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National Consensus Development and Strategic Planning for Health Care Quality Measurement

Fall 2025 Cycle Endorsement and Maintenance (E&M) Technical Report

ADVANCED ILLNESS AND POST-ACUTE CARE COMMITTEE

April 2026

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Executive Summary

For over 2 decades, the United States (U.S.) has focused on improving health care quality for Americans. One of the ways this has been done is by developing and implementing clinical quality measures to quantify the quality of care provided by health care providers and organizations. These clinical quality measures are based on standards related to the effectiveness, safety, efficiency, person-centeredness, and timeliness of care.[1]

At Battelle, we have a strong collective interest in ensuring that the health care system works as well as it can. Health care professionals use quality measures to support health care improvement, benchmarking, and accountability of health care services and to identify weaknesses, opportunities, and gaps in care delivery and outcomes.[1,2]

Battelle is a certified consensus-based entity (CBE) funded through the Centers for Medicare & Medicaid Services (CMS) National Consensus Development and Strategic Planning for Health Care Quality Measurement Contract. As a CMS-certified CBE, we facilitate the review of quality measures for endorsement. Battelle's Partnership for Quality Measurement (PQM) members support consensus-based processes by serving on committees, ensuring informed and thoughtful reviews of quality measures across a range of focus areas aligned with a person's journey through the health care system. Battelle engages PQM members to carry out the consensus-based E&M process, which relies on robust and focused discourse, efficient information exchange, effective engagement, and inclusion of a multitude of voices that represent the health care community (Figure 1).

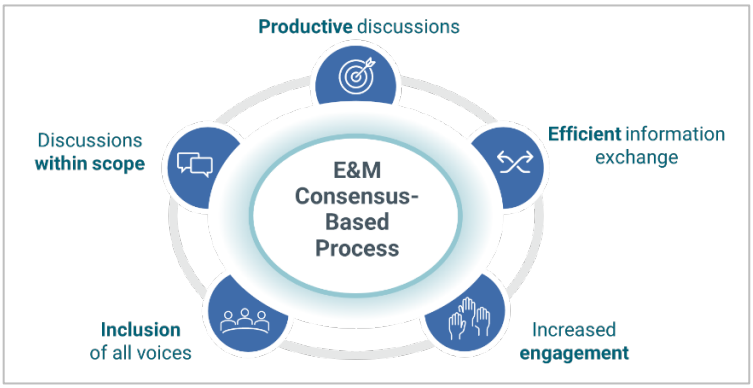

Figure 1. E&M Consensus-Based Process

One of those focus areas is Advanced Illness and Post-Acute Care, which includes measures that focus on infection prevention and control, as well as risk-standardized hospitalization, mortality, and transfusion for individuals living with kidney disease. More than one in seven adults in the United States are estimated to have chronic kidney disease (CKD).[3] Between 2002 and 2022, the number of individuals with newly registered end-stage renal disease (ESRD) increased by 31.3%.[4] During the same period, the number of individuals living with ERSD increased substantially—rising by 88.2% from 2002 to 2019, followed by a decline in 2020, and a gradual increase from 2020 to 2022. This trend reflects a growing population of individuals living with ESRD, underscoring the importance of measuring and improving the quality of care delivered to this population.

Individuals on dialysis have a significantly lower number of expected remaining years of life compared to age-matched individuals in the general population.[4] Hospitalizations are a key indicator of patient outcomes, and, on average, hemodialysis patients are admitted to the hospital 1.5 times a year.[4] Anemia is a frequent and serious complication of CKD that can

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influence patients' outcomes and quality of life; thus, evaluating anemia treatment, which minimizes the need for transfusion, is an area of importance.[5]

For this measure review cycle, developers submitted five measures to the Advanced Illness and Post-Acute Care committee for endorsement consideration. Of the five measures reviewed by the committee (Figure 2), the committee endorsed all five measures (Table 1) based on the PQM Measure Evaluation Rubric within version 2.1 of the E&M Guidebook.

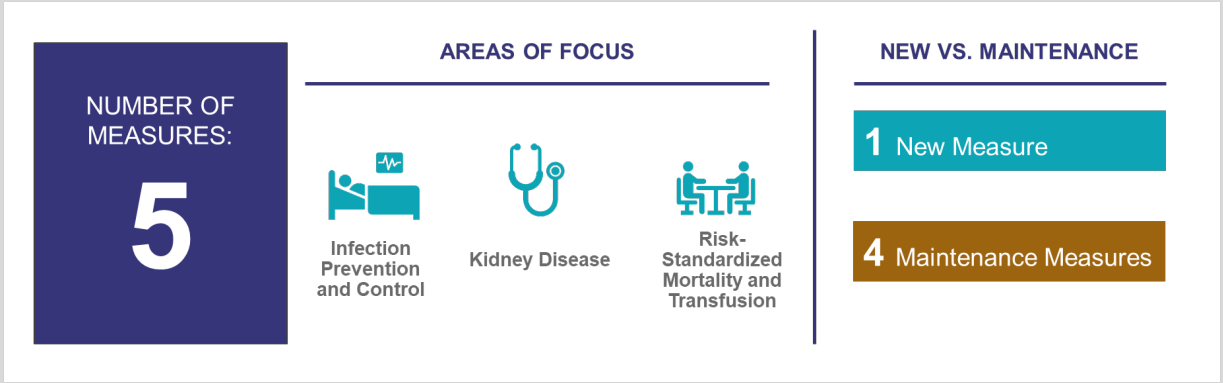

Figure 2. Fall 2025 Measures for Committee Review

Table 1. Measures Reviewed by the Advanced Illness and Post-Acute Care Committee

CBE Number	Measure Title	New/Maintenance	Developer/Steward	Final Endorsement Decision
0369	Standardized Mortality Ratio for Dialysis Facilities	Maintenance	University of Michigan Kidney Epidemiology and Cost Center (UM-KECC)/CMS	Endorsed
1463	Standardized Hospitalization Ratio for Dialysis Facilities (SHR)	Maintenance	UM-KECC/CMS	Endorsed
2978	Hemodialysis Vascular Access: Long-Term Catheter Rate (LTC)	Maintenance	UM-KECC/CMS	Endorsed
2979	Standardized Transfusion Ratio for Dialysis Facilities	Maintenance	UM-KECC/CMS	Endorsed
5320	Percentage of Chronic Hyperphosphatemia in Dialysis Patients	New	UM-KECC/CMS	Endorsed

Endorsement and Maintenance (E&M) Overview

Battelle's E&M process ensures that measures submitted for endorsement are evidence based, scientifically sound, and both safe and effective. This means that the use of the measure will increase the likelihood of desired health outcomes, will not increase the likelihood of unintended adverse health outcomes, and is consistent with current professional knowledge.

We organize measures for E&M by five project areas. Each project topical area has a committee that evaluates, discusses, and assigns endorsement decisions for measures under endorsement review. PQM members representing all facets of the health care system make up these committees. Each E&M committee has an Advisory Group and a Recommendation Group (Figure 3).

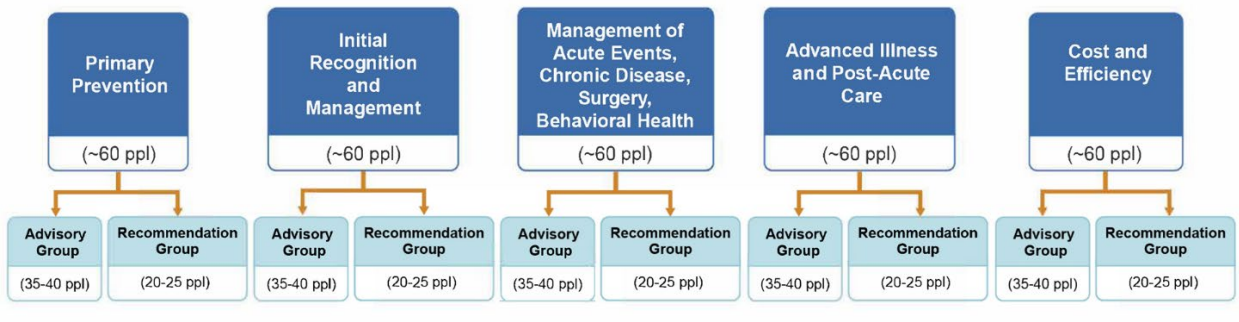

Figure 3. E&M Committee Structure

The goal is to create inclusive committees, made up of interested parties, that balance experience, expertise, and perspectives. The interested parties include those who are impacted or affected by quality and cost/resource use. Figure 4 gives an overview of the perspectives that members represent on E&M committees.

Figure 4. E&M Interested Parties

For the Fall 2025 cycle, the Advanced Illness and Post-Acute Care committee consisted of 11 patient partners (i.e., patients, caregivers, advocates) and 20 clinicians, with specialties in palliative care, nephrology, cardiology, and others (Figure 5). The committee also included seven population health experts.

Appendix A provides a list of committee members, and the PQM website has the full committee rosters and bios are on the respective project pages.

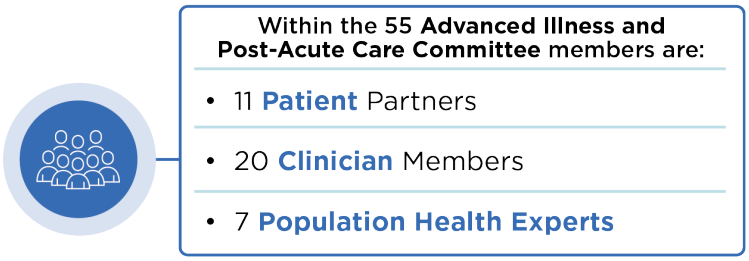

Figure 5. Advanced Illness and Post-Acute Care Committee Members

At the beginning of each E&M cycle, committee members complete a measure-specific disclosure of interest (MS-DOI) form identifying potential conflicts with the measures under endorsement review for the respective E&M cycle. Members are recused from voting on measures potentially affected by a perceived conflict of interest (COI) based on Battelle's COI policy.

Each E&M cycle (i.e., Fall or Spring) has a designated Intent to Submit (ITS) deadline, when measure developers/stewards must submit key information (e.g., measure title, type, description, specifications) about the measure. One month after the Intent to Submit deadline (Table 2), measure developers/stewards submit the full measure information by the respective Full Measure Submission deadline.

Table 2. Intent to Submit and Full Measure Submission Deadlines by Cycle

E&M Cycle	Intent to Submit*	Full Measure Submission*
Fall	October 1	November 1
Spring	April 1	May 1

**Deadlines are set at 11:59 PM (ET) of the day indicated. If the deadline falls on a weekend or holiday, the deadline will be the next immediate business day.*

We then publish measures to the PQM website for a 30-day public comment period, which occurs prior to the endorsement meeting and concurrently with the development of the staff preliminary assessments (PAs). For this evaluation cycle, the public comment period opened on November 17, 2025, and closed on December 16, 2025. The public comment period solicits both supportive and non-supportive comments with respect to the measures under endorsement review. Any interested party may submit a comment on any of the measures up for endorsement review for a given cycle (i.e., Fall or Spring). Developers/stewards can provide written responses to any public comments received directly on the measure's webpage. These responses are under the "Comments" tab of each measure page on the PQM website.

Prior to the close of the public comment period, we host a Public Comment Listening Sessions to gather additional public comments on the measures; these virtual sessions are organized by project with measures grouped by topic/condition. Any interested party may attend to give a brief spoken statement on one or more of the measures. This cycle's session was on December 10, 2025.

We post all public comments received during this 30-day period, including those shared during the Public Comment Listening Sessions, to the respective measure page on the PQM website.

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We received five public comments for the measures this cycle. If a measure received any comments, the measure's evaluation summary includes a summary of these comments.

Following the Public Comment Listening Sessions, we convene the Advisory Group of each E&M project during a public virtual meeting. The purpose of these meetings is to gather initial feedback and questions about the measures under endorsement review. Developers/stewards can share written responses to Advisory Group feedback after these meetings. This process ensures comprehensive input and engagement from all stakeholders involved. For the Advanced Illness and Post-Acute Care committee, the Advisory Group convened on December 3, 2025 and we published a summary of the member feedback and developer/steward responses on the PQM website.

Prior to the Recommendation Group endorsement meeting, we share the full measure submission details, including all attachments, the PQM Measure Evaluation Rubric, the staff PAs, the public comments, Advisory Group feedback, and the developer/steward responses with the Recommendation Group for review. The Advanced Illness and Post-Acute Care Recommendation Group convened on February 9, 2026. The Measure Evaluation Summaries section of this report includes brief summaries of the Recommendation Group deliberations and voting results, and the PQM website has a detailed meeting summary.

During the endorsement meeting, the Recommendation Group focuses their discussions on key themes from the public comments, the Advisory Group meetings, the associated developer/steward responses, independent reviews, and the staff PAs. Measure developers/stewards attend endorsement meetings to provide a measure overview and answer questions from the Recommendation Group.

The Recommendation Group then considers the various inputs and renders a final endorsement decision via a vote. If the Recommendation Group has 20 or more members, consensus is 75% or greater agreement among all active, non-recused Recommendation Group members (Table 3). If the group has fewer than 20 members, the threshold for agreement is 70%. Maintenance measures that fail to reach the 75% consensus threshold but receive between 60% and 74% of votes to retain endorsement (i.e., endorse and/or endorse with conditions) are reconsidered at the end of the endorsement meeting. If the consensus threshold is 70%, maintenance measures are reconsidered if they receive between 60% and 69% of votes to retain endorsement. If the Recommendation Group does not reach consensus via vote after the reconsideration discussion, then the measure loses endorsement.

Table 3. Endorsement Decision Outcomes

Decision Outcome	Description	Maintenance Expectations
Endorsed	**Applies to new and maintenance measures.** The E&M committee agrees by 75% or greater (when 20 members or more) or 70% or greater (when fewer than 20 voting members) to endorse the measure.	Measures undergo maintenance of endorsement reviews every 5 years with a status report review at 3 years (*see Evaluations for Endorsement Maintenance for more details*).[±] Developers/stewards may request an extension of up to 1 year (two consecutive cycles), except if it has been more than 6 years since the measure's date of last endorsement.

Decision Outcome	Description	Maintenance Expectations
Endorsed with Conditions*	**Applies to new and maintenance measures**. The E&M committee agrees by 75% or greater (when 20 members or more) or 70% or greater (when fewer than 20 voting members) that the measure can be endorsed as it meets the criteria, but committee reviewers have conditions they would like addressed when the measure comes back for maintenance. If these the developer/stewards has not addressed these recommendations are not addressed, they should provide a rationale for the E&M committee to consider.	Measures undergo maintenance of endorsement reviews every 5 years with a status report review at 3 years (*see Evaluations for Endorsement Maintenance for more details*).± Developers/stewards may request an extension of up to 1 year (two consecutive cycles), except if it has been more than 6 years since the measure's date of last endorsement.
Not Endorsed°	**Applies to new measures only**. The E&M committee agrees by 75% or greater (when 20 members or more) or 70% or greater (when fewer than 20 voting members) to not endorse the measure.	None.
Endorsement Removed°	**Applies to maintenance measures only.** Either: • The E&M committee agrees by 75% or greater (when 20 members or more) or 70% or greater (when fewer than 20 voting members) to remove endorsement; or • A measure steward retires a measure (i.e., no longer pursues endorsement); or • A measure steward never submits a measure for maintenance, and the steward does not respond after targeted outreach; or • There is no longer a meaningful gap in care, or the measure has topped out (i.e., no significant change in measure results for accountable entities over time).	None.

± Maintenance measures may be up for endorsement review earlier if an emergency/off-cycle review is needed (see Emergency/Off-Cycle Reviews for more details).

** The E&M committee determines the conditions, with the consideration of what is feasible and*

appropriate for the developer/steward to execute by the time of maintenance endorsement review.

°Measures that fail to reach the consensus threshold are not endorsed.

The "Endorsed with Conditions" category serves as a means of endorsing a measure but with conditions set by the Recommendation Group. These conditions take into consideration what is feasible and appropriate for the developer/steward to execute by the time of maintenance endorsement review.

After the E&M endorsement meeting, Battelle posts committee endorsement decisions and associated rationales to the PQM website for 3 weeks for the appeals period. During this time, any interested party may request an appeal regarding any E&M committee endorsement decision.

In the case of a measure being endorsed or endorsed with conditions, the appeal must:

- Cite evidence of the appellant's interests that are directly and materially affected by the measure, and provide evidence that the CBE's endorsement of the measure has had, or will have, an adverse effect on those interests; and
- Cite the existence of a CBE procedural error or show that the E&M committee did not consider information that was available by the cycle's ITS deadline and that information is reasonably likely to affect the outcome of the original endorsement decision.

In the case of a measure not being endorsed, the appeal must be based on one of two rationales:

- The committee did not apply the CBE measure evaluation criteria appropriately. For this rationale, the appellant must specify the evaluation criteria they believe were misapplied.
- The committee did not follow the CBE E&M process. The appellant must specify the process step, how it was not followed properly, and how this resulted in the measure not being endorsed.

If Battelle determines that an appeal is eligible, we convene the Appeals Committee, consisting of the co-chairs from all five E&M project committees (n=10), to review and discuss the appeal. The Appeals Committee concludes its review by voting to uphold (i.e., overturn a committee endorsement decision) or deny (i.e., maintain the endorsement decision) the appeal. Consensus is 75% or greater agreement via a vote among members.

For the Fall 2025 cycle, the appeals period opened on February 25 and closed on March 17, 2026. The measures reviewed by Advanced Illness and Post-Acute Care committee did not receive any appeals.

Advanced Illness and Post-Acute Care Measure Evaluation

For this measure review cycle, the Advanced Illness and Post-Acute Care committee evaluated one new measure and four maintenance measures against standard measure evaluation criteria. During the Recommendation Group endorsement meeting, the committee voted to endorse five measures (Table 4).

Table 4. Number of Fall 2025 Advanced Illness and Post-Acute Care Measures Submitted and Reviewed

-	Maintenance	New	Total
Number of measures submitted for endorsement review	4	1	5
Number of measures withdrawn from consideration*	0	0	0
Number of measures reviewed by the committee	4	1	5
Number of measures endorsed	4	1	5
Number of measures endorsed with conditions	0	0	0
Number of measures not endorsed/ endorsement removed	0	0	0

**Measure developers/stewards can withdraw a measure from measure endorsement review at any point before the committee endorsement meeting.*

Summary of Potential High-Priority Gaps

During the committee's evaluation of the measures, committee members identified gap areas that are summarized below for future development and endorsement considerations.

Addressing Social and Structural Drivers of Outcomes

During discussions of CBE #0369, CBE #1463, CBE #2978, and CBE #2979, the Advisory and Recommendation Groups highlighted social and structural factors such as transportation barriers, access to skilled surgeons, inconsistent staff support, and fragmented communication across care settings that strongly influence the measures' outcomes yet are not captured in current measures. In the discussion of CBE #1463, the subject matter expert (SME) noted that dialysis facilities already have strong incentives to reduce missed treatments; however, addressing transportation is challenging for facilities due to federal regulations around inducements.

Patient Treatment Burden and Lived Experience

During discussions of CBE #5320 and CBE #1463, the Recommendation Group highlighted the impact of pill burden and dialysis time on adherence and well-being (e.g., phosphorus control often trades off with nutrition and pill load). The Advisory Group cautioned that strict thresholds

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might lead to unintended consequences like nutrition trade-offs and highlighted the importance of balancing facility levers with patient burden. Regarding pill burden, the developer explained that dialysis facilities may face trade-offs between reducing pill burden and managing the cost of higher-potency binders. They stated that effective phosphorus management requires comprehensive strategies including dietitian support and optimization of dialysis prescriptions.

Patient Choice and Autonomy

During discussions of CBE #2978, patient partners described having preferences for catheters or concerns about grafts, emphasizing the need to reflect patient voice without penalizing facilities honoring informed choice. The Advisory Group considered how expanded exclusions may protect against coercion while maintaining fairness. The developer explained that the measure includes a pathway to respect patient choice; specifically, the measure excludes a patient maintaining a catheter by preference after a defined period to avoid penalizing facilities for honoring patient autonomy.

Differentiating Avoidable versus Unavoidable Events

While discussing CBE #1463 and CBE #2979, the Recommendation Group noted the importance of distinguishing avoidable from preventable hospitalizations and transfusions to better target quality improvement.

For CBE #1463, the developer indicated that dialysis facilities must conduct Quality Assessment and Performance Improvement (QAPI) reviews, including root-cause analysis of hospitalizations. For CBE #2979, the developer stated that facilities actively monitor average hemoglobin levels and make individualized medication adjustments to minimize transfusion likelihood, especially given the impact of acute hospitalizations.

Summary of Major Concerns

Actionability and Patient Impact of Standardized Mortality Ratio (SMR)

A patient partner opposed the use of mortality as an outcome, calling it too broad, emotionally distressing, and insufficiently actionable at the facility level. The Recommendation Group noted concerns about the interpretability and usefulness of SMR for patients with limited facility choice. The Advisory Group and public comment suggested exploring a standardized risk rate for clearer benchmarking.

Summary of Methodological Issues

The following brief summaries of the measure evaluation highlight the methodological issues the committee considered.

Reliability Concerns

The Recommendation Group discussed major reliability limitations for CBE #0369, CBE #1463, and CBE #2979, questioning their stability, especially for small facilities, and appropriateness for accountability and public reporting. The Advisory Group and public comments echoed reliability concerns, particularly for hospitalization and transfusion data.

For CBE #0369, the developer emphasized that dialysis facilities review each patient death, assess root causes, and identify whether processes such as infection control, fluid management, or potassium management require improvement. The developer confirmed that for CBE #1463, mitigation strategies (e.g., small facility adjustments, measure-domain composites, etc.) should be required in any accountability program using the measure, especially for smaller facilities. For CBE #2979, the developer indicated that they have robust methods, which have undergone multiple refinement cycles, for identifying transfusion events. They stated that uncertainty may relate to the inter-unit reliability (IUR).

Validity Concerns

For CBE #0369, the Recommendation Group and staff assessments highlighted concerns regarding variation analysis across entities. The developer indicated that there is natural variation in comorbidity distributions across facilities.

In discussions of CBE #1463, the Recommendation Group inquired about small-to-moderate validity correlations and how facilities were using the measure to drive behavior change and improvement. The developer explained that correlations are directionally correct, but dialysis facilities vary, which reduces correlation strength. The developer indicated that dialysis facilities must conduct QAPI reviews, including root-cause analysis of hospitalizations. Additionally, ESRD Networks and alternative payment models have historically driven improved cultural practices such as preventing clinical decline.

Risk Adjustment

In discussions of CBE #1463, CBE #2978, and CBE #5320, the Recommendation Group highlighted that the current risk adjustment models do not account for several variables including nutrition, frailty, social risk, and advance care planning, limiting comparability across facilities with different patient mixes. For CBE #1463, the developer found that patient-level race and sex analyses were inconsistent, and facility-level results were unchanged by risk adjustment, leading the technical expert panel (TEP) to conclude that risk adjustment was unnecessary for the measure.

For CBE #0369 and CBE #2979, the Recommendation Group echoed questions from the staff assessment regarding the lack of calibration evidence. The developer explained that for CBE #0369, they conducted calibration modeling comparing expected vs. observed mortality by decile and found that the model is well-calibrated. They used the same risk-adjustment strategy as used for CBE #1463. For CBE #2979, the developer indicated that the process for the transfusion model showed strong alignment between predicted and observed values.

Measure Evaluation Summaries

CBE #0369 – Standardized Mortality Ratio for Dialysis Facilities [UM-KECC/CMS – Maintenance

Specifications | Comment Summary Guide

***Substantive Changes: None**

Description: The Standardized Mortality Ratio (SMR) is defined as the ratio of the number of deaths that occur for Medicare end stage renal disease (ESRD) dialysis patients (both Fee For Service and Medicare Advantage) treated at a particular facility to the number of deaths that would be expected given the characteristics of the dialysis facility's patients and the national event rate for dialysis facilities. This measure is calculated as a ratio but can also be expressed as a rate.

When used for public reporting, the measure calculation will be restricted to facilities with at least three expected deaths in the reporting year. This restriction is required to ensure patients cannot be identified due to small cell size.

Committee Final Vote: Endorse

Vote Count: Endorse (11 votes; 79%), Remove Endorsement (3 votes; 21%), Recusals (0).

Summary of Public Comments: Battelle received one comment from the American Society of Nephrology (ASN) prior to the meeting. ASN supported using the measure for dialysis facilities but recommended excluding deaths from voluntary withdrawal and converting the metric to a true risk-standardized rate for accurate benchmarking and quality improvement, as opposed to a ratio.

Summary of Measure Evaluation: An endorsement committee last reviewed this maintenance measure during the Spring 2020 cycle. CMS's Public Reporting and Dialysis Facility Care Compare currently use the measure.

Discussion Topic/Theme	Committee Discussion Summary
Reliability	• The Advisory Group raised concerns about the low IUR of ≈ 0.47, particularly for small facilities, and questioned whether the measure provides sufficiently consistent estimates to support accountability use. They highlighted potential for selection bias if facilities avoid high-risk or complex patients to influence expected-to-observed mortality ratios. Staff rated Reliability as "Not Met," noting that SMR's reliability falls significantly below established thresholds, and shorter reporting windows (<4 years) do not improve reliability. A Recommendation Group member suggested that, given the reliability concerns, the measure would be appropriate as a quality improvement measure. • The developer explained that reliability is constrained by small facility sizes and fewer events in dialysis facilities compared to hospitals, but the measure remains an important survival metric. To protect small facilities from being

Discussion Topic/Theme	Committee Discussion Summary
	unfairly flagged as outliers, the developer uses statistical approaches such as broader confidence intervals, minimum expected-death thresholds, and modeling strategies designed to balance fairness with detecting real performance differences.
Validity and Risk Adjustment	• The Advisory Group and public comment questioned whether the measure accurately reflects facility performance due to concerns about selection bias and handling of hospice or dialysis withdrawals. Most Recommendation Group reviewers agreed with the staff rating of "Not Met But Addressable" for the Validity domain due to a lack of calibration evidence and variation analysis across entities, and requested clarity from the developer. • The developer reported that they compared predicted versus observed mortality by decile and found that the risk model is well-calibrated. They employed the same risk-adjustment strategy as was used in CBE #1463 and acknowledged natural variation in comorbidity distributions across facilities.
Interpretability and Actionability of Mortality	• Patient partners in the Advisory and Recommendation Groups raised questions about the interpretability and actionability of mortality as an outcome. The Advisory Group discussed actions dialysis facilities can take to reduce mortality that are reflected in the measure, while a Recommendation Group member said the measure is too broad and not directly tied to actionable facility-level practices. The same member noted that mortality has limited interpretability for patients. In contrast, another Recommendation Group member emphasized that mortality differences between facilities can still signal meaningful quality issues and should remain part of public reporting. • The developer emphasized that mortality has long been a key dialysis quality indicator and remains a stakeholder priority in Dialysis Facility Care Compare. Although mortality is a one-time event, facilities are expected to review every patient death, identify root causes, and determine whether clinical processes need improvement. They noted that facility-level interventions such as strengthening infection control, optimizing fluid management, and preventing hyperkalemia can reduce mortality.
Importance of Assessing Mortality	• The Recommendation Group discussed whether eliminating the measure might create harm or remove important signals from public reporting. A committee member noted that despite the mortality being a broad measure, differences across facilities might indicate serious quality issues that warrant further investigation. Additionally, a mortality measure allows facilities to compare themselves to other facilities and identify areas of improvement. A patient partner added that knowing how mortality differs across facilities can serve an important data point when patients are choosing care.

Appeals: None.

CBE #1463 – Standardized Hospitalization Ratio for Dialysis Facilities (SHR) [UM-KECC/CMS] – Maintenance

Specifications | Comment Summary Guide

***Substantive Changes: None**

Description: The standardized hospitalization ratio is the ratio of the number of hospital admissions that occur for Medicare ESRD dialysis patients (both Fee for Service and Medicare Advantage) treated at a particular facility to the number of hospitalizations that would be expected given the characteristics of the dialysis facility's patients and the national norm for dialysis facilities. This measure is calculated as a ratio but can also be expressed as a rate.

Committee Final Vote: Endorse

Vote Count: Endorse (13 votes; 87%), Remove Endorsement (2 votes; 13%), Recusals (0).

Summary of Public Comments: Battelle received one comment from ASN prior to the meeting. ASN suggested implementing a more rigorous risk-adjusted hospitalization rate measure, as conditions distinct from kidney disease are often drivers of hospitalizations for patients with dialysis. They indicated that this measure should be modified to be a true risk-standardized rate as opposed to a ratio.

Summary of Measure Evaluation: An endorsement committee last reviewed this maintenance measure during the Spring 2020 cycle. CMS's Dialysis Facility Care Compare, End-Stage Renal Disease Quality Incentive Program (ESRD QIP), and Dialysis Facility Reports (DFRs) currently use this measure.

Discussion Topic/Theme	Committee Discussion Summary
Importance and Relevance of the Measure	• The Advisory Group recognized the measure's central role in capturing a high-priority outcome for dialysis patients. Patient partners in the Recommendation Group further emphasized that the measure reflects an outcome deeply important to patients and families, describing hospitalization as both disruptive and emotionally burdensome. One patient partner expressed their surprise seeing a rate of 1.5 admissions per patient per year for patients in the highest deciles and found this was an important reminder of the seriousness of hospitalization in this population. The Recommendation Group stated that dialysis facilities can meaningfully influence hospitalizations through dialysis adequacy, dietitian and social work support, vascular access management, and medication optimization. • The developer acknowledged that literature on patient importance is limited, but they stressed that, based on clinical experience and patient preference, avoiding hospitalization strongly aligns with patient goals.
Reliability	• The Advisory Group expressed methodological concerns with the measure similar to CBE #0369, regarding low reliability and potential selection bias. Although staff rated the measure "Not Met" for the Reliability domain, with only

Discussion Topic/Theme	Committee Discussion Summary
	about 20% of facilities meeting the expected threshold of 0.6, many Recommendation Group members felt the developer could address this issue. • The developer confirmed that mitigation strategies (e.g., small facility adjustments, measure-domain composites) should be used by any accountability program using the measure, especially for smaller facilities.
Weighing Reliability, Validity, and Importance	• The Advisory Group noted that hospitalization may often reflect non-kidney-related events and agreed with the public comment's suggestion of implementing a more rigorous risk-adjusted hospitalization rate measure. Staff rated Validity as "Not Met but Addressable," citing partial support from available testing and the need for further evidence on calibration and factor variance. The Recommendation Group also noted the small to moderate validity correlations and asked if facilities are using the drill-downs to improve. Another committee member highlighted that hospitalization is a system-wide issue and hospitals have successfully used similar measures to drive behavior change. • The Recommendation Group debated whether the identified reliability and validity concerns should outweigh the measure's importance. Some members argued that, despite the concerns, the measure still conveys meaningful differences in care. • The SME noted that low reliability stems mainly from small sample sizes, which cannot be improved without changing the unit of analysis. They cautioned that eliminating the measure over these limitations would remove most dialysis outcome measures and reduce critical public health visibility.
Patient Experience and Barriers to Care	• The Advisory Group noted that there are non-clinical drivers of hospitalization (e.g., medication access, transportation, caregiver dynamics, and socioeconomic stress) and suggested dialysis facilities could play a larger role in mitigating these issues. Patient partners in the Recommendation Group reinforced this, stating that the impact of these issues on patients is profound and systemic.

Appeals: None.

CBE #2978 – Hemodialysis Vascular Access: Long-Term Catheter Rate (LTC) [UM-KECC/CMS] – Maintenance

Specifications | Comment Summary Guide

***Substantive Changes: None**

Description: Percentage of adult hemodialysis patient-months using a catheter continuously for three months or longer for vascular access.

Committee Final Vote: Endorse

Vote Count: Endorse (15 votes; 100%), Remove Endorsement (0 votes; 0%), Recusals (0).

Summary of Public Comments: Battelle received one comment from ASN prior to the meeting. ASN suggested adding exclusions such as 1) expected life span of < 6 months who are not enrolled in hospice and 2) patients bridging to a transplant that is expected within 6 months. They suggested incorporating a definition of frailty, similar to how CMS approached community-based elder care models.

Summary of Measure Evaluation: An endorsement committee last reviewed this maintenance measure during the Spring 2020 cycle. CMS's Dialysis Facility Care Compare, the ESRD QIP, and DFRs currently use the measure.

Discussion Topic/Theme	Committee Discussion Summary
Importance and Measure Relevance	• The Advisory Group highlighted the 50% rise in long-term catheter use between 2018-2022 and suggested this may reflect shared decision-making and patient preferences. • Recommendation Group members agreed that the measure addresses a meaningful area of clinical variation and remains important for quality oversight, with a patient partner emphasizing that implementing measures requires iterative refinement as care delivery evolves.
Access to Vascular Surgeons and Structural Barriers	• The Advisory Group raised concerns that systemic factors, particularly limited access to vascular and transplant surgeons, may significantly influence catheter persistence. • The Recommendation Group continued this discussion, with patient partners describing substantial geographic and provider-quality discrepancies in access to skilled vascular surgeons and reporting personal experiences in which limited access directly worsened outcomes. They emphasized that these barriers are major real-world determinants of vascular access success and difficult for a measure to capture.
Catheters vs. Grafts/Fistulas and Patient Choice	• The Advisory Group expressed uncertainty about how new exclusions reconcile patient autonomy with accurate performance measurement and whether expanded exclusions may reduce applicability or create fairness concerns. • The Recommendation Group further discussed patient choice, with a patient partner sharing that based on personal experience across several states, they believe catheters may be safer or more feasible than grafts; they recommended that developers more explicitly integrate lived experience in access pathway design. The Recommendation Group discussed evidence supporting permanent access over catheter use for long-term outcomes but agreed that patient preference plays an important role. • The developer noted that expanding exclusions is necessary to address data gaps such as missing patient choice information and limited visibility into exhausted access. While the expanded exclusions improve the measure's accuracy, they remove about 5-6% of cases. They added that patients over age 84 represent only a small share of the dialysis population (about 2-3%) and are therefore excluded.

Discussion Topic/Theme	Committee Discussion Summary
	• The developer explained that updated exclusion pathways formally recognize sustained patient preference for catheter use so the measure does not penalize facilities for honoring patient choice.
Exclusion Criteria and Data Limitations	• The Recommendation Group discussed suggestions from a public comment about adding exclusions for patients with limited life expectancy or those imminently awaiting transplant. They discussed how these decisions should be operationalized and whether the exclusions were feasible given available data sources. • The developer stated that while the exclusions were conceptually reasonable, they would be difficult to implement because no data sources reliably identify such patients. Hospice enrollment might be another feasible exclusion, but such data are not consistently available for all payer types.

Appeals: None.

CBE #2979 – Standardized Transfusion Ratio for Dialysis Facilities [UM-KECC/CMS] – Maintenance

Specifications | Comment Summary Guide

***Substantive Changes: None**

Description: The risk adjusted facility level Standardized Transfusion Ratio (STrR) is specified for all adult dialysis patients. It is a ratio of the number of eligible red blood cell transfusion events observed in patients dialyzing at a facility, to the number of eligible transfusion events that would be expected under a national event rate, after accounting for the patient characteristics within each facility.

Committee Final Vote: Endorse

Vote Count: Endorse (16 vote; 94%), Remove Endorsement (1 vote; 6%), Recusals (0).

Summary of Public Comments: Battelle received one comment from ASN prior to the meeting. ASN argued the importance of recognizing that the need for blood transfusions, which are not under the purview of the dialysis facility, is often unrelated to kidney disease. They argued that available data on transfusions are of low reliability, which compromises the accuracy and interpretability of the measure. They stated that the measure should be modified to true risk-standardized rate.

Summary of Measure Evaluation: An endorsement committee last reviewed this maintenance measure during the Fall 2019 cycle. CMS's Dialysis Facility Care Compare, ESRD QIP, and DFRs currently use the measure.

Discussion Topic/Theme	Committee Discussion Summary
Importance and Clinical Relevance of Transfusion Outcomes	• The Advisory Group noted that transfusions often arise from conditions unrelated to kidney disease (e.g., gastrointestinal bleeding), raising questions about the extent to which dialysis facilities should be accountable. They asked how the measure reflects adherence to anemia management guidelines, because hospital-side decisions, rather than dialysis facility processes, influence transfusion events. • The Recommendation Group emphasized that, although outcomes are multifactorial, transfusion events are meaningful for patients and directly tied to anemia management practices that facilities can influence. They noted the shift toward outcome measures (e.g., hospitalization, mortality, transfusion) aligns with patient priorities and offers clearer incentives for quality improvement. A committee member expressed tolerance for some uncertainty in reliability and validity, emphasizing that outcome measures draw attention to patient experience.
Reliability Concerns	• The Advisory Group expressed methodological concerns similar to those raised for CBE #0369, especially regarding reliability of transfusion data, which may vary across hospital settings and claims sources. They asked the developer to speak to these issues in the endorsement meeting. Staff rated Reliability as "Not Met," and a majority of Recommendation Group reviewers agreed, citing low reliability indices and concerns about consistency across facilities. The public comment also echoed these concerns, arguing that transfusion data may be of low reliability, affecting measure accuracy and interpretability. • The developer clarified that transfusion-capture methods (especially hospital-based events) have undergone multiple rounds of refinement, and the accuracy of identifying transfusion events is strong despite modest IUR values.
Validity	• Staff rated Validity as "Not Met But Addressable," and a majority of Recommendation Group reviewers agreed, citing a lack of calibration and risk factor variation evidence. When asked to address this concern, the developer stated that the calibration process for the transfusion model showed strong alignment between predicted and observed values.

Appeals: None.

CBE #5320 – Percentage of Chronic Hyperphosphatemia in Dialysis Patients [UM-KECC/CMS] – New

Specifications | Comment Summary Guide

***Substantive Changes: None**

Description: Percentage of adult dialysis patients with a rolling average phosphorus value greater than or equal to 6.5 mg/dL and pediatric dialysis patients with a rolling average phosphorus value greater than or equal to 7.0 mg/dL.

Committee Final Vote: Endorse

Vote Count: Endorse (13 votes; 93%), Do Not Endorse (1 vote; 7%), Recusals (0).

Summary of Public Comments: Battelle received one comment from the ASN prior to the meeting. ASN suggested adding exclusions such as 1) expected life span of < 6 months who are not enrolled in hospice and 2) patients bridging to a transplant that is expected within 6 months. They suggested incorporating a definition of frailty, similar to how CMS approached community-based elder care models.

Summary of Measure Evaluation: The committee reviewed this new measure for initial endorsement. The developer has noted that the measure is planned for use in CMS's Public Reporting and Payment Programs.

Discussion Topic/Theme	Committee Discussion Summary
Appropriateness of Phosphorus Thresholds	• The Advisory Group and Recommendation Group discussed the measure's phosphorus thresholds. The Advisory Group expressed concern that the measure focuses on a laboratory value rather than clinically meaningful outcomes, while the Recommendation Group noted the absence of randomized trials. • The Advisory and Recommendation Groups inquired about patients who remained chronically above the threshold, with the Recommendation Group asking whether the developer had examined the characteristics of those patients. • A patient partner expressed support for the measure, noting that specific thresholds help facilities maintain consistent care. • The developer explained that the TEP selected a 6.5 mg/dL 6-month average threshold for adults because such a threshold identifies a high-risk group with clearly demonstrated adverse outcomes. They emphasized that, although clinical practice generally targets <5.5 mg/dL, the measure's threshold flags elevated risk rather than a recommended clinical goal.
Nutritional Risk and Unintended Consequences	• The Advisory Group and Recommendation Group raised concerns about potential unintended consequences of the measure, particularly for patients at nutritional risk. • The Advisory Group recommended considering additional exclusions or higher thresholds for vulnerable patients and suggested evaluating possible nutritional trade-offs associated with strict phosphorus management. • The Recommendation Group inquired whether the developer could use more advanced nutrition measures (e.g., protein catabolic rate) to refine exclusions. • The developer explained that the measure excludes adults with low serum albumin (less than 3.5 mg/dL) or very low body mass index (BMI), as these indicators reflect high nutritional vulnerability.
Pill Burden and Patient Adherence	• The Advisory Group discussed the need to consider facility levers (e.g., diet counseling, dialysis adequacy, binders) relative to patient pill burden and dietary trade-offs.

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Discussion Topic/Theme	Committee Discussion Summary
	• The Recommendation Group emphasized concerns about high pill burden and its impact on adherence. • The developer acknowledged this substantial burden, with some patients taking up to 18 phosphate binders per day. They noted that facilities must balance reducing pill burden with managing the cost of higher potency binders under the ESRD payment model. They emphasized that effective phosphorus management relies on comprehensive strategies, including dietitian support and optimizing dialysis prescriptions.
Validity and Risk Adjustment	• A Recommendation Group patient partner requested the developer consider race and sex as variation factors. The developer confirmed that they had evaluated these variables and noted that patient-level analyses yielded inconsistent findings and facility-level risk adjustment minimally affected results.

Appeals: None.

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Appendix A: Advanced Illness and Post-Acute Care Committee Roster

Fall 2025 Cycle

Member	Affiliation/Organization	Primary Perspective	Advisory or Recommendation Group
Soojin Jun *(Patient Co-Chair)*	Patients for Patient Safety US	Patient Participant	Recommendation Group
Tipu Puri *(Technical Co-Chair)*	UChicago Medicine	Clinician	Recommendation Group
James Austin	-	Patient Participant	Advisory Group
Samira Beckwith	Chapters Health System	Facility/Institution	Recommendation Group
Joshua Calliste	Healthfirst	Purchaser/Plan	Advisory Group
Karen Campos	American College of Physicians	Other Interested Party	Recommendation Group
Sarah Chuzi	Northwestern Medicine	Clinician	Advisory Group
David Clayman	Mathematica	Clinician	Advisory Group
Elizabeth Coleman	-	Population Health Expert	Advisory Group
Katherine Di Palo	Montefiore Medical Center	Clinician	Advisory Group
Kathleen Dwyer	Legacy Healthcare Services	Clinician	Recommendation Group
Lama El Zein	EmblemHealth	Purchaser/Plan	Recommendation Group
Karie Fugate	-	Patient Participant	Recommendation Group
Sara Galantowicz	Human Services Research Institute	Other Interested Party	Recommendation Group
Paul Galchutt	Transforming Chaplaincy, Rush University	Patient Participant	Advisory Group
Kimberly Geoffrey	-	Patient Participant	Advisory Group
Cameron Gettel	Yale CORE	Clinician	Advisory Group
Sarah Godfrey	Mayo Clinic	Clinician	Advisory Group

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Member	Affiliation/Organization	Primary Perspective	Advisory or Recommendation Group
Laura Green	-	Population Health Expert	Advisory Group
Brenda Groves	KFMC Health Improvement Partners	Patient Participant	Recommendation Group
Morris Hamilton	KPMG LLP	Other Interested Party	Advisory Group
Dorothy Hiersteiner	National Core Indicators	Other Interested Party	Advisory Group
Maria Jaramillo Catalina	-	Population Health Expert	Advisory Group
Andrea Jersey	Ethica Health	Clinician	Recommendation Group
Victoria Johnson	Upstate Area Health Education Center	Population Health Expert	Advisory Group
Raymond Jones	University of Alabama at Birmingham	Researcher	Advisory Group
Warren Jones	Diabetes Foundation of Mississippi	Population Health Expert	Recommendation Group
Lisa Kitko	University of Rochester School of Nursing; University of Rochester Medical Center	Researcher	Advisory Group
Gerri Lamb	Arizona State University College of Nursing and Health Innovation	Clinician	Recommendation Group
Elizabeth Marfeo	Tufts University	Clinician	Advisory Group
Emily Martin	University of California, Los Angeles	Clinician	Recommendation Group
Kyle Matthews	-	Patient Participant	Recommendation Group
Kay Miller Temple	University of North Dakota School of Medicine and Health Sciences	Population Health Expert	Advisory Group
Amy Pease	AG Pease, RN Consulting PLLC	Clinician	Advisory Group
Silvia Perez-Protto	Cleveland Clinic	Clinician	Advisory Group
Lori Piltz	-	Patient Participant	Advisory Group
Heather Raygoza	Saint Joseph Hospital-CommonSpirit	Clinician	Advisory Group
Lauri Redus	Hilo Benioff Medical Center	Facility/Institution	Advisory Group

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Member	Affiliation/Organization	Primary Perspective	Advisory or Recommendation Group
Eric Rosenberg	University of Florida; UF Health Shands Hospital	Clinician	Recommendation Group
Patricia Rowan	Mathematica	Researcher	Advisory Group
Anthony Sanchez	-	Patient Participant	Advisory Group
Karl Sandin	Creighton University School of Medicine	Clinician	Advisory Group
Andrea Schweiger	Martha T. Berry Medical Care Facility	Other Interested Party	Advisory Group
Kristin Seidl	University of Maryland	Clinician	Recommendation Group
Carol Siebert	The Home Remedy, PLLC/Occupational Therapy	Population Health Expert	Recommendation Group
Marcia Spoto	Nazareth College	Facility/Institution	Advisory Group
Samuel Stolpe	Johnson & Johnson	Researcher	Advisory Group
Michelle Stuercke	Transitional Care Management	Clinician	Advisory Group
Rebecca Swain-Eng	SEA Healthcare	Other Interested Party	Advisory Group
Sarah Thirlwell	James A. Haley VA Hospital	Clinician	Advisory Group
Heather Thompson	LHC Group	Facility/Institution	Recommendation Group
Janice Tufte	-	Patient Participant	Advisory Group
Ronald Walters	MD Anderson Cancer Center	Clinician	Advisory Group
Stephen Weed	-	Patient Participant	Recommendation Group
Stephanie Wladkowski	Bowling Green State University	Researcher	Recommendation Group

Partnership for Quality Measurement Organizations

Battelle

Measure Stewards

Centers for Medicare & Medicaid Services

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Measure Developers

University of Michigan Kidney Epidemiology and Cost Center

Appendix B: 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 Plans
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	Contracting Officer
COIs	Conflicts of Interest
COR	Contracting Officer's Representative
CPG	Clinical Practice Guidelines

Acronym	Definition
CQL	Clinical Quality Language
CQM	Clinical Quality Measure
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

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Acronym	Definition
HOQR	Hospital Outpatient Quality Reporting
HQMF	Health Quality Measurement Format
HQR	Hospice Quality Reporting
HQRP	Hospice Quality Reporting Program
HRRP	Hospital Readmission Reduction Program
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

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Acronym	Definition
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
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

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Acronym	Definition
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
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

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Acronym	Definition
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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