: None.

2.1.19 MUC2025-023 CollaboRATE Shared Decision-Making Tool for Ambulatory or Outpatient Surgery Patients (Surgical CollaboRATE OAS-PM) [American College of Surgeons]

Description: This measure assesses facility level compliance with administration of the CollaboRATE Shared Decision-Making tool to patients undergoing outpatient or ambulatory surgery. To be compliant, facilities must offer 95% of patients the option to complete the CollaboRATE survey within 1 week of the shared decision-making conversation. CollaboRATE has been administered as a paper handout, via mail, electronic mail, computer or web interface, voice recorded telephone interviews, SMS text messages, and through MyChart EHR integration. It is available in 11 different languages, as well as for use in pediatrics, and patients with special considerations such as those with proxies or who are unable to speak for themselves.[19]

Public Comment Summary: Battelle received 24 written public comments on this measure and 10 spoken public comments. A comment from the measure developer noted that current measures in the Ambulatory Surgical Center Quality Reporting (ASCQR) Program and Hospital OQR Program often rely on adverse event and complication-based measures as the primary metrics for quality of care, even though patients in hospital outpatient departments and ASCs are often lower risk with lower frequencies of adverse events. This can lead to lower variation in outcomes and the inability to distinguish quality of care. Other public comments expressed support for encouraging and increasing shared decision-making as something that is both important to patients and supports the best health outcomes.

[19] For full description, review the 2025 Measures Under Consideration List.

Public comments raised some concerns about this measure. A commenter noted that this measure may place burden on the facility where the procedure will be performed, whereas the shared decision-making process is usually conducted in the physician office, not in the surgical center. Commenters also expressed concern that there was limited information available for implementation and testing, particularly validity testing. Commenters also shared concerns about the measure becoming a checkbox measure because it assesses the administration of the tool and may not incentive providers to make the process meaningful. Finally, commenters shared concerns about the need to harmonize this tool with existing patient-reported surveys, such as CAHPS.

Closing Gaps of Care Considerations: Older patients or those with disabilities may require assistance or proxy support to complete the survey. Certified EHR adoption rates are significantly lower among rural physicians, and urban facilities are more likely to have robust technological infrastructure to administer the CollaboRATE survey electronically. The tool is available in 11 different languages.[20]

Measure Review Final Vote:

Ambulatory Surgical Center Quality Reporting Program: The committee did not reach agreement on use of the measure in the Ambulatory Surgical Center Quality Reporting Program.

- **Vote Count:** Recommend 12 (57%), Do Not Recommend 9 (43%), No Recusals.

Hospital Outpatient Quality Reporting Program: The committee did not reach agreement on use of the measure in the Hospital Outpatient Quality Reporting Program.

- **Vote Count:** Recommend 11 (52%), Do Not Recommend 10 (48%), No Recusals.

Discussion Themes	Committee Member Discussion
Importance to Patients	• Patient committee members discussed the importance of shared decision-making from their perspective. They explained that what may seem clear to a physician may not always be clear to the patient.
Attribution & Program Selection	• Committee members raised concerns about the tool being used outside the purview of hospitals/surgical centers, increasing expenses related to outpatient surgery, and increasing survey burden for patients. Committee members believed this measure would be more appropriate for evaluating performance of the surgeon's office. • One committee member shared that critical access hospitals have little control over the behaviors of surgeons and that a single surgeon can negatively impact reimbursement for the entire hospital. • The measure developer commented that they wanted to keep this measure in the outpatient setting because the number of ambulatory surgeries is increasing and there is not nearly as much information about what is going on in outpatient settings as in inpatient settings.

[20] For complete information on the Closing Gaps of Care literature review for this measure, including references cited, please refer to the Hospital Recommendation Group Meeting slide deck.

Discussion Themes	Committee Member Discussion
Survey Burden	• Committee members discussed survey burden for patients receiving surgery in outpatient settings. They noted that this survey would be additional to the OAS CAHPS that is already required. In 2028, the Information Transfer Patient-Reported Outcome Performance Measure (PRO-PM) and the Total Hip or Total Knee PRO-PM will both be voluntary and then required in the subsequent year. Committee members believed that this places a large survey burden on this patient population.

Areas for Future Consideration: Several committee members encouraged CMS and the measure developer to more fully consider how attribution decisions and care-setting selection may influence performance results, and to use this reflection to determine whether the ASCQR and Hospital OQR programs are the most appropriate programs for this measure. Some members also suggested exploring applicability within MIPS. In addition, multiple committee members emphasized the need for greater harmonization with related measures across programs and care settings to help reduce patient survey burden and promote consistency.

2.1.20 MUC2025-065 Malnutrition Care Score [The Academy of Nutrition and Dietetics]

Description: Composite: This measure assesses the percentage of eligible encounters of adults aged 18 years and older at the start of the eligible encounter during the measurement period, with a length of stay equal to or greater than 24 hours, who received optimal malnutrition care where care performed was appropriate to the patient's level of malnutrition risk and severity. Malnutrition care best practices recommend that for each eligible encounter, adult inpatients are:

1. screened for malnutrition risk or for a dietitian referral order to be placed,
2. assessed by a registered dietitian (RD) or registered dietitian nutritionist (RDN) to confirm findings of malnutrition risk, and if identified with a “moderate” or “severe” malnutrition status in the current performed nutrition assessment,
3. receive a “moderate” or “severe” malnutrition diagnosis by a physician or eligible clinician as defined by the Centers for Medicare & Medicaid Services (CMS), and
4. have a current nutrition care plan performed by an RD/RDN.

Public Comment Summary: Battelle received 10 written public comments and nine spoken public comments, many of which were specific to implementation in the cancer hospital setting. The comments indicated that malnutrition is a common safety risk in cancer patients. Nutrition is also a component of best-practice cancer care. Commenters viewed this measure as an easy addition because other settings already use it. However, there was some concern about using the measure in rural settings, which may not have 24-hour access to registered dieticians.

Closing Gaps of Care Considerations: Malnutrition in older adults is common, under-recognized, and linked to higher mortality, morbidity, functional decline, and poorer quality of life. Urban health care facilities are more likely to staff a dietician/nutritionist than rural facilities. Medicare and most other insurers use a payment model based on medical diagnoses, including malnutrition, to reimburse hospitals for a patient’s stay. An insurer may issue a denial for any diagnostic code if they believe the medical record documentation submitted with the claim is

insufficient to support application of the code. Lastly, patients have differing understanding, interpretation of, and identification with malnutrition risk and malnutrition terminology.[21]

Measure Review Final Vote:

Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program: The committee reached consensus agreement to recommend the measure for use in the Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program.

- **Vote Count:** Recommend 19 (95%), Do Not Recommend 1 (5%), No Recusals.

Discussion Themes	Committee Member Discussion
Importance to Patients	• A patient committee member commented that this measure is important for cancer patients, who often experience malnutrition.
Rural Hospitals	• One committee member commented that rural acute care hospitals are moving toward developing remote and hybrid positions for registered dietician coverage. The benefit of this measure is not only to promote evidence-based guidelines of malnutrition care but also to promote creative solutions to staffing shortages.

Areas for Future Consideration: With strong support for this measure, CMS may wish to consider other applicable programs with patient populations that would benefit from a measure of malnutrition.

2.1.21 MUC2025-020 Advance Care Planning (ACP) [CMS]

Description: Percentage of patients aged 18 years and older at the start of the measurement period with one or more inpatient encounters during the measurement period who have an advance care planning document or documentation of an advance care planning discussion resulting in a documented decision in the electronic health record (EHR) by the time of hospital discharge for at least one hospital encounter during the measurement period.

Public Comment Summary: Battelle received 100 written public comments and 10 spoken comments on the measure. Themes from the public comments included beliefs that any opportunity to interact and assess patients' end-of-life wishes should be encouraged prior to a surgical procedure. Health care providers should remain confident during unforeseen adverse outcomes. Some commenters stated that this measure appears reasonable and aligns with ongoing efforts to reduce hospital-acquired infections, and to improve care quality and patient safety. Commenters felt the measure supports patient-centered care.

Commenters emphasized that ACP helps ensure patient wishes are known and respected, reduces unwanted interventions, eases decisional burden on families, and mitigates moral distress for clinicians. Many cited personal and professional experiences in which the absence of ACP documentation led to suffering, confusion, or care misaligned with patient values. There was widespread endorsement of expanding ACP measurement to adults aged 18 and older, recognizing that serious illness, trauma, and loss of decision-making capacity can occur at any age. Commenters viewed inpatient encounters as critical moments when ACP information is

[21] For complete information on the Closing Gaps of Care literature review for this measure, including references cited, please refer to the Hospital Recommendation Group Meeting slide deck.

often urgently needed, while also emphasizing that ACP should be a longitudinal process occurring across care settings rather than a single documentation event during hospitalization.

Public comments raised concerns regarding uncertainty about what constitutes a documented decision on ACP, patient burden, and about patients completing ACP repeatedly due to hospital EHRs lacking interoperability. Many commenters cautioned against requiring a "documented decision" as an outcome of ACP discussions, noting that meaningful conversations may appropriately result in deferral or refusal, which should still satisfy measure intent. Without flexibility, commenters warned the measure could incentivize rushed or check-box -driven documentation rather than authentic, patient--centered communication. Commenters also raised concerns about documentation burden and that the measure's testing in a limited number of health IT systems may not reflect rural, post--acute, or outpatient settings.

Closing Gaps of Care Considerations: ACP in older populations may increase potentially burdensome care at end of life, highlighting the importance of aligning ACP with the patients' true preferences. Because ACP initiatives are often sponsored by urban or suburban-based health care institutions, rural populations are less likely to have access to ACP discussions facilitated by a health care practitioner. Care is typically fragmented for patients dually eligible for Medicare and Medicaid because they are administered separately and cover different services. Integrated models such as Program of All-Inclusive Care for the Elderly (PACE), Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs), and Medicare-Medicaid Plans (MMPs) have been developed to coordinate care, but only a small fraction of patients are currently enrolled in integrated models. Medicare beneficiaries are more likely than non-Medicare beneficiaries to have ACP documented in an EHR preoperatively. Patients with limited English proficiency experience barriers in end-of-life decision-making and care planning.[22]

Measure Review Final Vote:[23]

Hospital Inpatient Quality Reporting Program: The committee reached consensus agreement to recommend the measure for use in the Hospital Inpatient Quality Reporting Program.

- **Vote Count:** Recommend 19 (90%), Do Not Recommend 2 (10%), No Recusals.

Hospital Value-Based Purchasing Program: Although consensus was not reached, the majority of the committee expressed some support for use of the measure in the Hospital Value-Based Purchasing Program.

- **Vote Count:** Recommend 14 (67%), Do Not Recommend 7 (33%), No Recusals.

Medicare Promoting Interoperability Program: The committee reached consensus agreement to recommend the measure for use in the Medicare Promoting Interoperability Program.

- **Vote Count:** Recommend 16 (76%), Do Not Recommend 5 (24%), No Recusals.

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[22] For complete information on the Closing Gaps of Care literature review for this measure, including references cited, please refer to the Hospital Recommendation Group Meeting slide deck.

[23] Because MUC2025-020 is specified and was tested at the hospital inpatient level, CMS leadership removed this measure from voting consideration for all non-relevant programs. The Recommendation Group still discussed the following programs but did not vote on them: Ambulatory Surgical Center Quality Reporting Program; End-Stage Renal Disease Quality Incentive Program; Home Health Quality Reporting Program; Hospital Outpatient Quality Reporting Program; Inpatient Psychiatric Facility Quality Reporting Program; Inpatient Rehabilitation Facility Quality Reporting Program; Long-Term Care Hospital Quality Reporting Program; Merit-based Incentive Payment System; Rural Emergency Hospital Quality Reporting Program; Skilled Nursing Facility Quality Reporting Program; and Skilled Nursing Facility Value-Based Purchasing Program.

Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program: The committee reached consensus agreement to recommend the measure for use in the Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program.

- **Vote Count:** Recommend 20 (95%), Do Not Recommend 1 (5%), No Recusals

Discussion Themes	Committee Member Discussion
Exclusions	• Committee members voiced that this measure should allow exclusions for patients who refuse. CMS indicated they were not considering changes to exclusions at this time.
Care Setting	• A committee member stated that ACP is essential for patient-centered care, but hospitals are not the ideal setting to have these discussions because patients are often acutely ill and under stress. • One committee member stated that having ACP conversations with people in the hospital can feel confrontational. • ACP conversations may also become rote process, especially when they happen at the beginning of a hospitalization and can be awkward. • CMS stated the goal of implementing this measure would be to normalize ACP conversations as part of routine care. • Committee members encouraged CMS to continue monitoring of this measure after implementation to ensure it promotes meaningful ACP discussions, rather than it becoming a "checkbox" measure.

Areas for Future Consideration: The committee encouraged CMS to carefully monitor this measure after implementation to ensure the measure does not incentivize rushed or checkbox-driven documentation rather than authentic patient-centered communication. The committee also encouraged CMS to monitor documentation burden associated with implementing this measure.

2.2 Clinician Committee Measures

2.2.1 MUC2025-034 Low Density Lipoprotein Cholesterol (LDL-C) Monitoring and Management [American Heart Association]

Description: Percentage of patients aged 18 years and older with clinical atherosclerotic cardiovascular disease (ASCVD) who received a low-density lipoprotein cholesterol (LDL-C) test via lipid panel and achieved an LDL-C of <70mg/dL on the most recent test during the measurement period.

Public Comment Summary: The measure received 26 written comments, two spoken comments, and a congressional support letter. Commenters noted strong evidence that lowering LDL-C reduces ASCVD risk, highlighted recent reversals in cardiovascular mortality trends, and noted uncontrolled LDL-C levels require enhanced clinical management, particularly for those with chronic kidney disease (CKD), where ASCVD is a leading cause of mortality. Commenters noted alignment with Kidney Disease: Improving Global Outcomes (KDIGO) recommendations to assess and treat LDL-C in CKD, and with American Heart Association (AHA) and American College of Cardiology (ACC) guidelines that target LDL-C <70 mg/dL for ASCVD patients.

Commenters also highlighted the measure's focus on outcomes rather than prescribing practices and noted that patients view LDL-C values as clear, actionable indicators of risk and treatment progress.

Commenters recommended refinements to enhance interpretability and feasibility, including considering a <55 mg/dL target for very high-risk patients; allowing exceptions for multimorbidity; incorporating shared decision-making; reporting LDL-C monitoring and goal attainment separately, particularly in multiplayer or low integration settings; permitting a 50% LDL-C reduction as an alternative metric when baseline values are unavailable; and monitoring subgroups (e.g., women and racial/ethnic minority groups) to avoid widening gaps in testing and control. One professional society raised feasibility concerns for older adults and suggested refining the specifications before advancing the measure in MIPS.

Closing Gaps of Care Considerations: Older adults face challenges due to multimorbidity, frailty, cognitive impairment, and polypharmacy, which complicate treatment decisions and hinder control. Urban patients undergo lipid testing more often than rural patients, and uninsured individuals—despite similar disease prevalence as insured patients—are far less likely to receive treatment or achieve control. Language and health literacy barriers further limit effective management; many patients do not know their LDL-C targets or grasp the seriousness of high cholesterol. The review underscores the need to improve testing, treatment access, and patient education.[24]

Measure Review Final Vote:

Merit-based Incentive Payment System: The committee reached consensus agreement to recommend the measure for use in the Merit-based Incentive Payment System.

- **Vote Count:** Recommend 21 (78%), Do Not Recommend 6 (22%), No Recusals.

Discussion Themes	Committee Member Discussion
Measure Type & Specification	• Committee members stated that the outcome-based design improves upon statin-dispensing measures by supporting a broader set of interventions such as lifestyle changes, physical activity, dietary modification, and non-statin therapies. • Several committee members noted that achieving LDL-C <70 mg/dL often requires multiple therapies that may be costly and administratively complex. • Committee members requested clarity on denominator criteria, including the requirement for a lipid panel within the measurement year and how to treat patients without recent testing. • The developer noted that a defined LDL-C goal may drive routine testing and help close care gaps in older adults, women, rural residents, and underrepresented minorities. • Committee members debated whether to use separate scores (testing and goal attainment) or a single composite outcome, recognizing implications for missing data.

[24] For complete information on the Closing Gaps of Care literature review for this measure, including references cited, please refer to the Clinician Recommendation Group Meeting slide deck.

Discussion Themes	Committee Member Discussion
Target Population	• The developer confirmed that the denominator is designed to require a lipid panel in the calendar year and explained that focusing on the ASCVD population reflects the strongest evidence and high prevalence of uncontrolled LDL-C. • Some committee members cautioned that limiting the denominator to ASCVD patients may reduce population-wide screening incentives.
Performance Threshold & Attribution	• Committee members supported the measure but warned that a 100% performance target is not feasible and recommended awarding full MIPS credit at a high but achievable threshold (e.g., ~90%). • Committee members noted that age, multimorbidity, and polypharmacy make universal attainment unrealistic. • Committee members suggested that team-based or system-level attribution may be more appropriate because lipid management often involves multiple clinicians. • CMS clarified the measure would likely be placed in a MIPS Value Pathway (MVP), though some members noted MVP design can limit meaningful choice.
Measure Exceptions	• A committee member asked how to document exceptions when non-billing staff deliver care and whether pregnancy qualifies as an exception. • The developer clarified that exceptions align with other CMS measures, including pregnancy-related circumstances, and can be reported using ICD or HCPCS codes, while acknowledging documentation challenges outside structured encounters.
Patient & Gaps of Care Considerations	• Members emphasized the importance of shared decision-making to support understanding, treatment agreement, and sustained adherence. • A committee member noted the measure promotes prevention and chronic disease management, but highlighted access challenges related to medications, testing, and follow-up care. • Several committee members raised concerns that affordability, coverage restrictions, and limited access to non-statin therapies could hinder clinicians' ability to meet targets. • Committee members stressed that socioeconomic status, rural practice environments, and medical complexity could disproportionately impact performance and requested CMS anticipate implications for widening care gaps. • The developer reiterated that a clear LDL-C goal may help reduce gaps in care among historically underserved groups.

Discussion Themes	Committee Member Discussion
CBE Endorsement	• Committee members noted that the measure is not endorsed by a consensus-based entity and that endorsement provides assurance of a measure's validity and reliability. CMS stated that endorsement is a separate, resource-intensive process and its absence should not be interpreted negatively.

Areas for Future Consideration: Committee members recommended that CMS refine the LDL-C measure with additional guidance around measure specification and explore program performance thresholds that consider real-world implementation challenges. They urged CMS to clarify the denominator, testing intervals, and treatment of missing data, and to report LDL-C testing and goal attainment separately. Members encouraged CMS to reinforce system-level accountability, support team-based care, and address access barriers. They also supported obtaining CBE endorsement to affirm the scientific acceptability of this measure.

2.2.2 MUC2025-042 Rate of Timely Follow-up on Abnormal Screening Mammograms for Breast Cancer Detection [Brigham and Women's Hospital]

Description: This electronic Clinical Quality Measure (eCQM) reports the percentage of female patients aged 40 to 75 years with at least one abnormal screening (BI-RADS 0) or screening-to-diagnostic (BI-RADS 4, 5) mammogram during the measurement period (i.e., calendar year) who received timely diagnostic resolution defined as either follow-up imaging with negative/benign/probably benign results or a breast biopsy within 60 days after their index (i.e., first) abnormal screening mammogram. Negative/benign/probably benign follow-up imaging was defined as diagnostic mammography, breast ultrasound or magnetic resonance imaging (MRI) with BI-RADS ratings of 1, 2, or 3. Relevant diagnostic breast biopsy procedures were defined as core needle biopsy, fine needle aspiration, and surgical excision. Breast Imaging – Reporting and Data System (BI-RADS) ratings: 0-incomplete, 1-negative, 2-benign, 3-probably benign, 4-suspicious, 5-highly suggestive of malignancy.

Public Comment Summary: Battelle received 11 written comments and four spoken comments on the measure. Commenters supported the measure's potential to strengthen breast cancer care, noting that breast cancer is the second leading cause of cancer-related death among U.S. women and that delays in follow-up after abnormal screening results drive disease progression and poorer outcomes. Commenters said the measure could close quality gaps by tracking both the timeliness and completeness of follow-up, thereby improving screening and diagnostic processes. They identified technical challenges, because imaging reports and BI-RADS assessments often reside in unstructured EHR fields, and they noted the risk of penalizing clinicians for delays outside their control, including scheduling constraints, patient navigation barriers, and patient-driven postponements. They also observed that smaller or rural facilities may lack sufficient IT infrastructure, creating a disproportionate resource burden.

Closing Gaps of Care Considerations: Individuals over 70 are more likely to experience delayed follow-up after an abnormal screening mammogram, underscoring the need for targeted interventions for older populations. Women in rural areas face higher false positive rates, longer delays before biopsy, and reduced access to core needle biopsy procedures, reflecting systemic limitations in rural health care capacity. Insurance status further influences timely care. Patients with Medicaid or without insurance are more likely to delay breast imaging or diagnostic procedures due to out-of-pocket costs, compared to those with

employer-sponsored coverage. Non-English-speaking Latina patients experience markedly longer care pathways than English-speaking Latina or white patients.[25]

Measure Review Final Vote:

Merit-based Incentive Payment System: Although consensus was not reached, the majority of the committee expressed some support for use of the measure in the Merit-based Incentive Payment System.

- **Vote Count:** Recommend 20 (71%), Do Not Recommend 8 (29%), No Recusals.

Discussion Themes	Committee Member Discussion
Clinical Importance and Performance Threshold	• Committee members emphasized the significant patient safety and emotional impact associated with delayed diagnostic follow-up after abnormal mammograms. • Committee members supported the 60-day threshold as clinically meaningful and evidence based, although some noted feasibility challenges for resource-limited settings. • Members suggested a 60-day follow-up standard with flexibility through stratification, improvement scoring, or tiered time frames, and recommended piloting a "time to first diagnostic contact" metric. They supported retaining age 40 for average-risk screening and explicitly including high-risk patients under 40.
Attribution and Operational Feasibility	• Committee members discussed challenges in assigning responsibility, given reliance on scheduling workflows, technologist availability, and imaging capacity. • The developer explained that they completed feasibility, reliability, and validity testing at the individual clinician level, and committee members observed that reliability improves further when the measure is reported at the group level. • Several committee members recommended group-level attribution because it better reflects shared operational responsibility and reduces the risk of holding individual clinicians accountable for system-level factors outside their control.
Data Completeness & Reporting	• Committee members expressed concern that BI-RADS information is not consistently captured in discrete EHR fields, which may force reliance on Natural Language Processing (NLP) or text-search extraction methods. • Committee members requested that CMS provide guidance on which data extraction methods are acceptable for eCQM reporting and clarify compliance expectations. • They recommended piloting the measure across diverse settings, phasing in adoption with technical assistance, and harmonizing follow-up and screening measures while supporting public reporting of timeliness indicators.

[25] For complete information on the Closing Gaps of Care literature review for this measure, including references cited, please refer to the Clinician Recommendation Group Meeting slide deck.

Discussion Themes	Committee Member Discussion
Measure Scope and Alignment	• Committee members recommended including younger individuals who are at high risk for breast cancer and receive early screening. • Committee members encouraged harmonizing the diagnostic follow-up measure with the existing breast cancer screening measure to create a closed-loop quality framework and support continuity of care. • Committee members advised CMS to consider how MIPS inclusion, attribution decisions, and implementation guardrails affect fairness and feasibility.

Areas for Future Consideration: Committee members urged CMS to adopt clear attribution rules that default to group or TIN reporting and use clinician-level reporting only when volumes support reliable estimates. They supported dual attribution options, defined exclusions, and site-based adjustments.

In voting considerations, members requested clear eCQM guidance, including expectations for NLP or text search when BI-RADS data are not discrete, and encouraged alignment with structured BI-RADS fields and FHIR standards. They emphasized strengthening interoperability to reduce fragmented care and defining acceptable evidence of follow-up. They recommended piloting across diverse settings, phasing in adoption with technical assistance, and harmonizing follow-up and screening measures while supporting public reporting of timeliness indicators.

2.2.3 MUC2025-043 Rate of Timely Follow-up on Positive Stool-based Tests for Colorectal Cancer Detection [Brigham and Women's Hospital]

Description: This electronic Clinical Quality Measure (eCQM) reports the percentage of patients aged 45 to 75 years with at least one positive stool-based colorectal cancer screening test (i.e., high-sensitivity guaiac fecal occult blood test, fecal immunochemical test, or Cologuard) during the measurement period (i.e., calendar year) who completed a colonoscopy within 180 days after their index (i.e., first) positive stool-based test result date.

Public Comment Summary: Battelle received 21 written comments and four verbal comments on the measure. Commenters overwhelmingly supported the measure's intent and design, consistently emphasizing its importance in promoting timely follow-up after positive stool-based colorectal cancer screening tests. A commenter supported the 180-day timeframe for diagnostic colonoscopy, noting that earlier access could change outcomes and that financial constraints, work leave, and workforce shortages often delay procedures. Strong support also came from a physician commenter who emphasized that the measure reinforces accountability for completing diagnostic colonoscopies and would incentivize health systems to improve timely access. One commenter advocated for including the measure in MIPS, stating that adoption would meaningfully address persistent gaps in colorectal cancer screening and follow-up. Similarly, a commenter described the measure as an important acknowledgment of the critical role of colonoscopy within the screening continuum. Another expressed strong support as well and endorsed the 180-day follow-up time frame. Commenters encouraged CMS to grant credit for documented patient outreach and navigation activities, especially in cases where delays stem from circumstances outside clinicians' control, such as payer-driven prior authorization processes. This recommendation aimed to ensure clinicians are not penalized for system-level

delays. Commenters recommended expanding future iterations of the measure to include all non-invasive colorectal cancer screening modalities rather than limiting it to stool-based tests. They also encouraged CMS to explore shortening the follow-up interval to 90 days to further promote timely diagnostic evaluation.

Closing Gaps of Care Considerations: Patient- and system-level factors intersect with implementation of the measure. Age strongly influences colonoscopy decision-making, as older adults face higher procedural risks (e.g., perforation) and more comorbidities, requiring individualized care while maintaining timely follow-up. Geographic barriers reduce follow-up rates, with rural and remote patients experiencing limited access to gastroenterology specialists and longer travel to endoscopy facilities; a longer follow-up interval may help some patients navigate these constraints. Insurance coverage is a critical determinant of timely follow-up: federal requirements ensure private insurance coverage for diagnostic colonoscopy after a positive stool-based test, but uninsured patients continue to face financial barriers. Language proficiency also affects screening and follow-up, as individuals with limited English proficiency are less likely to be up to date with colorectal cancer screening and may have difficulty understanding results and the need for prompt diagnostic colonoscopy.[26]

Measure Review Final Vote:

Merit-based Incentive Payment System: The committee did not reach agreement on use of the measure in the Merit-based Incentive Payment System.

- **Vote Count:** Recommend 16 (57%), Do Not Recommend 12 (43%), No Recusals.

Discussion Themes	Committee Member Discussion
Reliability & Case Minimums	• Committee members stated that the measure is more reliable at the facility level than at the clinician level due to small case counts and low signal-to-noise ratios. • Committee members cautioned that many practices may not meet the case minimums needed for reliable MIPS benchmarking. • Committee members noted that the measure was developed with facility and integrated system data and questioned expanding it to reporting at the clinician and group level without stronger reliability evidence.
Attribution	• Committee members expressed concern that clinicians are held accountable for diagnostic colonoscopy even when health plans or third-party vendors send at-home stool-based tests to patients without clinician involvement. • Committee members emphasized that limited specialist availability, prior authorization delays, and fragmented referral pathways—especially in rural settings—are outside clinician control but still affect measure performance. • Committee members agreed that integrated delivery systems with coordinated navigation are better positioned to meet the measure's expectations and cautioned that holding individual clinicians

[26] For complete information on the Closing Gaps of Care literature review for this measure, including references cited, please refer to the Clinician Recommendation Group Meeting slide deck.

Discussion Themes	Committee Member Discussion
	accountable for processes they do not oversee raises accountability and fairness concerns. • The measure developer shared that testing supported implementation at the clinician group level with further refinement for individual clinician level implementation needed.
Follow-Up & Care Workflow	• Committee members debated using a 90- or 180-day follow-up window; some preferred 90 days to reduce diagnostic delays, while others supported 180 days due to workforce shortages, limited endoscopy capacity, authorization delays, and transportation and socioeconomic barriers. • A member noted that a 180-day interval may feel too long for patients and may be perceived as a lapse in communication or care. • Committee members emphasized that the 180-day window aims to support system-level improvement without suggesting that earlier follow-up is unnecessary. • Committee members stressed the need for clinical triage and urged systems to prioritize patients with positive stool-based tests ahead of routine screenings. They stated that explicit triage protocols, especially in open-access models, improve patient safety and support the measure's intent.

Areas for Future Consideration: Committee members advised CMS to enhance measure reliability by prioritizing group-level reporting within MVPs and phasing implementation through integrated systems before expanding to individual clinicians. They stressed the need for clear attribution when health plans or vendors distribute stool-based tests. Members supported retaining a 180-day follow-up window with a 90-day stratification to promote timely care and encouraged prioritizing positive results in triage workflows. They recommended refining exclusions and considering emerging non-invasive modalities as practice evolves. Members emphasized incorporating patient-level factor considerations, including documented outreach and patient-level barriers, and called for greater transparency in reliability reporting and alignment with MVPs.

2.2.4 MUC2025-020 Advance Care Planning (ACP) [CMS]

Description: Percentage of patients aged 18 years and older at the start of the measurement period with one or more inpatient encounters during the measurement period who have an advance care planning document or documentation of an advance care planning discussion resulting in a documented decision in the electronic health record (EHR) by the time of hospital discharge for at least one hospital encounter during the measurement period.

Public Comment Summary: See MUC2025-020 in the Hospital section of this report.

Closing Gaps of Care Considerations: People living in rural areas have fewer opportunities for ACP. Care is typically fragmented for patients dually eligible for Medicare and Medicaid because they are administered separately and cover different services. People with limited English proficiency experience barriers in end-of-life decision-making and care planning, which may lead to more aggressive interventions at end of life and lower rates of comfort measures

and do-not-resuscitate orders. Medicare patients are also more likely to have preoperative ACP documentation in the EHR than those with other insurance types.[27]

Measure Review Final Vote: CMS removed the measure from voting consideration for the Merit-based Incentive Payment System, as the measure is neither specified nor has it been tested at the clinician level. The committee still discussed the measure but did not vote.

Discussion Themes	Committee Member Discussion
Measure Purpose and Appropriateness in MIPS	• Committee members discussed including the ACP measure in MIPS, stating that ACP conversations often occur too late in hospital or emergency settings. • CMS explained that the measure expands eligibility to adults starting at age 18 and adds codes to capture more ACP activities. • CMS stated that earlier conversations around ACP may reduce stigma. • Committee members supporting early engagement emphasized that the measure focuses on identifying a health care proxy rather than requiring completion of Medical Orders for Life-Sustaining Treatment (MOLST) or Physician Orders for Life-Sustaining Treatment (POLST) forms. • Members requested clearer specifications and updates on measure re-specification work in ambulatory settings. • CMS stated that it is refining context-of-use and advancing cross-program alignment.
Denominator Criteria	• Committee members expressed mixed views on including all adults in the denominator. • Some committee members supported including young adults, while others stated that a universal denominator may not be appropriate for healthier populations. • Committee members questioned using age alone as a criterion and proposed chronic condition-based criteria or alignment with existing MIPS measures. • CMS explained that chronic condition documentation in claims and EHR data is inconsistent and difficult to use for denominator specification.
Feasibility	• Committee members stated that universal application could increase administrative burden, especially in high-volume outpatient settings. • Committee members warned that the measure could promote checkbox documentation instead of meaningful ACP discussions. • Members recommended clearer population definitions and more targeted approaches to improve feasibility.

[27] For complete information on the Closing Gaps of Care literature review for this measure, including references cited, please refer to the Clinician Recommendation Group Meeting slide deck.

Discussion Themes	Committee Member Discussion
Unintended Consequences and Cultural Considerations	• Committee members emphasized the need to account for cultural and religious differences in ACP discussions. • Committee members cautioned that the measure could unintentionally worsen care gaps for rural and underserved populations.

Areas for Future Consideration: Committee members emphasized balancing earlier ACP patient engagement with practical implementation in ambulatory settings. They questioned whether age alone should determine eligibility and encouraged CMS to explore alternative denominators and better alignment across measures. Members stressed prioritizing meaningful, patient-centered conversations rather than administrative tasks, particularly in high-volume practices. They urged CMS to incorporate cultural, religious, and community considerations to avoid widening care gaps and requested clearer population definitions and context of use.

2.3 Post-Acute Care/Long-Term Care Committee

2.3.1 MUC2025-020 Advance Care Planning (ACP) [CMS]

Description: Percentage of patients aged 18 years and older at the start of the measurement period with one or more inpatient encounters during the measurement period who have an advance care planning document or documentation of an advance care planning discussion resulting in a documented decision in the electronic health record (EHR) by the time of hospital discharge for at least one hospital encounter during the measurement period.

Public Comment Summary: See MUC2025-020 of the Hospital section of this report.

Closing Gaps of Care Considerations: See MUC2025-020 of the Hospital section of this report.

Measure Review Final Vote: Because MUC2025-020 is specified and was tested at the hospital inpatient level, CMS leadership removed this measure from voting consideration for all non-relevant programs. The Recommendation Group still discussed the following programs but did not vote on them: Home Health Quality Reporting Program, Inpatient Rehabilitation Facility Quality Reporting Program, Long-Term Care Hospital Quality Reporting Program, Skilled Nursing Facility Quality Reporting program, and Skilled Nursing Facility Value-Based Purchasing Program.

Discussion Themes	Committee Member Discussion
Patient-Centeredness	• The PAC/LTC Recommendation Group broadly agreed that ACP should be meaningful and patient-centered, not reduced to a documentation or compliance exercise. • Members emphasized the importance of initiating ACP conversations by asking what matters most to the individual, rather than focusing narrowly on discrete clinical decisions such as resuscitation status or hospitalization preferences. • Members raised concerns that certain populations—particularly younger individuals and those with chronic conditions—are

Discussion Themes	Committee Member Discussion
	sometimes excluded from decision-making, underscoring the need for inclusive approaches. • Personal and professional experiences shared by members highlighted the dynamic and evolving nature of ACP, noting that patient preferences may change with age, health status, or life events. • Several members raised concerns about unintended consequences, such as "ACP fatigue" or superficial documentation rather than promoting a meaningful conversation. • CMS representatives indicated that feedback would inform future refinements of the measure. The discussion concluded with consensus that ACP is essential to honor patient preferences and improve care quality
Staff Training	• Committee members stressed that who conducts ACP conversations matters, cautioning against reliance on non-clinical or insufficiently trained staff. • The group acknowledged that ACP is already required in some programs and should be integrated thoughtfully into care planning with appropriate staff training.
Cultural Considerations	• Cultural sensitivity emerged as a central theme, with members noting that stigma, mistrust, or cultural norms may limit willingness to engage in ACP discussions in some communities. • Participants emphasized the need to monitor gaps in ACP completion and to address language and cultural barriers to ensure fair implementation.
Portability & EHR Documentation	• Committee members expressed concern about the portability of ACP documents across states and care settings, noting that fragmented systems place patients at risk during transitions of care. • Suggestions included creating a national repository for ACP documents and standardizing EHR fields to improve accessibility and continuity across settings. • Members identified electronic health record field standardization and interoperability as a critical step to make ACP documentation actionable during transitions of care and to ensure documentation is actionable at the point of care.
Implementation Flexibility	• Members proposed aligning ACP updates with existing care planning cycles (e.g., quarterly or annual reviews) and triggering reassessment after significant health changes or transitions. • Members expressed strong caution against rigid timelines, with broad support for flexibility to accommodate individual readiness and circumstances.

Areas for Future Consideration: CMS and measure developers should ensure ACP is a

meaningful, patient-driven process rather than a compliance task. The committee emphasized conversations should reflect what matters most to individuals and acknowledged that preferences evolve over time. Measures should promote inclusive and culturally responsive engagement, address gaps in participation, and avoid unintended consequences such as superficial documentation or ACP fatigue. Effective implementation depends on appropriately trained clinical staff, thoughtful integration into existing care planning workflows, and flexibility to accommodate individual readiness and life changes. Finally, advancing EHR standardization, interoperability, and portability of ACP documentation is essential to ensure patient preferences are accessible and actionable across care settings and transitions, ultimately supporting higher-quality, goal-concordant care.

3.0 Discussion of Common Themes from the 2025-2026 PRMR Recommendation Meetings

During the series of PRMR meetings, Recommendation Group members' feedback on measures for use in CMS programs fell into several recurring themes. The most common rationales for "do not recommend" votes were concerns about measure attribution, risk-adjustment models, the need for additional clarity on specifications, usability or feasibility challenges, and concerns about impacts on rural, low-resource, or low-volume hospitals. Committee members also encouraged CMS to ensure measures undergo CBE endorsement to review the scientific acceptability of the measure prior to MUC List inclusion or implementation; they also encouraged CMS to consider phased implementation within both pay-for-reporting and pay-for-performance programs.

In addition, committee members provided robust feedback to CMS on future considerations for measure development and use. These topics included measure harmonization, patient engagement and burden reduction, special considerations for rural or low-volume hospitals, and health IT infrastructure.

Figure 7 shows the synthesis of topics that members would like to see measure developers and CMS dedicate resources to addressing in future CMS programs during pre-rulemaking.

Figure 7. Areas for Future Consideration

Ensure Measure Attribution Reflects Real-World Accountability and Systems of Care

Throughout discussions, committee members emphasized the need to ensure that measure attribution reflects the entities that truly shape the health care process. Committee concerns about attribution focused on the health system- and community-wide effects that can have unintended negative impacts on clinician and hospital performance on the proposed measures.

During the Clinician Recommendation Group meeting, members said that several of the measures under consideration hold clinicians accountable for outcomes or actions largely driven by system-level factors or external entities.

Examples:

- Abnormal mammogram follow-up measure (MUC2025-042): members stated that timeliness is driven by scheduling capacity, technologist availability, and navigation workflows. They raised concerns that individual radiologists might be penalized for processes beyond their control.
- Positive stool-based test follow-up (MUC2025-043): participants noted that tests are often "sent directly to patients by health plans," meaning clinicians may not order—or even know about—the test, yet would still be held accountable for ensuring timely colonoscopy.
- EDAC measures (MUC2025-053, 030, 031, 039): in addition to clinician-level attribution concerns, the Hospital Committee expressed concerns that hospitals may have limited influence over outpatient follow-up and community-based care, which can impact their performance for these measures.
- ECAT (MUC2025-072): the committee also had concerns about the attribution of this measure because ED delays stem from hospital-wide and outpatient care capacity constraints.
- CollaboRATE measure (MUC2025-023): committee members expressed significant concern about attribution, noting that applying the measure at the hospital or surgical center level may be inappropriate when key drivers of performance—namely surgeons and their office practices—operate outside the facility's direct control. Members cautioned that use of the measure beyond the surgeon's practice could increase outpatient surgery costs and patient survey burden, while unfairly penalizing facilities, particularly critical access hospitals, where the actions of a single surgeon could negatively affect overall reimbursement.

Across discussions, members urged CMS to structure attribution in ways that more accurately reflect real-world care delivery patterns. For example, specifying measures for group- or system-level attribution when processes are operationally shared or externally constrained. They also recommended incorporating guardrails such as multiple performance thresholds, stratified reporting, or phased implementation across programs to reduce misattribution and unintended penalties.

Refine Risk-Adjustment Models through Inclusion of Social Risk Factors, Clinical Completeness, and Community-Level Factors

Committee members frequently stressed the importance of strengthening risk-adjustment models to ensure fair comparisons across hospitals serving very different patient populations.

Examples:

- Hospital mortality measures (MUC2025-036, 037, 040, 046): members highlighted the need to include socioeconomic status, frailty, palliative markers, and social risk variables, noting that missing elements could lead to inappropriate penalties.
- LDL-C outcome measure (MUC2025-034): members raised concerns that socioeconomic status, multimorbidity, polypharmacy, and rural resource limitations could disproportionately affect performance.
- Postoperative VTE (MUC2025-067): member concerns focused on the absence of social-risk adjustments and how EHR fragmentation may bias numerator capture for patients for whom all care is received within one health system compared to patients who receive care from multiple health systems.
- Sepsis measures (MUC2025-055, 045): committee members highlighted the need for unified definitions of sepsis, pointing out that inconsistent definitions across measures undermine risk-adjustment validity.

Members also underscored the role of community- and system-level constraints.

Examples:

- EDAC measures (MUC2025-053, MUC2025-030): the committee cited the limited availability of skilled nursing facilities, home health services, primary care, specialty follow-up, and behavioral health resources as drivers of ED use, observation stays, and readmissions in these measures.
- ECAT (MUC2025-013): committee members emphasized that ED crowding and boarding are often influenced by inpatient bed capacity, post-acute placement delays, and regional staffing shortages; factors that extend beyond the ED itself.

Members encouraged CMS and measure developers to continue evaluating how patient-level and community-level factors interact with measure specifications, attribution, and program use, particularly as measures transition from reporting to payment. They emphasized that addressing these contextual influences is critical to ensuring fair comparisons and supporting the intended use of measures to drive improvement rather than creating unintended consequences. Although incorporating social risk or community-level data elements may be constrained by data availability and other limitations, committee members emphasized the importance of maintaining rigor and transparency in risk-adjustment modeling. Across multiple measures, members recommended pursuing CBE endorsement once methodology is revised to support transparency and confidence in the risk adjustment models.

Expand Feasibility Testing Across Diverse EHR Platforms, Including Rural and Resource-Limited Environments

Committee members noted that patients often receive care across multiple health systems and EHR platforms. Committee members asserted this complicates measurement for outcomes that rely on longitudinal data capture, post-discharge events, or follow-up care. Members cautioned that hospitals and clinicians may be disadvantaged if outcome events or follow-up care occur outside their EHR environment and are not reliably captured. Several members highlighted that organizations operating within integrated delivery systems or single-vendor EHR environments may perform better on measures simply due to more complete data capture, raising concerns for hospitals and practices using multiple EHRs or caring for mobile patient populations.

Members emphasized the importance of wider feasibility testing to account for diverse EHR

systems in hospitals and clinics.

Examples:

- Mammography follow-up measure (MUC2025-042): committee concerns centered on inconsistent BI-RADS data capture across EHR platforms; some sites relied on discrete fields, while others required string-search or NLP methods, prompting requests for CMS clarification on allowable reporting approaches.
- Complex antibiotic measures (MUC2025-016, 019): members had concerns that capturing labs, vitals, timing of antibiotic doses, and exclusion criteria would be particularly challenging for small or rural hospitals with limited EHR sophistication.
- Postoperative VTE (MUC2025-067): members identified potential bias against multi-facility systems where VTE events could be under-captured if patients receive care in an unaffiliated EHR environment.
- ECAT (MUC2025-072): members highlighted challenges with timestamp accuracy, transfer workflows, gaming concerns, and the uncertainty of whether measure performance would reflect true quality of care or EHR mechanics. Across discussions, members requested multi-vendor testing, technical guidance on discrete fields, and phased implementation to ensure readiness across diverse environments.
- Antibiotic stewardship measures (MUC2025-016 and MUC2025-019): members noted that smaller and rural hospitals may lack the advanced EHR functionality and specialized clinical staffing needed to support complex electronic logic, capture exclusions, and reliably implement eCQMs. These limitations raise concerns that measured performance could reflect documentation or infrastructure constraints rather than true prescribing practices.

Members continually discussed FHIR as a promising but still maturing solution to interoperability challenges. Committee members expressed support for CMS's broader strategy to advance FHIR-based data exchange to support eCQMs, reduce reporting burden, and standardize data capture. However, members cautioned that adoption remains uneven across settings and vendors, limiting near-term feasibility for some measures. Members noted that while FHIR can facilitate automated reporting and data portability, premature reliance on FHIR-dependent infrastructures could widen gaps between high- and low-resource care environments if not paired with phased implementation and technical support.

Support Iterative Refinement, Continuous Testing, and Development of Complementary Balancing Measures

Building on themes previously explored, committee discussions highlighted the importance of viewing measures as part of an ongoing implementation and monitoring process where measures may be refined or removed as needed.

Examples:

- Postoperative VTE measure (MUC2025-067): members emphasized the need for a balancing measure to detect overuse of anticoagulation, consistent with CMS's confirmation that such a measure is in development.
- Antibiotic measures (MUC2025-016, 019): committee members called to refine timing logic (e.g., evaluating treatment after the first dose rather than at the initial dose) to prevent unintended delays in sepsis care.

- Sepsis measures: committee members repeatedly encouraged continued testing as definitions and clinical practice evolve. Members noted that variation in sepsis definitions, coding practices, and evolving evidence creates risk for inconsistent signals across measures. They viewed iterative refinement and periodic re-evaluation of specifications as necessary to maintain clinical credibility, support alignment across measures, and ensure that performance reflects true improvements in care rather than changes in documentation.
- LDL-C Monitoring and Management measure (MUC2025-034): committee members also discussed the importance of iterative development for this measure. Committee members generally supported the measure's outcome design but encouraged continued refinement of denominator criteria, performance thresholds, and handling of exceptions to reflect real-world practice, multimorbidity, and patient access barriers.

Across these measures, committee members emphasized that continuous testing, feedback, and refinement—paired with appropriate balancing measures—are critical to effective measurement. Members encouraged CMS to leverage reporting periods, pilot testing, and post-implementation monitoring to identify unintended consequences early and make timely adjustments. They viewed this iterative approach not only as a safeguard against harm but also as a mechanism to build trust, encourage adoption, and ensure that measures continue to advance patient-centered, evidence-based care over time.

Improve Alignment and Harmonization Across Related Measures and Programs to Reduce Burden

Committee deliberations demonstrated the importance of harmonizing measures within clinical pathways and across CMS programs.

Examples:

- Abnormal mammogram (MUC2025-042) and positive stool-based test follow-up measures (MUC2025-043): members stressed the value of aligning diagnostic follow-up measures with corresponding screening measures so the "loop" between screening and diagnostic evaluation is closed.
- Postoperative VTE measure (MUC2025-067): several members expressed concerns about overlap with PSI-12, noting the potential for duplicative penalties and urging CMS to articulate a coordinated roadmap for the evolving hospital harm framework.
- EDAC measures (MUC2025-053, 030, 031, 039): members raised the need for consistent rationale and harmonized follow-up windows across related conditions.
- Sepsis suite (MUC2025-055, 047, 045): members revealed a desire for alignment across process, structure, and outcome measures and consistent and consistent use of a single sepsis definition.

Across these measures, committee members encouraged CMS to implement measures thoughtfully, using reporting programs prior to payment implementation, to allow time for refinement, alignment, and burden reduction. Members emphasized that harmonization and sequencing are critical to ensuring measures work together to drive improvement rather than creating fragmented or duplicative requirements.

Evaluate Measure Impacts and Implementation Challenges in Rural, Low-Volume or Economically Disadvantaged Communities

Throughout their discussions, committee members emphasized that rural, low-volume, and economically disadvantaged facilities may have disproportionate challenges implementing and performing on some measures due to constraints in staffing, health IT capacity, and community resources.

Examples:

- Antibiotic stewardship measures (MUC2025-016 and MUC2025-019): members noted that smaller and rural hospitals may lack the advanced EHR functionality and specialized clinical staffing needed to support complex electronic logic, capture exclusions, and reliably implement eCQMs. These limitations raise concerns that measured performance could reflect documentation or infrastructure constraints rather than true prescribing practices.
- EDAC measures (MUC2025-053, 030, 031, and 039): committee members questioned whether low-volume hospitals can consistently meet minimum case thresholds and emphasized that rural facilities often have limited influence over 30-day outcomes due to constrained outpatient access, fewer post-acute care options, and transportation barriers.
- ECAT (MUC2025-072): members highlighted that ED boarding and prolonged LOS are frequently driven by regional capacity constraints, such as limited psychiatric services and inpatient beds, which disproportionately affect rural and safety-net hospitals.
- Dialysis Facility Discussion of Patient Life Goals PRO-PM (MUC2025-011): members noted resource constraints for patient-reported measures. Members also expressed concern about survey burden and staffing capacity in facilities with limited resources.

Across these measures, committee members encouraged CMS to conduct targeted impact analyses by hospital type and offer tailored technical assistance to support measure adoption and reduce the risk of unintended consequences in rural and resource-limited settings.

Validate and Review Measure Performance in Pay-for-Reporting Programs Prior to Implementation in Value-Based Purchasing Programs

Committee members repeatedly emphasized the importance of sequencing the implementation of new or substantially revised measures through pay-for-reporting programs before advancing them into value-based purchasing (VBP) programs.

Examples:

- Sepsis readmissions measure (MUC2025-055): members advised that CMS monitor the measure in the Hospital IQR Program for several years before considering use in the HRRP. Members stressed that a reporting period would allow hospitals time to adapt workflows, address data capture challenges, and use performance feedback for improvement.
- Community-Onset Sepsis Standardized Mortality Ratio (SMR) measure (MUC2025-045): committee members expressed support for the measure's intent but emphasized the need for additional validation, multi-EHR testing, and endorsement prior to consideration in the HVBP Program.
- Postoperative VTE measure (MUC2025-067): committee members also supported a phased approach for this measure, citing feasibility concerns, measure complexity, and the need to monitor for potential overtreatment and unintended consequences before financial

application.

- ECAT measure (MUC2025-072): the committee raised similar concerns, with members cautioning against early use in HVBP until sufficient experience is gained through IQR reporting.

Across measures, committee members characterized pay-for-reporting programs as a critical learning and refinement phase, enabling CMS and stakeholders to build confidence in measure reliability, fairness, and actionability prior to incorporating measures into payment programs.

Promote Meaningful Patient Engagement while Minimizing Patient Burden

Committee discussions consistently affirmed the value of incorporating patient perspectives into quality measurement, while also cautioning that patient-reported measures must be purposeful, feasible, and clearly linked to meaningful improvements in care. Members stressed that poorly aligned or duplicative patient-reported measures risk increasing burden without delivering commensurate benefit, particularly for patients with complex medical needs or high care utilization.

Examples:

- Dialysis Life Goals measure (MUC2025-011): multiple committee members expressed concern about survey fatigue among dialysis patients and questioned whether the measure would meaningfully influence outcomes.
- CollaboRATE (MUC2025-023): members highlighted concerns about redundancy with other surveys (e.g., OAS CAHPS), the burden placed on facilities to administer the survey outside their workflow, and potential confusion for patients.
- Hospital ACP (MUC2025-020): members emphasized that ACP should remain patient-centered and conversational rather than mechanical or burdensome.

Across these discussions, committee members encouraged CMS to take a strategic and streamlined approach to patient-reported measurement. Members urged CMS to prioritize measures that clearly influence care delivery or patient experience, reduce redundancy across programs, and align survey administration with existing workflows. There was broad support for harmonizing patient-reported measures where feasible, minimizing duplication, and ensuring that the rationale and use of patient-reported data are transparent to both patients and providers.

4.0 2025-2026 PRMR Cycle Next Steps

Detailed summaries of the PRMR Hospital, Clinician, and PAC/LTC Recommendation Group meetings are available at the PQM website. Moving forward, CMS will consider the Recommendation Group votes, discussion points, conditions, and recommendation rationales in future rulemaking for the measures and programs reviewed during the 2025-2026 PRMR cycle.

Appendix A: Acronyms

Please note: The following list encompasses acronyms that Battelle commonly encounters and uses in its work as a CBE. Not all the acronyms will appear in this document.

Acronym	Definition
ACA	Affordable Care Act
ACC	American College of Cardiology
ACO	Accountable Care Organization
AGC	After Government Contract
AHIP	Formerly known as American Health Insurance Partnership
AHRQ	Agency for Healthcare Research and Quality
AI Pilot	Artificial Intelligence Pilot
AIPAC	Advanced Illness and Post-Acute Care
AIR	American Institutes for Research
ANOVA	Analysis of Variance
ASCO	American Society of Clinical Oncology
ASCQR	Ambulatory Surgical Center Quality Reporting Program
ASCs	Ambulatory Surgical Centers
C&E	Cost and Efficiency
CAH	Critical Access Hospital
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CBE	Consensus-Based Entity
CBE ID	Consensus-Based Entity Identification
CDC	Centers for Disease Control and Prevention
CDS	Clinical Decision Support
CDSS	Clinical Decision Support System
CIS	Clinical Information Systems
CMIT	CMS Measures Inventory Tool
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
CO	Community Onset
COIs	Conflicts of Interest
COR	Contracting Officer's Representative
CPG	Clinical Practice Guidelines
CQL	Clinical Quality Language
CQM	Clinical Quality Measure

Acronym	Definition
CQMC	Core Quality Measures Collaborative
CSAC	Consensus Standards Approval Committee
DEL	CMS Data Element Library
Del.	Deliverable
DOI	Disclosure of Interest
dQMs	Digital Quality Measures
DRC	Direct Reference Code
E&M	Endorsement and Maintenance
EC	Electronic Copy
eCQI	Electronic Clinical Quality Improvement
eCQM	Electronic Clinical Quality Measures
ED	Emergency Department
EHR	Electronic Health Record
EPC	Evidence-Based Practice Center
ESRD QIP	End-Stage Renal Disease Quality Improvement Program
EVI	Expected Value of Information
FAQs	Frequently Asked Questions
FFS	Fee-For-Service
FHIR	Fast Healthcare Interoperability Resources
FMS	Full Measure Submission
FY	Fiscal Year
HACRP	Hospital-Acquired Conditions Reduction Program
HCBS	Home and Community-Based Services
HCD	Human-Centered Design
HEDIS	Healthcare Effectiveness Data and Information Set
HH QRP	Home Health Quality Reporting Program
HH VBP	Home Health Value-Based Purchasing
HHS	Department of Health and Human Services
HIQR	Hospital Inpatient Quality Reporting
HOPD	Hospital Outpatient Department
HOPE	Hospice Outcomes and Patient Evaluation
HOQR	Hospital Outpatient Quality Reporting
HQMF	Health Quality Measurement Format
HQR	Hospice Quality Reporting
HQRP	Hospice Quality Reporting Program
HRRP	Hospital Readmissions Reduction Program

Acronym	Definition
HSAG	Health Services Advisory Group
HTML	Hypertext Markup Language
HVBP	Hospital Value-Based Purchasing
IAW	In Accordance With
ICD	International Classification of Diseases (International Statistical Classification of Diseases and Related Health Problems)
IHI	Institute for Healthcare Improvement
IMPACT Act	Improving Medicare Post-Acute Care Transformation Act
IPF	Inpatient Psychiatric Facilities
IPF QRP	Inpatient Psychiatric Facility Quality Reporting Program
IPPS	Inpatient Prospective Payment System
IQR	Inpatient Quality Reporting
IR	Initial Recognition
IRF	Inpatient Rehabilitation Facilities
IRF QRP	Inpatient Rehabilitation Facility Quality Reporting Program
IT	Information Technology
ITS	Intent to Submit
LLMs	Large Language Models
LTACH	Long-Term Acute Care Hospitals
LTCH	Long-Term Care Hospital
LTCH QRP	Long-Term Care Hospital Quality Reporting Program
MA	Medicare Advantage
MACRA	Medicare Access and CHIP Reauthorization Act
MACS	Medicaid: Adult Core Set
MAQIP	Medicare Advantage Quality Improvement Program
MAT	Measure Authoring Tool
MCCS	Medicaid: Child Core Set
MCO	Managed Care Organization
MERIT	Measures Under Consideration Entry/Review Tool
MIPPA	Medicare Improvement for Patients and Providers Act of 2008
MIPS	Merit-based Incentive Payment System
MLTSS	Managed Long-Term Service and Support
MMS	Measures Management System
MS-DOI	Measure-Specific Disclosure of Interest
MSR	Measure Set Review
MSSP	Medicare Shared Savings Program

Acronym	Definition
MUC	Measures Under Consideration
n	Sample Size
NCDC	National Consensus Development and Strategic Planning for Health Care Quality Measurement Contract
NCQA	National Committee for Quality Assurance
NHDNG	Novel Hybrid Delphi and Nominal Groups
NHQI	Nursing Home Quality Initiative
NLP	Natural Language Processing
NQF	National Quality Forum
NQS	CMS National Quality Strategy
NTTAA	National Technology Transfer and Advancement Act
OMB	Office of Management and Budget
OP	Option Period
OY	Option Year
PA	Preliminary Assessment
PAC/LTC	Post-Acute Care/Long-Term Care
PaLS	Patient Life Goals Survey
PAM	Patient Activation Measure
PCHQR	PPS-Exempt Cancer Hospital Quality Reporting
PDF	Portable Document Format
PIE Form	Pre-Meeting Initial Evaluation Form
PL	Project Leader
PM	Project Manager
PMP	Project Management Plan
POC	Point of Contact
PPS	Prospective Payment System
PQA	Pharmacy Quality Alliance
PQM	Partnership for Quality Measurement
PRA	Paperwork Reduction Act
PRMR	Pre-Rulemaking Measure Review
PRO	Patient-Reported Outcome
PROM	Patient-Reported Outcome Measure
PRO-PMs	Patient-Reported Outcome Performance Measures
Q&A	Question & Answer
QC	Quality Control
QCDR	Qualified Clinical Data Registries

Acronym	Definition
QDM	Quality Data Model
QI	Quality Improvement
QMDSA	Quality Measure Developer and Steward Agreement
QPP	Quality Payment Program
REHQR	Rural Emergency Hospital Quality Reporting (Program)
SDOH	Social Determinants of Health
SES	Socioeconomic Status
SLIN	Subline Item Number
SMEs	Subject Matter Experts
SMP	Scientific Measures Panel
SNF	Skilled Nursing Facilities
SNF QRP	Skilled Nursing Facility Quality Reporting Program
SNF VBP	Skilled Nursing Facility Value-Based Purchasing
SOP	Standard Operating Procedure
SOW	Statement of Work
SSA	Social Security Administration
STAR	Submission Tool and Repository
SUD	Substance Use Disorder
TBD	To Be Determined
TEP	Technical Expert Panel
TL	Task Lead
UMLS	Unified Medical Language System
USCDI	United States Core Data for Interoperability
VSAC	Value Set Authority Center
Yale CORE	Yale Center for Outcomes Research and Evaluation

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