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National Consensus Development and Strategic Planning for Health Care Quality Measurement

Guidebook of Policies and Procedures for Pre-Rulemaking Measure Review (PRMR) and Measure Set Review (MSR)

Working Draft
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Changes to the Guidebook

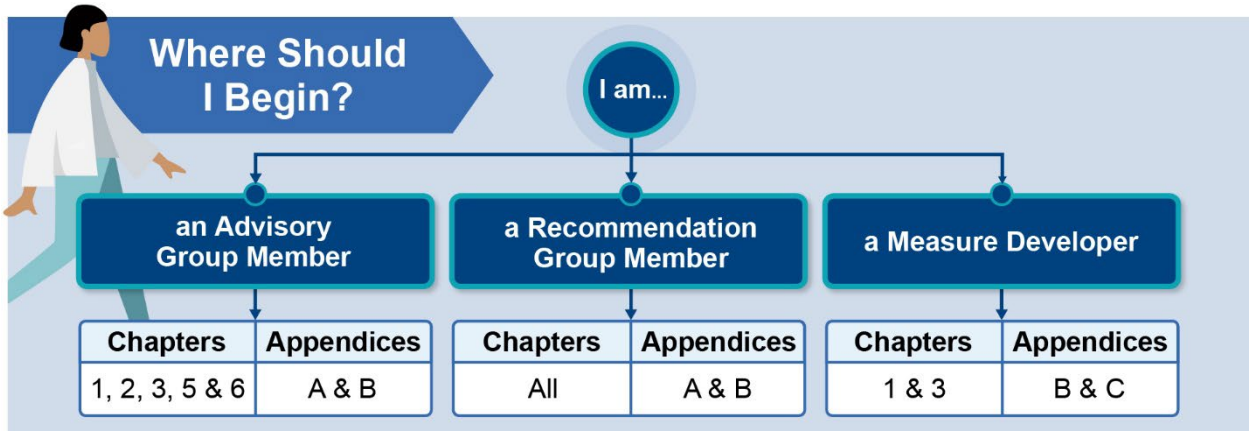
Battelle conducts the Pre-Rulemaking Measure Review (PRMR) process annually to provide recommendations on the selection of quality and efficiency measures for use by the Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services (CMS). Similarly, Battelle conducts the Measure Set Review (MSR) annually to provide recommendations on the continued use of measures in CMS programs.

This guidebook introduces both processes and incorporates changes as suggested by interested parties through a public comment period. Battelle annually updates the guidebook, and all proposed changes undergo a public comment period. We encourage interested parties to also consult the Partnership for Quality Measurement (PQM) website for additional documentation and process details.

The 2026 edition of this guidebook clarifies existing processes and policies and introduces new ones, including:

- **PRMR Recommendations Meeting Structure:** The meeting now includes both the Advisory Group and Recommendation Group. The Advisory Group provides their input first, and then the Recommendation Group discusses and votes.
- **PRMR Measure Previews:** Battelle will host virtual previews to help committee members prepare for their PRMR Recommendations Meeting. Advisory and Recommendation Group members may ask clarifying questions about Measures Under Consideration (MUCs).
- **MSR Performance and Impact Analyses:** Each of the up to 50 preliminary MSR measures will have a Performance and Impact Analysis that references publicly available performance data and other information about measure characteristics.
- **PQM Website Workspace Enhancements:** The updated workspace centralizes member details and features a discussion board, resources, news, and events.
- **Public Comment Posting:** Battelle will post public comments, as written, by the end of the public comment period unless otherwise noted. Commenters should submit only information they are comfortable making public and avoid including prohibited content. (See Appendix D.)

The information in this document is intended to support planning efforts. Battelle may update the guidebook as needed to reflect changing circumstances or requirements. Battelle will communicate any significant updates to interested parties via the communications modes described in Section 5.3 as soon as possible.



Chapter 1. Pre-Rulemaking Measure Review & Measure Set Review

1.1 Overview

The goal of the PRMR and MSR processes is to solicit interested-party input to inform the selection and continued use, respectively, of health care quality and efficiency measures for use in CMS Medicare quality programs. The interested parties include those who are impacted or affected by the use of quality and efficiency measures such as patients/recipients of care and caregivers, clinicians, health care organizations, measure developers and stewards, as well as purchasers and health care plans.

This section provides an overview of how PRMR and MSR enable HHS CMS to receive input on measure selection and continued use.

1.1.1 Pre-Rulemaking Measure Review

HHS, per statute,[1] annually publishes (by December 1) the MUC List for potential federal rulemaking. **The PRMR process supports consensus recommendations regarding the inclusion of measures under consideration in CMS quality reporting and value-based programs**. Through the PRMR process, interested parties assess whether a measure is appropriate for use in the intended CMS program(s) and target population(s). The interested parties evaluate measures on whether they are meaningful, tailored to a unique program and population need, balanced and scaled to meet program-specific goals, and demonstrate a clear vision of near- and long-term program impacts.

Pre-Rulemaking Measure Review (PRMR) is pronounced *Primer*.

[1] 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.

1.1.2 Measure Set Review

MSR, another process enabled by statute,[2] centers on interested-party reviews of measures across various CMS programs. The purpose of the MSR process is to optimize the CMS measure portfolio via review of measures for continued use in programs.

While reviewing a measure for continued use, interested parties consider the measure's current properties and performance trends as well as whether the measure continues to support the program's needs and priorities.

1.1.3 PRMR and MSR Scope and Approach

Both PRMR and MSR processes foster collaboration and balance the contributions of various interested parties, resulting in substantiated recommendations for measure selection or continued use to address national health care priorities, fill critical measurement gaps, and increase alignment of measures across programs. The PRMR process assesses the appropriateness of measures included on the MUC List for the intended program and population. By contrast, the MSR process reviews the relative strengths and weaknesses of CMS's current measure portfolio to consider whether those measures continue to meet program and population needs, and whether measure removals would reduce redundancy in the portfolio or create a measurement gap.

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

The **MSR process** builds recommendations around measure use to optimize the CMS measure portfolio in the quality reporting and value-based programs.

Table 1 summarizes the distinctions between these processes in terms of their overarching goals, approaches, and criteria for measure evaluation. Appendix B has additional information on the evaluation criteria.

[2] Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, 134 Stat. 1182 (2020). The Consolidated Appropriations Act (2021) granted the consensus-based entity the authority to provide input on the removal of quality and efficiency measures. https://www.congress.gov/bill/116th-congress/house-bill/133/text.

Table 1. Summary of PRMR and MSR Scope and Approach

	Pre-Rulemaking Measure Review (PRMR)	Measure Set Review (MSR)
Goal	To achieve consensus as to whether MUC List measures are appropriate for the intended CMS program(s) and target population(s)	To build consensus around measure use recommendations through the identification of opportunities to optimize the CMS measure portfolio
Requirement	Statute requires the process	None, although statute enables the process
Focus	Within targeted program and population	Across the entire CMS measure portfolio
Approach	Evaluate the appropriateness of each measure for a specific intended use	Evaluate how measures align with program goals and determine most effective way to achieve the measures' purpose
Evaluation Criteria	1. *Meaningfulness of the concept of interest in the context of use*: Measure is evaluated and tailored to unique needs of specific program-target population 2. *Appropriateness of scale*: Measure portfolio is balanced and scaled to meet target program- and population-specific goals; specifically, measure is evaluated in the context of all the measures currently within the program measure portfolio 3. *Time-to-value realization*: Measure has plan for near- and long-term positive impacts on the targeted program and population as measure matures	1. *Meaningfulness in the context of use:* Measure set is evaluated across program, target population, and time 2. *Patient health care journey*: Measure set redundancy is identified and mitigated, specifically, by evaluating if the measure addresses the right aspect of care, in the right setting, and at the right point in a patient's journey to maximize the desired outcome 3. *Data stream burden reduction*: Measure set redundancy in data streams is identified and mitigated, specifically by evaluating the burden associated with reporting the measure and considering other related measures

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1.1.4 Annual PRMR and MSR Timeline

Figure 1 provides the high-level schedule of annual PRMR and MSR activities including:

- Committee member nominations
- MSR process (internal preliminary assessments, public comment periods, committee evaluations, educational meetings, and committee meetings)
- PRMR process (internal preliminary assessments, public comment periods, measure previews, committee evaluations, educational meetings, and committee meetings)

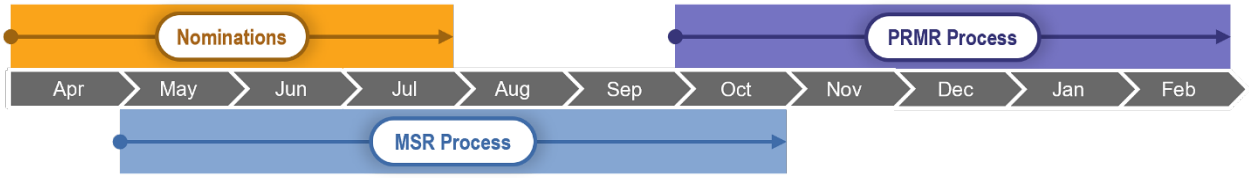


Figure 1. Standard Timeline of PRMR and MSR Activities

Subsequent chapters of this guidebook provide details about each of these activities.

Chapter 2. Organization of Interested-Party Committees

2.1 Overview

Battelle, the consensus-based entity (CBE) that currently holds the CMS National Consensus Endorsement Contract (NCDC), created the Partnership for Quality Measurement (PQM) by bringing together members from across the health care quality landscape who are interested in promoting meaningful quality measurement. Through PQM, Battelle convenes interested parties into committees to participate in PRMR and MSR.

2.1.1 PRMR Committees

PRMR has three committees grouped by care setting: Hospital, Clinician, and Post-Acute Care/Long-Term Care (PAC/LTC). These committees consist of a varied membership representing all facets of the health care system. Battelle emphasizes the inclusion of patients/recipients of care, caregivers, patient advocates, and traditionally underrepresented groups to provide input on measures needed for specific care settings, both within and across various CMS programs and patient populations. Committee members serve a 3-year term.

PRMR and MSR committees enable participation of up to **180** members in CMS measure selection and continued use.

This committee structure supports the Novel Hybrid Delphi and Nominal Groups (NHDNG), a multi-step hybrid technique used in PRMR, which maximizes engagement of all members and structures facilitation by using standard criteria. See Section 2.3.4 for more details on the structure of each PRMR committee into an Advisory Group and Recommendation Group.

2.1.2 MSR Committee

The MSR Recommendation Group does not have a separate nominations process; Battelle annually selects members currently serving on PRMR committees to concurrently serve a 1-year term on the MSR Recommendation Group. We consider the measure characteristics for each MSR cycle to guide membership composition, which consists of 25 to 30 members from across the three PRMR committees (i.e., Hospital, Clinician, and PAC/LTC). Unlike the PRMR committees, MSR has no Advisory Group and one Recommendation Group, which supports a modified NHDNG approach.

2.2 Committee Nomination Process

Battelle staff annually conduct a review of committee member appointments. This includes an internal assessment of current membership to identify gaps in expertise and to determine recruitment needs, a call for public nominations, and targeted outreach.

We publish a call for nominations on the PQM website and send an announcement to all PQM members. Nominees submit their applications through the PQM website. Both self-nominations and third-party nominations are welcome. Third-party nominations must indicate that the

organizational or individual nominee has been contacted and is willing to serve. Nominees complete an application form and a Disclosure of Interest (DOI) form (Appendix A).

Battelle prioritizes selection of individuals who have participated in similar panels/committees in the past or who can demonstrate knowledge of these processes; fit into more than one roster category (discussed in detail in Section 2.2.1); and possess lived experience interacting with the health care system. We balance this approach with the need to include underrepresented voices, which may include individuals with relevant background and experience who have not had an opportunity to participate in these processes before. Battelle's goal is to create committees that encompass the roster categories, with a balance of experience, expertise, and perspectives.

All nominees must complete an organizational/personal DOI; if appointed, committee members complete a measure-specific DOI.

Before finalizing the appointments, Battelle posts a draft roster of nominees on the PQM website to solicit public comment over a 2-week period. Once appointed, all committee members complete a measure-specific DOI form (Appendix A) at the start of each PRMR or MSR review process. Committee members must complete and submit the organizational/personal DOI and the measure-specific DOI forms in a timely fashion and prior to any measure discussion at PRMR and MSR Recommendations Meetings.

2.2.1 Committee Member Roster Categories

To be eligible for participation, nominees should (1) have relevant expertise and demonstrated experience related to the use of quality and efficiency measures and/or (2) belong to at least one of the following roster categories outlined in Table 2.

Committees consist of a combination of those who are most impacted by adoption and implementation of the measures and those who bring broader and system perspectives to the PRMR and MSR processes. The committee membership is composed of both individual and organizational seats.

Table 1. Roster Categories and Target Number of Individuals for PRMR and MSR

Roster Category	PRMR Advisory Group Targets	PRMR Recommendation Group Targets	MSR Recommendation Group Targets
Patients/recipients of care, families, caregivers, patient advocates	**4**	**3**	**3**
Clinicians, including primary care providers and specialists	**4**	**3**	**3**
Facility associations	**3**	**2**	**3**
Clinician associations	**3**	**3**	**3**
Facilities/institutions including accountable care organizations (ACOs)*, hospitals or hospital systems, and post-acute/long-term care facilities	**4**	**5**	**3**
Purchasers and plans (state, federal, and/or private)	**3**	**2**	**2**
Persons who have experience with population health	**6**	**4**	**4**
Researchers in health services or alternative payment models	**2**	**2**	**2**
Other interested parties (e.g., EHR vendors and experts in areas such as quality improvement/implementation science, care coordination, patient safety, behavioral health, and national policymakers)	**3**	**3**	**3**
Federal liaisons (non-voting)	TBD, based on specific measures under discussion	TBD, based on specific measures under discussion	N/A
Average Total	**32**	**27**	**26**
Range	**(30-35)**	**(25-30)**	**(25-30)**

*The facilities/institutions roster category for the Clinician Committee includes a target of two ACOs for the PRMR Advisory Group, two for the PRMR Recommendation Group, and one for the MSR Recommendation Group.

2.2.2 Federal Liaisons

Members of federal agencies may also serve on PRMR committees as non-voting federal liaisons. Federal liaisons do not go through the nominations and selection process. Instead, CMS, in collaboration with Battelle, identifies which federal agencies should participate based on the specific programs and measures under discussion. Federal liaisons participate in the PRMR Recommendations Meeting discussions by providing context about measures and answering questions.

2.2.3 Appointment of Subject Matter Experts (SMEs)

Battelle may add individuals with specialized expertise as non-voting members to the Recommendation Group (either PRMR or MSR), as needed.

For example, for a health care cost measure under review, we may invite researchers and experts in health care financing to participate in the Recommendation Group if no existing members of the group have that expertise.

The measure characteristics guide the process of SME recruitment. For example, following preliminary staff reviews of MUC List measures, Battelle staff will note any specific clinical expertise that the group may need to evaluate each measure. If the PRMR roster does not currently have that expertise, Battelle will work with the Recommendation Group co-chairs to identify the criteria for a potential SME. Next, Battelle will identify potential candidates from among PQM members and their networks. Prior to any measure discussion, SMEs must provide disclosure statements for each measure they discuss.

2.2.4 Time Commitment

Nominees commit to participating in scheduled calls and meetings, providing timely responses to requests for feedback, and being available for ad hoc meetings and conference calls.

For each PRMR cycle (one per year) the time commitment is about 40-60 hours over the course of approximately 3 months, generally November through January. All committee members are expected to:

- Answer emails requesting availability or other requests, including submission of DOI forms
- Attend a virtual orientation meeting
- Conduct assessments of assigned measures under consideration for that PRMR cycle (Note: not all members may be asked to provide written feedback on all measures, but members should be familiar with all measures.)
- Attend a PRMR Measure Preview to prepare for the PRMR Recommendations Meeting
- Review the meeting materials in advance of the PRMR Recommendations Meeting
- Attend a 1- to 2-day PRMR Recommendations Meeting
  - Advisory Group members attend virtually
  - Recommendation Group members may have the option to attend in person; a virtual option is always available

For each MSR cycle (one per year), the time commitment is about 30-40 hours over the course of approximately 2 months, generally September through October. MSR committee members are expected to:

- Answer emails regarding availability or other requests, including submission of DOI forms
- Attend a virtual orientation meeting
- Conduct assessments of assigned measures for review
- Review materials in advance of the 2-day MSR Recommendations Meeting
- Attend a 2-day MSR Recommendations Meeting (Note: MSR Recommendations Meetings may occasionally be in person with a virtual participation option)

In the event a member cannot fulfill their commitment and/or is non-responsive to communications for a prolonged period of time, Battelle staff will attempt to contact the member to understand their challenges with fulfilling their commitment. Otherwise, Battelle staff may find a replacement. If the member serves as a representative from a member organization, Battelle staff will contact the organization to find a replacement. If the member serves as an individual representative, Battelle will identify another PQM member to serve on the committee.

2.3 PRMR Committee Structure

Committees provide recommendations directly to CMS.

Battelle convenes three overarching committees to provide input into measure reviews:

- Hospital Committee
- Clinician Committee
- PAC/LTC Committee

Figure 2 details the committee composition.

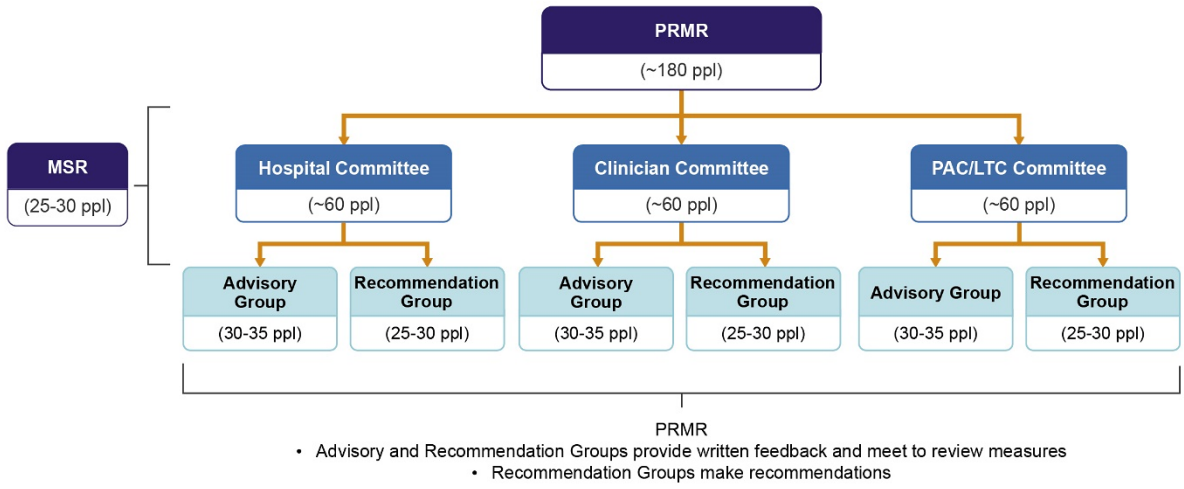


Figure 2. Organization of Interested-Party Committees

2.3.1 Hospital Committee

The Hospital Committee provides input on the selection of measures for hospital and hospital-related settings, including inpatient acute, outpatient, cancer, and psychiatric hospitals. The Hospital Committee provides annual pre-rulemaking input related to:

- Ambulatory Surgical Center Quality Reporting Program (ASCQR)
- End-Stage Renal Disease Quality Incentive Program (ESRD QIP)
- Hospital-Acquired Conditions Reduction Program (HACRP)
- Hospital Inpatient Quality Reporting Program (Hospital IQR)
- Hospital Outpatient Quality Reporting Program (Hospital OQR)
- Hospital Readmissions Reduction Program (HRRP)
- Hospital Value-Based Purchasing Program (HVBP)
- Inpatient Psychiatric Facility Quality Reporting Program (IPFQR)
- Medicare Promoting Interoperability Program (Promoting Interoperability)
- Prospective Payment System (PPS)-exempt Cancer Hospital Quality Reporting Program (PCHQR)
- Rural Emergency Hospital Quality Reporting Program (REHQR)

2.3.2 Clinician Committee

The Clinician Committee provides input on the selection of measures for clinicians' performance across CMS Medicare quality reporting and value-based programs. This committee also evaluates measures for ACOs and health plans, and, dependent on the measures under consideration, may require one or more subcommittees to ensure the appropriate expertise to evaluate and review these measures. The Clinician Committee provides annual pre-rulemaking input related to:

- Medicare Part C and D Star Ratings
- Medicare Shared Savings Program (Shared Savings Program)
- Merit-based Incentive Payment System (MIPS)

2.3.3 PAC/LTC Committee

The PAC/LTC Committee provides input on the selection of measures for post-acute care and long-term care facilities, including home health agencies, hospices, and skilled nursing facilities. The PAC/LTC Committee provides annual pre-rulemaking input related to:

- Home Health Quality Reporting Program (Home Health QRP)
- Hospice Quality Reporting Program (HQRP)
- Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)
- Long-Term Care Hospital Quality Reporting Program (LTCH QRP)
- Skilled Nursing Facility Quality Reporting Program (SNF QRP)

- Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP)

2.3.4 Advisory and Recommendation Groups

Each PRMR 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). Section 3.3 includes a description of the PRMR process.

Advisory Group: members' participation includes providing written feedback during the PRMR process and attending the PRMR Recommendations Meeting as non-voting discussants. Advisory Group feedback is foundational to the recommendations part of the pre-rulemaking process.

Recommendation Group: members' participation includes providing written feedback as well as attending measure review meetings and voting on measure recommendations.

Advisory Group vs. Recommendation Group

Each of Battelle's PRMR committees has an Advisory Group and a Recommendation Group. Advisory Group members review and provide feedback on measures at Recommendations Meetings. This ensures that a larger number of voices contribute to the consensus-building process.

The Advisory Groups' input is critical to the Recommendation Groups' final votes and consensus recommendations to CMS. Both groups work in tandem to provide meaningful input on the selection of measures.

Recommendation Group Co-Chairs: Battelle staff and the two co-chairs facilitate the discussion during PRMR Recommendations Meetings. Annually, Battelle identifies two members from each committee's Recommendation Group; one co-chair is a patient representative, and the other co-chair represents one of the remaining Recommendation Group roster categories. Each co-chair serves a 1-year term. Their role is to:

- Co-facilitate, along with Battelle staff, the discussion during the PRMR Recommendations Meeting
- Ensure the Recommendation Group discussion encompasses Advisory Group feedback and public comments
- Work with Battelle staff to achieve consensus among the Recommendation Group
  - Assist Battelle staff in anticipating questions and identifying additional information that may be useful to the Recommendation Group
  - Advise Battelle staff in appointing SMEs as non-voting members of the committee to augment committee discussions
  - Participate as full voting members

To ensure representation across the various populations of interested parties, Battelle recruits

approximately 60 members to each of the setting-specific PRMR committees. We appoint 30 to 35 people to each Advisory Group and 25-30 people to each PRMR Recommendation Group. Battelle develops a roster for each setting-specific PRMR committee based on the categories in Table 2. PRMR committees are made up of individuals representing their own interests (individual seats) and individuals representing the interests of an organization (organizational seats).

Individual vs. Organizational Seats

PRMR committee rosters include both individual and organizational seats. In roster categories designated as organizational, the organization selects the representative.

2.3.5 Appointment to the Advisory and Recommendation Groups and Term Length

Battelle randomly appoints Recommendation Group participants on an annual rotational basis from the committee roster of eligible nominees, ensuring representation.

Controlled rotation increases transparency.

For example, if the target is seven "clinicians, including primary care providers and specialists," then we randomly assign three of the seven to the Recommendation Group. The other four people serve on the Advisory Group.

The process of random assignment is:

***Step 1*:** Within each roster category, identify the pool of eligible nominees.

***Step 2*:** Among participants, allocate to Advisory or Recommendation Group.

If the appointed Recommendation Group member is unable to participate, we will draw an additional member from the roster category pool of eligible nominees. Individuals serve on the Advisory or Recommendation Group for an entire measure review cycle. For the next cycle, Battelle will randomly select a new Recommendation and Advisory Group. All committee members will serve on the Recommendation Group at least once during their 3-year term.

During the 3-year appointment, committee members will rotate between Advisory and Recommendation Groups. Every member will serve at least 1 year on the Recommendation Group.

In the event a member vacates their spot prior to their term end, Battelle will identify a replacement based on the vacated roster category. Organizations may replace their representatives as they choose to ensure consistent participation; the total length of the member term will not change. If an individual committee member is unable to fulfill their term (for any reason), Battelle removes their name from the roster during the annual nominations process and potentially gives their seat to another nominee. An incoming nominee, if selected for a committee, serves a full 3-year term.

There is no limit to how many times an individual or organization can serve on a committee.

Battelle reserves the right to remove committee members due to inactivity before their term is complete.

Prior to the PRMR and MSR Recommendations Meetings, Battelle will post any interim updates to rosters on the PQM website.

2.3.6 Patient Appointments

We welcome the critical expertise of patients/recipients of care and caregivers. To promote meaningful engagement, we conduct targeted orientations with patient and family committee members in advance of each meeting to familiarize them with the more technical aspects of the work and to affirm the importance of their participation in the group. Honoraria may be available.

To ensure that the patient perspectives are well-represented in Recommendations Meetings and that the PRMR process continually integrates new voices, Battelle will intentionally assign patient representatives to Advisory and Recommendation Groups. We will initially assign patient representatives who are new to quality measures or quality measure review to the Advisory Group to gain familiarity with the PRMR process. Experienced patient representatives may serve multiple terms as a Recommendation Group member.

2.4 MSR Committee Structure

PRMR committee members play a significant role in the MSR process as well. MSR has a single Recommendation Group, and Battelle draws the group's members from all three PRMR committees (Hospital, Clinician, and PAC/LTC). The MSR Recommendation Group has 25 to 30 members.

When inviting PRMR committee members to serve on MSR, Battelle considers several factors, including level of engagement, roster category, and particular expertise or perspective as related to the specific set of measures under review.

MSR Recommendation Group appointments are on an annual basis.

Chapter 3 includes additional information on the MSR schedule, and Section 3.4 includes details on the MSR process.

Chapter 3. PRMR and MSR Process and Evaluation

3.1 Overview

The PRMR and MSR evaluations involve iterative measure reviews. Reviews are a combination of Battelle-led Preliminary Assessments (PAs) and committee member input. Both evaluations use a multi-step process meant to increase member engagement and to structure facilitation by using standard criteria and practices. However, there are some differences in their implementation.

- PRMR uses a modified NHDNG technique to build consensus among committee members, leveraging experienced and trained facilitators.
- The MSR process involves measure portfolio qualitative assessment across programs and is guided by interested parties' input.

Figure 3 presents an overview of these processes.

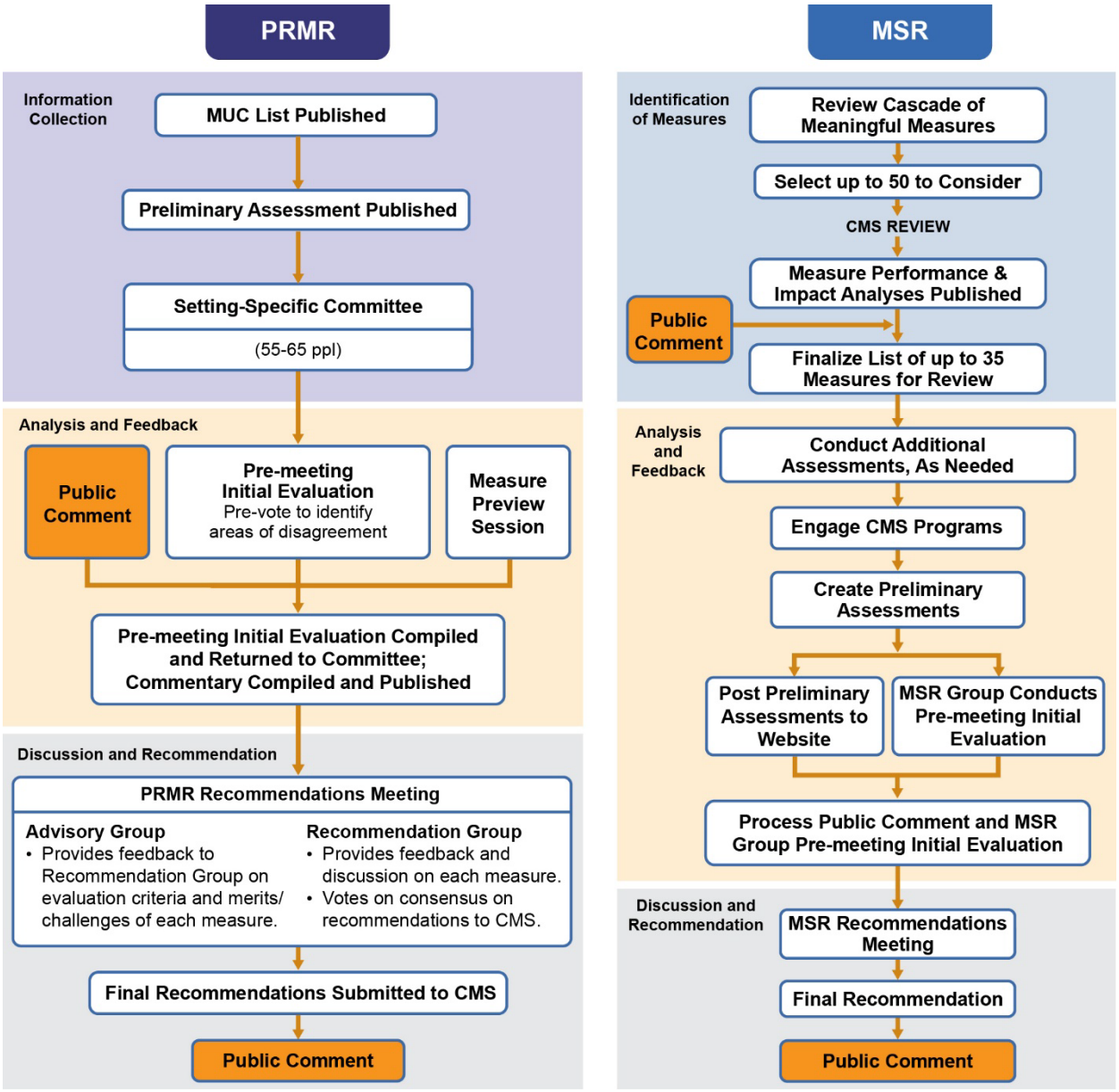


Figure 3. PRMR and MSR Process Workflow

3.2 Approach for Gathering Input

For PRMR and MSR, Battelle solicits input through four methods tailored to the unique needs and engagement levels of interested-party groups. Table 3 presents an overview of the approach for gathering input.

Table 2. Overview of the Approach for Gathering Input

Interested-Party Groups Engaged	Number of Individuals Engaged	Format of Input	PRMR	MSR
General Public	Unlimited	Members of the public provide written comments on the PQM website during the posted public comment period.	✓	✓
PRMR Committee	55-65	Advisory and Recommendation Group members ask clarifying questions about MUCs during PRMR Measure Previews with Battelle, appropriate CMS staff, and measure stewards/developers.	✓	N/A
Advisory Group	30-35	The Advisory Group provides feedback on evaluation criteria and merits/challenges of each measure in writing and during discussion session with Recommendation Group facilitators.	✓	N/A
Recommendation Group	25-30	The Recommendation Group provides feedback on evaluation criteria and merits/challenges of each measure in writing and meets to vote on measures.	✓	✓

Gathering input in this manner enables both structured and unstructured formats of information collection. The approach has built-in levels of both broad and focused information-gathering and encourages a wide range of input.

3.3 PRMR Process

Each PRMR cycle follows the steps outlined below, and Section 3.7 details the timeline.

Step 1: MUC List Released

HHS makes the MUC List publicly available by December 1 of each calendar year.

Step 2: Preliminary Assessments (PAs)

Also, by December 1, Battelle staff develop PAs for the measures on the MUC List and publicly disseminate the PAs. The PAs include evaluation of each measure's scientific acceptability properties. These assessments involve multiple data sources, including the information submitted through the CMS MUC Entry/Review Information Tool (MERIT); discussion with measure stewards and developers, as needed; and the PQM Submission Tool and Repository (STAR) database, as needed. The PA evaluates

whether a measure meets criteria related to importance, reliability, validity, feasibility, and usability in the context of its specific intended use. This information allows the committee to focus its review on the PRMR goals—to assess if a measure is appropriate—rather than engaging in discussions better suited to the endorsement and maintenance (E&M) process. Committee members and the public can view PAs within the PRMR tabbed measure display on the PQM website.

Step 3: Information Collection

Prior to the Recommendations Meetings, both groups complete the Pre-Meeting Initial Evaluation (PIE) Form, and the general public has the opportunity to provide written public comment. Battelle also hosts PRMR Measure Previews to help committee members prepare.

a) **PIE Form:** Battelle provides the Advisory Group and Recommendation Group of each PRMR committee with guidance on evaluating the assertions of each measure. Both groups consider the evidence presented in the PAs and submit initial feedback on the measures via the PIE Form, which captures committee members' answers to the PRMR Evaluation Guiding Questions in Appendix B.

Both the Advisory and Recommendation Groups submit ratings and explanations of ratings on the measures via the Pre-Meeting Initial Evaluation (PIE) Form.

b) **Public Comment:** Battelle issues a 21-day comment period concurrent with publication of the MUC List (on or before December 1 of each year). Battelle staff compile the comments received during the public comment period and make them publicly available on the PQM website no later than 5 days after the close of the public comment period.

c) **PRMR Measure Previews:** Battelle hosts three PRMR Measure Previews, one per setting (i.e., Hospital, Clinician, PAC/LTC) to help Advisory Group and Recommendation Group members prepare for their PRMR Recommendations Meeting. CMS measure leads, measure developers, and stewards/owners attend, and committee members may call upon the developers and steward/owners to answer clarifying questions about their measures. Battelle moderates the previews and compiles information to share with the committees. While PRMR Measure Previews *do not* include public comment or voting opportunities, members of the public can join the webinars in "listen only" mode.

Step 4: Information Synthesis

Battelle staff compile and synthesize information from the public comment process, PIE Forms, and Measure Previews. Staff then share this information with the Advisory Group and the Recommendation Group and identify areas of non-consensus to focus on during the PRMR Recommendations Meeting.

Step 5: PRMR Recommendations Meeting Procedure

In mid- to late-January, each setting-specific Recommendation Group and Advisory Group meet for 1 or 2 full days (depending upon the number of measures under review). The meetings are open to the public.

Battelle staff facilitate PRMR Recommendations Meetings and work with co-chairs to ensure discussions remain productive, within scope, and encompasses all voices. Battelle staff and the co-chairs also establish meeting ground rules and goals, conduct course corrections as needed, and ensure the committees reach decisions.

The meeting procedures are:

a) Battelle staff review the PA for each MUC using the PRMR criteria, including summarizing public comment and PIE results.

b) A CMS representative presents a brief overview of programmatic objectives and an overview and/or contextual background on the MUC.

c) Advisory Group members identify key discussion points and considerations for the Recommendation Group. Advisory Group members participate as non-voting discussants, offering feedback on evaluation criteria and on each measure's merits and challenges. Recommendation Group co-chairs ensure the Recommendation Group discussion includes the Advisory Group perspective.

d) Battelle, as the lead facilitator, along with co-chairs, then opens the Recommendation Group discussion. The group consecutively discusses similar measures (such as those that address a Cascade of Meaningful Measures priority area, such as "safety" measures). CMS staff, Battelle facilitators, co-chairs, and measure developers respond to the clarifying questions on the PA and the specifications of the measure, as necessary.

e) Recommendation Group members then vote on the measures discussed individually. The group also individually votes on instrument-derived measures (e.g., Consumer Assessment of Healthcare Providers and Systems [CAHPS]). (See Appendix C for the CBE policy on instrument-derived measures.)

Recommendation Groups make final consensus recommendations to CMS in January of each calendar year.

f) Battelle's trained facilitators evaluate and communicate whether a vote achieved Consensus Agreement or Agreement, and meeting summaries note dissenting views. Chapter 4 provides more detail on the consensus, defining conditions of recommendations, and the voting process.

This iterative and graduated process of measure review improves efficiency and utilizes a meaningful approach for making final recommendations. Such an approach allows for efficient information exchange among committee members, which is particularly important when each member offers a unique point of view.

Step 6: Second Public Comment Opportunity

Battelle publishes final recommendations from the Recommendations Meetings on the PQM website on February 1 of each year for a second 15-day public comment period. The purpose of this opportunity is to provide additional feedback on the measures under consideration and the final recommendations to CMS. The feedback from the public comment period does not have an impact on the final recommendations.

3.4 MSR Process

Battelle aims to strategically consider all measures used in CMS quality programs for MSR over the course of a 5-year period. To make the MSR process manageable, Battelle has divided the portfolio into three cycles using the Cascade of Meaningful Measures as a guide (see Table 4).

Table 3. Anticipated* MSR Review Schedule

Year	Cycle	Cycle Description	Cascade of Meaningful Measures Priorities (Number of Measures**)
Year 1 – Pilot Year	N/A	To pilot the MSR process, the year 1 cycle focused on measures in the End-Stage Renal Disease (ESRD) Quality Improvement Program (QIP).	• N/A (15)
Year 2	**Cycle C:** Cost-Effectiveness and Efficiency in Health Care Utilization	This group of measures addresses the financial and operational aspects of health care delivery.	• Value, Affordability, and Efficiency (107)
Year 3	**Cycle A:** Patient-Centered and Outcome-Focused Care	This group of measures focuses on the individualized needs of patients, emphasizing personalized care plans, preventive measures, and chronic disease management.	• Person-Centered Care (81) • Wellness and Prevention (43) • Chronic Conditions and Related Acute Events (74)
Year 4	**Cycle A:** Safety in Health Care Delivery	This group of measures focuses on creating a safe health care environment for all.	• Safety (139)
Year 5	**Cycle D:** Behavioral Health, Care Coordination, and Closing Gaps in Care in Health Care Delivery	This group of measures focuses on quality of behavioral health care, ensuring a coordinated health care environment, and closing gaps of care in health care delivery.	• Behavioral Health (42) • Seamless Care Coordination (38) • Closing Gaps in Care (4)

* Cascade of Meaningful Measure priorities selected for MSR in any given year may change depending on CMS priorities or other considerations.

** Number of measures for previous years (Years 1-4) reflects the number of measures in the priority inventory at that time. Current counts, obtainable through CMIT, may differ due to subsequent measure additions or removals.

The 2026 MSR cycle follows the steps outlined below:

Step 1: Review of Cascade of Meaningful Measures (Cascade) Priorities

Every MSR cycle, Battelle proposes a set of measures across programs and populations within a select Cascade priority for review for candidate MSR measures.

The Cascade of Meaningful Measures (Cascade) is a framework to help CMS prioritize existing health care quality measures, to align or reduce the number of measures, and to identify gaps where new measures may need to be developed. The Cascade priorities are Value, Affordability, and Efficiency; Person-Centered Care; Wellness and Prevention; Chronic Conditions and Related Acute Events; Behavioral Health; Safety; Seamless Care Coordination; and Closing Gaps of Care.

Selection of a Cascade priority and measures within that priority may be informed by conversations with key interested parties such as PRMR committee members, CMS, and other national policymakers and through environmental scans from conferences and other national health care priority activities.

This graduated approach manages the volume of measures under review for each cycle.

Step 2: Measure Selection Process

a) Battelle reviews all measures within the selected Cascade priorities and, with CMS input, narrows the list down to up to 50 measures based on CMS rulemaking and other considerations.

b) Battelle creates a measure Performance and Impact Analysis using performance data and publicly available information in CMIT to summarize each measure's specification, rationale for use, CBE endorsement status and history, and other characteristics.

c) The public has 15 days to comment on the set of up to 50 measures and their measure Performance and Impact Analyses on the PQM website. The purpose of the first public comment period is to solicit information on measure importance, feasibility considerations, and unintended consequences for the initial set of up to 50 measures and gather rationales for prioritizing measures for the final set of measures. Battelle staff compile and synthesize the comments.

d) Battelle considers public comments, Performance and Impact Analysis results, and potential duplication or overlap with other measures in use to select up to 35 measures for the final set of measures for committee review and discussion.

Figure 4 summarizes the measure selection process.

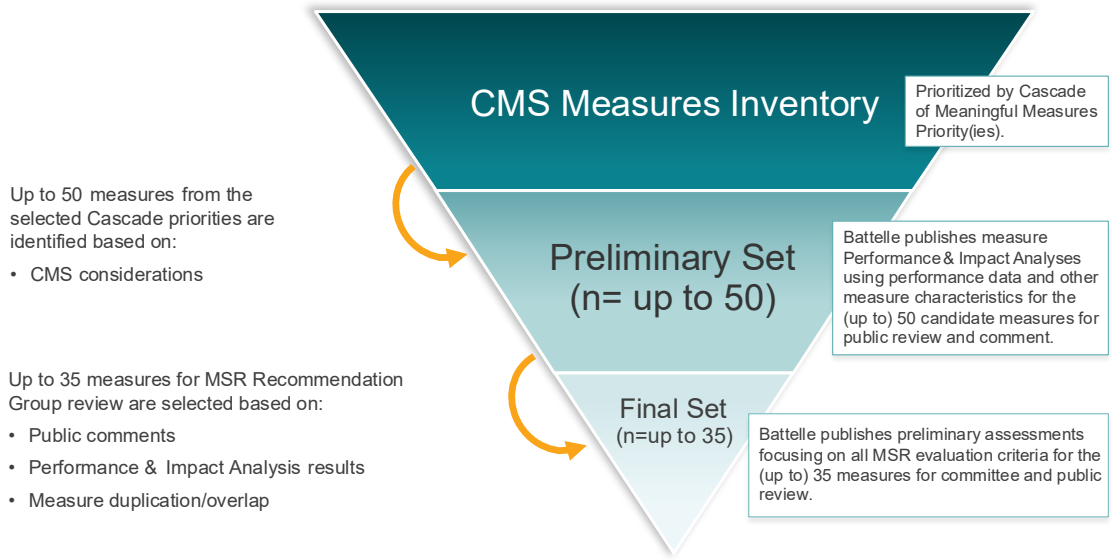


Figure 4. MSR Selection Process

Step 3: Information Collection & Synthesis

Battelle synthesizes information from various sources to create comprehensive Preliminary Assessments (PAs) on the final set of up to 35 measures. The PAs include:

- Information from CMIT.
- Measure endorsement history from the PQM STAR database, if applicable.
- Battelle's review of each measure's performance and impact.
- Review against related or similar measures to identify redundancies related to:
  - Data capture (i.e., data stream burden reduction; e.g., where a lack of harmonization or alignment leads to data collection burden).
  - Patient journey (e.g., where multiple measures address the same aspect of patient care).

  Battelle bases these reviews on the individual measures' purposes.
- Information from ad hoc expert interviews on implementation in real-world settings. (Battelle may conduct these interviews, as needed.)

CMS and other measure stewards have the opportunity to review and provide feedback on the draft PAs prior to publication.

Battelle then publishes the PAs on the PQM website for MSR Recommendation Group and public review. Committee members and the public can view PAs within the tabbed measure display on the PQM website, expected to go live for MSR in summer 2026.

Step 4: Recommendation Group Pre-Meeting Initial Evaluation

Battelle shares the comprehensive PAs with the MSR Recommendation Group along with guidance on how to evaluate measures against the measure evaluation criteria

using a PIE Form (see MSR Evaluation Guiding Questions in Appendix B for the PIE Form questions).

Battelle staff compiles and synthesizes information collected from the PIE Forms as well the public comment period. Battelle uses this information to identify areas of non-consensus to focus on during the Recommendations Meeting, and the Recommendation Group receives a summary of PIE results and public comments to consider as they vote.

Step 5: Recommendations Meeting Procedure

The MSR Recommendation Group meets for 1 or 2 full days (depending upon the number of measures for review). The meetings are open to the public. The meeting procedures are:

a) Battelle staff review the PA for each measure using the MSR criteria and summarizes the public comment and PIE Form results.

b) A CMS representative presents a brief overview and/or contextual background on the measure or measures under review, noting how the measure contributes to programmatic objectives.

c) Battelle as the lead facilitator, along with co-chairs, then calls on the Recommendation Group for discussion. CMS staff, Battelle staff, and measure stewards and developers respond to clarifying questions about the PA and the specifications of the measure, as necessary.

d) Recommendation Group members then vote on the measures discussed individually. They also vote individually on instrument-derived measures (e.g., CAHPS-based measures.) (See Appendix C for the CBE policy on instrument-derived measures). Once Battelle staff tabulates the vote for one measure, the group discusses and votes on the next measure. A simple majority determines the voting outcome for each measure.

This iterative and graduated process of measure review promotes efficiency and utilizes a meaningful approach for making final recommendations. Battelle staff and co-facilitators use established ground rules and goals for these Recommendations Meetings, conduct course corrections as needed, and ensure the committee reaches decisions.

Battelle summarizes the discussion from the meeting, including all dissenting views, and submits recommendations to CMS.

Step 6: Second Public Comment Opportunity

Battelle publishes final recommendations from the Recommendations Meeting on the PQM website for a second 15-day public comment period. The intent of this opportunity is to provide additional feedback on the reviewed measures and the final recommendations to CMS. The feedback from the public comment period does not impact the final recommendations; however, CMS receives a spreadsheet of comments and associated attachments. Battelle also posts a compilation of public comments on the PQM website.

3.5 Measure Steward/Owner and Measure Developer Engagement

Battelle strives to be transparent by including and engaging measure stewards/owners and measure developers at multiple points in the PRMR and MSR processes:

- **Educational Meeting:** Measure stewards/owners and measure developers are invited to attend an educational meeting for a process overview shortly after the start of each cycle. This meeting describes expectations for engagement and key timelines and milestones.
- **PAs:** Measure stewards/owners and measure developers review and provide input on draft PAs before they are publicly available to ensure accuracy and comprehensiveness.
- **Measure Previews:** Battelle invites measure stewards/owners and developers to attend the PRMR Measure Previews where CMS leads may call upon the stewards/owners and developers to answer questions raised by the committee about their measure.
- **Recommendations Meetings:** Measure stewards/owners and developers play an important role in the Recommendations Meetings, during which they may provide clarification on measure specifications, testing, and measure development decision points.

We encourage measure stewards/owners and developers to visit the PQM Measure Developers and Stewards webpage for additional information on their specific role in the PRMR process.

3.6 PRMR and MSR Measure Evaluation

3.6.1 Preliminary Assessments (PAs)

As described in Sections 3.3 and 3.4, Battelle staff develop PAs of measure properties in the context of each measure's intended or current program use. We draw the information from STAR, CMIT, and CMS MERIT, and we ask measure stewards/owners and developers to provide supplemental information, such as any prior or updated testing data, specific to measure properties.

Committee Evaluation Guidance

Appendix B includes more detailed information for committee members on how to appropriately consider measures under review.

These assessments generate evidence to support credibility of assertions of the measure properties. Committee members then consider the evidence in the PAs and whether the measure meets PRMR and MSR criteria. For PRMR, that means the evidence supports the measure's meaningfulness, appropriateness of scale, and time-to-value realization. For MSR, that means the evidence supports the measure's impact and shows that the measure developer/steward has addressed potential redundancies through meaningfulness, alignment with the patient health care journey, and data stream burden reduction. Committee members and the public can view PAs within the tabbed measure displays for PRMR and MSR (expected to go live for MSR in summer 2026) on the PQM website.

3.6.2 Pre-Meeting Initial Evaluation (PIE) Forms

Committee members evaluate—in PIE Forms—the measures based on the evidence presented in the PAs.

Committee members do not have to complete a PIE Form on each measure; Battelle assigns them a subset of measures to reduce burden. However, members should be familiar with all the measures under review by their committee.

PRMR and MSR criteria are intentionally open-ended to allow committees the opportunity to provide holistic feedback about measures under consideration for use or continued use in CMS programs. Battelle provides additional guidance to committees about how to apply each criterion (Appendix B). Committee members must specify and explain if they consulted additional evidence during their evaluation.

The PIE Form asks committee members to consider the evidence in the measure submission materials from CMS MERIT (PRMR only) and PAs (PRMR and MSR), provide feedback to questions (PRMR Evaluation Guiding Questions and MSR Evaluation Guiding Questions; see also Table 5 for criteria and Appendix B for additional guidance), and make one of the following determinations regarding the aforementioned evidence:

1. Evidence is complete and adequate although there may be considerations CMS should consider prior to implementation: Recommend
2. Evidence is either incomplete or inadequate and there is no plausible path forward: Do not recommend

As summarized in Table 6, for PRMR, "recommend" means recommending CMS add the measure to a Medicare quality program. In MSR, "recommend" means the measure meets all criteria and the current CMS program should retain it.

Table 4. Evaluation Criteria and Corresponding PIE Questions

Criteria	PIE Questions
PRMR & MSR Meaningfulness	
Importance: There is evidence that the measure focus is associated with a material outcome for persons and entities (Concept of Interest) and there is a rationale for why the measure's use in the selected quality program will generate benefits that exceed the burdens and barriers (Context of Use).	**Meaningfulness Questions to Consider:** When evaluating these criteria, committees should consider: • Is there evidence that the measure focus is associated with a material outcome for persons and entities? (Importance, Concept of Interest) • Does the submission or available materials explain why using this measure in the quality program provides/will provide more benefits than burdens and barriers? (Importance, Context of Use) • Do measure components and specifications align with the intent of the measure focus and target population? (Conformance) • Are the tools, processes, and people necessary to implement and report on the measure reasonably available? (Feasibility)
Conformance: Measure components and specifications are designed to align with the intent of the measure focus and target population.	
Feasibility: The tools, processes, and people necessary to implement and report on the measure are reasonably available.	

Criteria	PIE Questions
Validity & Reliability: There is demonstration through data or logic that there are known and effective ways that the person or entity should use to improve the measure focus (Validity) and most of the variation in the measure performance is attributable to true differences rather than measurement error (Reliability). *Usability:* Any barriers or facilitators to whether the person or entity could improve the measure focus are known and addressed.	• Did the developer show with data or reasoning that there are effective methods for improving the on the measure score? (Validity) • When appropriate, is the entity-level (measure score) testing appropriate to the measure type (e.g., signal-to-noise analysis, split-sample correlation), and does the testing show that performance differences reflect true differences instead of measurement error? (Reliability) • Did the submission materials identify and address any obstacles or support resources that might affect how the methods can be used? (Usability) Based on your review of the Preliminary Assessment for this measure and personal/professional experience, does it meet the Meaningfulness criteria?
PRMR-Specific Criteria	
Appropriateness of Scale: The measure is balanced and scaled to meet program-target population-specific goals.	**Questions to Consider:** When evaluating this criterion, committees should consider: • What does the evidence say about how benefits and risks/burdens/harms of this measure are spread among different groups of patients, communities, or measured entities within the specific CMS program? • If there are potential risks/burdens/harms, do they negatively impact specific groups of program beneficiaries or measured entities? How can these be reduced? Based on your review of the Preliminary Assessment and personal/professional experience, does this measure meet the Appropriateness of Scale criterion?
Time-to-Value Realization: There is a plan for near- and long-term positive impacts of measure use on the targeted program and population as the measure matures.	**Questions to Consider:** When evaluating Time-to-Value Realization, committee members should consider: • How might the benefits and harms/burdens/risks of this measure change over time? • How could measured entities and programs extend the benefits and prevent potential harm as the measure matures? • How might this measure support the collection of evidence for future measurement of the focus area? Based on your review of the Preliminary Assessment and personal/professional experience, does this measure meet the Time-to-Value Realization criterion?

MSR-Specific Criteria	
Alignment with the Patient Health Care Journey: The measure is implemented across the patient health care journey consistent with how patients experience and prioritize care.	**Questions to Consider:** When evaluating the Patient Journey in their review, committee members should consider: • Does the measure address the appropriate aspects of care to align with the patient health care journey? • Does the measure continue to reflect current care pathways across relevant settings (e.g., home, outpatient, acute care, post-acute care)? • Would removing the measure leave an important part of the patient journey unmeasured, or does another measure better cover that point in care? • Does the measure still help identify where gaps in care may occur along the care pathway? Based on your review of the Preliminary Assessment and personal/professional experience, does this measure meet the Patient Journey criterion?
Data Stream Burden Reduction: Measure set redundancy in data streams is identified and mitigated.	**Questions to Consider:** When evaluating Data Stream Burden Reduction, committee members should consider: • When considered within the full measure set, does the measure avoid creating multiple parallel data streams, and have any redundancies been addressed to reduce overall reporting burden? Based on your review of the Preliminary Assessment and personal/professional experience, does this measure meet the Data Stream Burden Reduction criterion?

Table 5. Overall Recommendation for the Designated CMS Medicare Quality Program

	Recommend	Do Not Recommend
MSR Measure	The committee recommends that this measure remain in use within the CMS program.	The committee does not recommend continued use of this measure within the CMS program.
PRMR Measure	The committee recommends that this measure be added to the CMS program.	The committee does not recommend that this measure be added to the CMS program.

3.7 Timeline

PRMR and MSR both involve multi-step processes spanning several months. The PRMR process entails a statutory requirement starting on December 1 with the release of the MUC List and ending by February 1 of each year when Battelle submits the recommendations to CMS.

Figure 5 provides an overview of PRMR activities and their associated timeline.

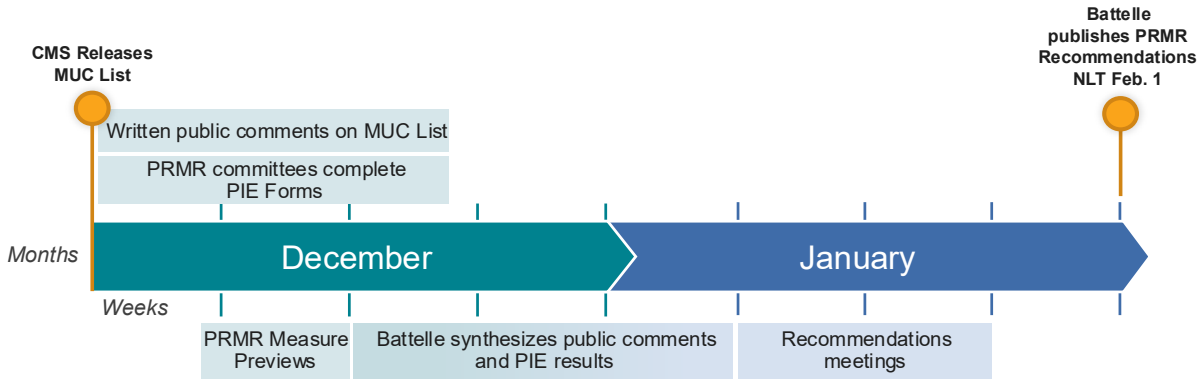


Figure 5. Overview of the PRMR Activities and their Associated Timelines

In contrast, the MSR timeline allows CMS program/measure leads to conduct program reviews following MSR recommendations. As such, the MSR timeline is subject to change in future cycles.

Figure 6 provides an overview of MSR activities and their associated timeline.

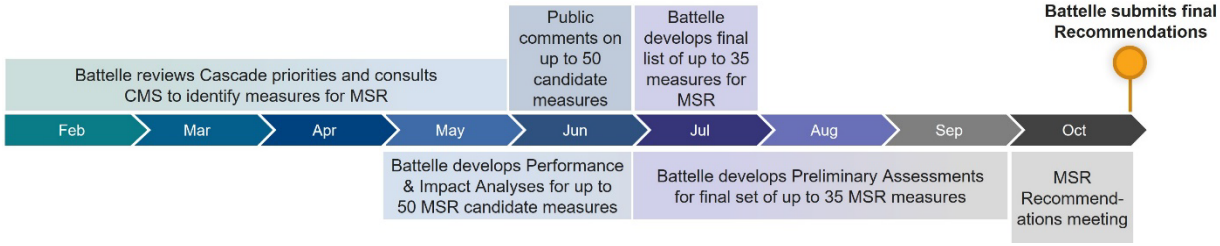


Figure 6. Overview of the MSR Activities and their Associated Timelines

Chapter 4. Voting Procedures

4.1 Overview

Battelle conducts a consistent, multi-step process meant to increase member engagement and focus on areas of disagreement. Both Advisory and Recommendation Group members provide feedback via the PIE Forms. During the meeting, the Advisory Group provides input first. The Recommendation Group then discusses and casts the final votes to submit recommendations to CMS.

CMS may request that committees discuss and provide feedback on MUC List measures without voting on them at PRMR and MSR Recommendations Meetings. Measures that do not undergo a vote won't be considered for use in the program, although CMS may use committee feedback to refine the measures before resubmitting them to the MUC List in a future year.

4.2 Establishing Consensus

4.2.1 PRMR Consensus

In the PRMR process, rather than relying on a simple majority, Battelle employs a modified NHDNG multi-step approach, an iterative consensus-building method designed to secure a minimum of 75% consensus agreement among voting members. To ensure rigor throughout the consensus development process, Battelle utilizes an evidence-based consensus index to evaluate whether committee votes have reached consensus agreement. This index measures the degree of disagreement within committee votes, factoring in differences in voting group sizes and varied ratings across groups.

Experienced Battelle staff facilitate the consensus-building process while working closely with co-chairs to address areas of disagreement and engage with dissenting views. This collaborative approach fosters meaningful, holistic discussions that support stronger and more convincing decisions. In addition, committees use written ratings, as described in Section 3.3, to further support the consensus process and yield the final recommendation.

Following discussion, PRMR voting members submit a vote to recommend a measure for use (a positive vote) or a vote to not recommend a measure for use (a negative vote). Committee members must participate in the consensus process in order to submit votes.

4.2.2 PRMR Considerations for Positive Votes

PRMR Recommendation Group members who submit a "recommend" vote can provide considerations to accompany their recommendations. Considerations should focus on specific actions that CMS can take to fine-tune the measure before implementation.

Considerations include improvements that could be made to the measure in the short term (i.e., in the current CMS rulemaking cycle) or on a longer timeline. Considerations may include stratification in reporting, obtaining CBE endorsement, or performing additional testing to demonstrate meaningfulness. Longer-term conditions might include re-specification of the measure focus or target population or the addition or removal of factors in the measure's risk adjustment model.

Recommendation Group members do not need to agree on the considerations. Battelle staff document the identified considerations in the PRMR Recommendations Report for CMS. In situations where the committee is considering a measure for more than one program, Battelle facilitators will call the Recommendation Group's attention to any previously noted considerations for discussion.

4.2.3 PRMR Reasoning to Substantiate Negative Votes

Committee members who submit a "do not recommend" vote must provide their reasoning in writing to substantiate their decision. This explanation should detail the specific concerns or issues that led to the conclusion that CMS should not implement the measure in the proposed program. Members are encouraged to articulate any potential risks, inefficiencies, or misalignments with the program that they perceive in the measure.

This detailed feedback is crucial for understanding the multiple perspectives within the committee and for informing future deliberations. By thoroughly documenting these concerns, Battelle staff can present a well-rounded view of the committee's deliberations in the PRMR Recommendations Report, offering CMS a clear understanding of the reasons behind "do not recommend" votes. This process not only enhances transparency but also contributes to a more informed decision-making process for CMS.

4.2.4 MSR Process Consensus

Unlike the PRMR process, MSR requires a simple majority, greater than 50%, to arrive at a voting outcome (i.e., recommend or do not recommend the continued use of the measure). PRMR employs a higher consensus standard because the decision to add a measure to a quality program may introduce burden to persons and entities; this is not the case for MSR.

4.3 Quorum

The purpose of a quorum is to ensure we have enough participation for a robust discussion ("discussion quorum") and that we have enough participation to support the claim that the recommendation reflects the agreement of the community ("voting quorum").

Although the Advisory Group attends the PRMR Recommendations Meeting, Recommendation Group member attendance and participation solely determine voting and discussion quorum.

Both PRMR and MSR follow the same quorum guidelines.

Discussion quorum: The discussion quorum requires the attendance of at least 60% of the Recommendation Group members at roll call at the beginning of the meeting. If less than 60% of members are in attendance, then the committee will not discuss the measures, and Battelle will hold a back-up meeting. Battelle conducts extensive outreach ahead of the meetings to confirm quorum will be achieved.

Voting quorum: The voting quorum requires at least 80% of active Recommendation Group members who have not been recused (see Chapter 6: Conflict of Interest Policy for more details). A higher voting quorum ensures representation of the community's various perspectives in the recommendations. If voting quorum is not met, Battelle will collect the votes for those present, not report out the results, and follow up with absent voting-eligible (i.e., not recused) participants until a voting quorum is reached. When possible, Battelle will encourage any absent voting-eligible participants to review notes or a recording of the relevant Recommendation

Group discussion prior to rendering a vote. If quorum is not reached, Battelle will submit a recommendation of “agreement not reached” to CMS.

We promote high attendance among voting members by engaging them early and often, including providing notice well in advance of scheduled meetings and sending detailed agendas and information packets for rating with sufficient time for review.

4.4 Voting Confidentiality and Independence

Battelle encourages open and honest discussion prior to voting, and the final vote should be based on individual evaluation. Each committee member is expected to vote independently, ensuring that their decision reflects their own professional judgment and assessment of the evidence.

Confidentiality is not a requirement of the PRMR/MSR voting process, but members should strive to make their decisions free from external influence.

By adhering to these guidelines, we ensure that our voting process is both robust and representative of the collective expertise within our committees.

4.5 Facilitation

Effective and organized meeting facilitation ensures discussions remain productive, within scope, and encompass all voices. Battelle staff have extensive experience facilitating committee meetings, webinars, and conference calls of comparable size and scope to PRMR and MSR committee meetings. Battelle staff work with co-chairs to establish meeting ground rules and goals, keep discussions on track, prevent a small number of participants from dominating discussions, and ensure the committees reach decisions.

Chapter 5. Public Engagement

5.1 Overview

Public engagement activities play a crucial role in ensuring transparent PRMR and MSR processes. Battelle welcomes comments from all interested parties and makes a concerted effort to engage communities with a wide range of backgrounds. To promote accessibility, all public communication complies with Section 508. This chapter of the guidebook describes methods for engaging the public (Section 5.2) and how the public can use the PQM website to keep informed of upcoming engagement opportunities (Section 5.3).

5.2 Methods of Engagement

Battelle invites members of the public to provide input on measures undergoing PRMR and MSR processes through written public comment via the PQM website. The public may also observe PRMR and MSR public meetings (Recommendations Meetings and PRMR Measure Previews). Members of the public may also nominate committee members (Section 2.2).

5.2.1 Public Comment Process

Members of the public have several opportunities to provide input on measures undergoing PRMR and MSR processes. Both PRMR and MSR have two opportunities each for written public comment when members of the public can submit comments through the PQM website. These steps are critical to ensuring rigor, transparency, and increased engagement. (See Appendix D for information about the PQM public comment posting policy.)

5.2.1.1 PRMR Public Comment Period

The first PRMR public comment period occurs when CMS releases the MUC List. The public then has 21 days to provide feedback on the measures.

There is a second public comment period for 15 days following the measure review meetings, during which members of the public can provide feedback on the committee recommendations to CMS.

5.2.1.2 MSR Public Comment Period

The first MSR public comment period occurs at the beginning of the cycle, during which members of the public have 15 days to comment on the 50 measures in the preliminary set and their Performance and Impact Analyses.

The second 15-day public comment opportunity occurs after Battelle publishes the MSR recommendations.

5.2.2 Public Meetings

5.2.2.1 PRMR Measure Previews

Members of the public may virtually attend these preparatory sessions in listen-only mode. PRMR Measure Preview information, including the meeting agenda and associated materials, is publicly available on the PQM website.

5.2.2.2 PRMR and MSR Recommendations Meetings

Members of the public may virtually attend all PRMR and MSR Recommendations Meetings. Meeting information, including the meeting agenda and all associated meeting materials, is available to the public on the PQM website. Battelle publishes the outcomes of the meetings, including meeting transcripts, meeting summaries, and PRMR and MSR final recommendation reports, on the PQM website.

5.2.3 Nominations for Committees

There is an annual open call for nominations on the PQM website where members of the public can apply to serve on a committee or nominate others. Additionally, members of the public can comment on the draft rosters, and the final committee rosters includes those comments. See Section 2.2 for details.

5.3 Modes of Communication

Battelle uses various communication tools, elaborated on in the following sections, to engage interested parties throughout the PRMR and MSR cycles.

5.3.1 PQM Website

The PQM website hosts all information relevant to upcoming opportunities for both public and PQM member engagement and serves as the platform for public comment. The PQM website (Figure 7) enables users to connect with Battelle staff through a “Contact Us” form. Once a user completes the form, a pop-up informs the user their message has been sent, and the user also receives an automated email acknowledging receipt. Users may also email Battelle staff directly at PQMsupport@battelle.org.

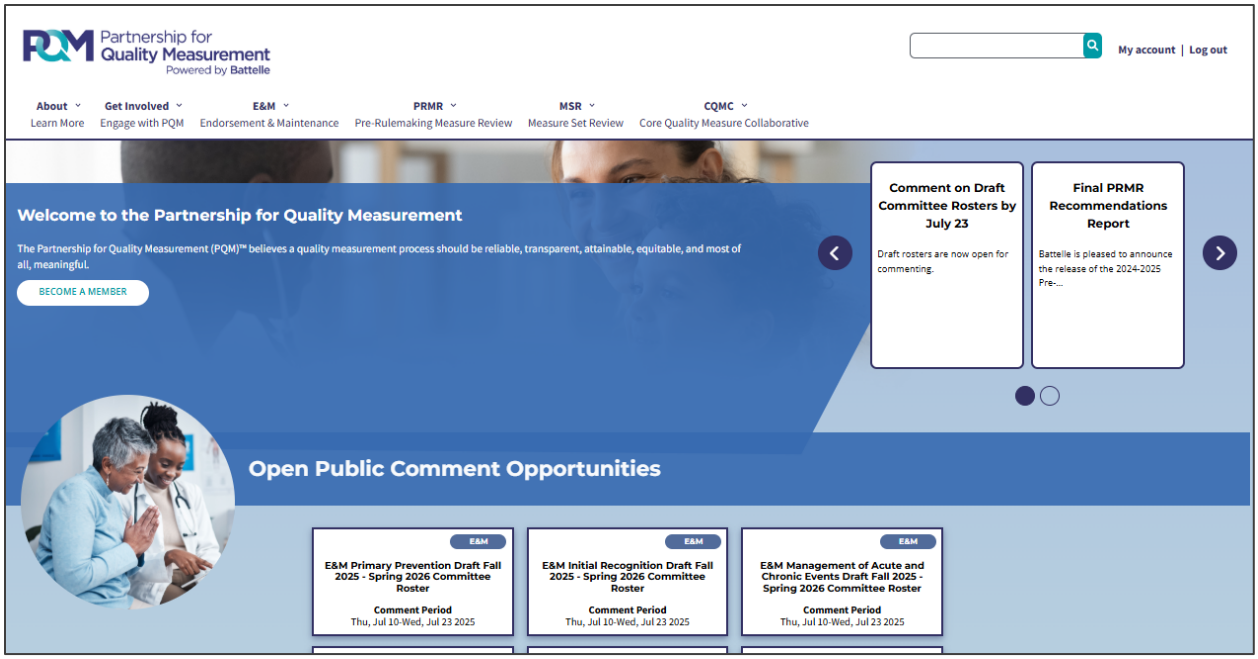


Figure 7. Screenshot of PQM Website www.p4qm.org

The PQM website announces public comment periods to interested parties through banners featuring the latest news and a calendar of events. Updates can include information on nomination periods, public comment period opportunities, or upcoming public meetings. Users may also access materials from current and past PRMR and MSR meetings, including meeting recordings, committee rosters, and meeting summaries.

5.3.2 PQM Workspace

Committee members can access a personalized committee workspace (Figure 8) after logging into the PQM website. There, they can view their committee assignment, term expiration, and details of active MUC List and MSR measures from the workspace home page. The workspace also features a discussion tab where members can view PQM posts, explore shared resources, and engage in discussion with other committee members. Additionally, members can access current PQM news and events specific to their committee assignment.

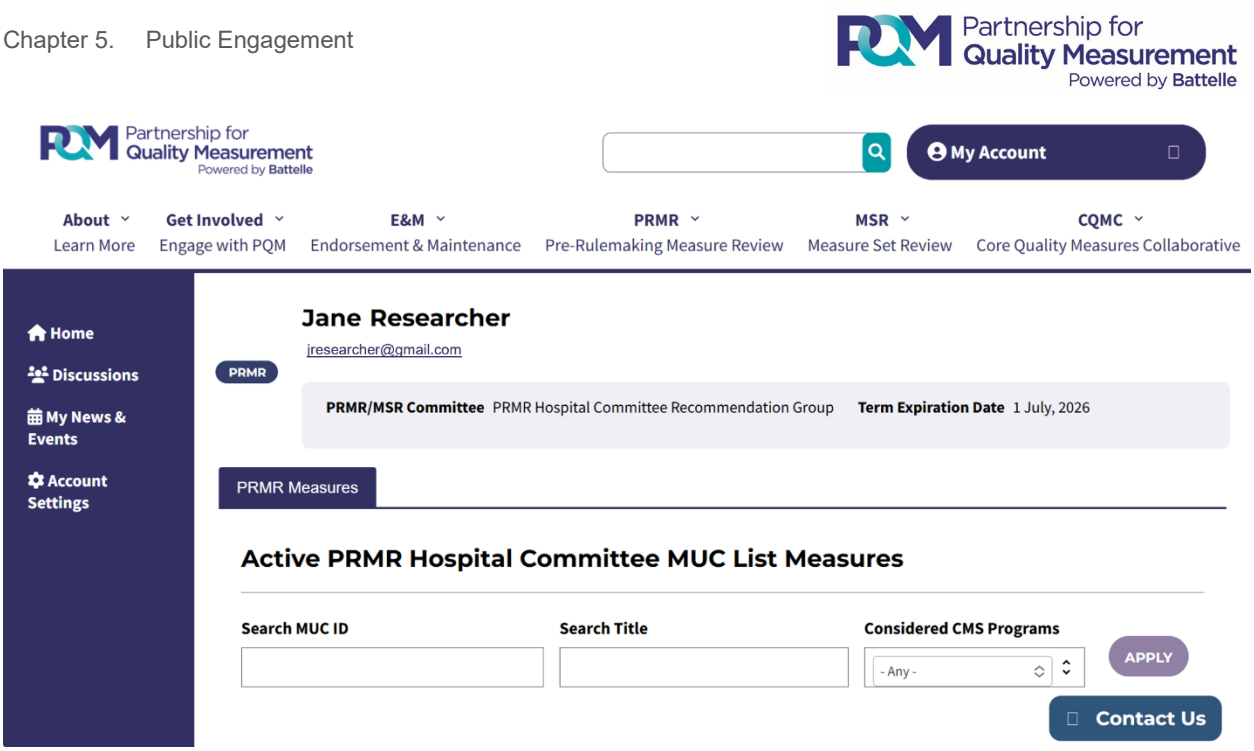


Figure 8. Screenshot of Committee Workspace

5.3.3 Newsletter and Email Alerts

Battelle shares updates on calls for nominations, public comment periods, committee meetings, meeting materials, and all status updates via newsletter and email alerts. Battelle uses Microsoft Outlook for all committee communications to increase the deliverability of the messages. Individuals may sign up for newsletters and email alerts through the PQM website.

Chapter 6. Conflict of Interest Policy

Battelle applies its Conflict of Interest (COI) policy to all committee members to ensure that committees perform functions in a manner free from bias and undue influence.

What is COI?

The term "conflict of interest" means any financial or other interest actual or perceived to (1) significantly impede the committee member's objectivity or (2) create an unfair competitive advantage for the member or an organization associated with a relevant party. Disclosure of a financial interest does not automatically mean a COI exists but may warrant further discussion and review. By participating as a committee member, each member consents to public disclosure of general information about the member's financial or business interests, professional associations, and experiences of interest to the public regarding COI.

Measure-Specific COI Examples

1) A member has directly and substantially contributed to the development of a measure being considered for selection, continued use, or removal. *Example: Serving on a technical expert panel.*

2) The member or their spouse, domestic partner, or child could receive direct financial benefit from a measure being recommended for selection, continued use, or removal. *Example. A spouse holds a patent required for a Measure Under Consideration.*

3) In the last 5 years, the member has received an indirect financial benefit, i.e., not related to the measure under review, of $10,000 or more from a measure developer whose measure is under review, or an indirect financial benefit of $10,000 or more, in the aggregate, from an organization or individual that may benefit from a measure being considered for the selection, continued use, or removal process.

4) The member is currently employed by the measure developer or has created a related or competing measure in the topic area.

How to Report

Each committee member must:

- Complete an initial personal and organizational (if organizational seat) DOI form (Appendix A) during the nomination process.
- Complete a "measure-specific DOI" form for each measure, or batch of measures, assigned to their committee. This form contains questions relevant to the specific measure(s) being reviewed. Battelle provides the blank measure-specific DOI form ahead of measure discussions.
- Disclose, in a spoken fashion, relevant interests at the beginning of the MSR or PRMR Recommendations Meeting.

If there is a perceived or actual COI, Battelle requires affected members to recuse themselves from any voting regarding the applicable measure(s) and, in some instances, from voting on competing and related measures. However, this requirement does not restrict committee members from participating in discussions or submitting public comments for the committee's consideration. In fact, committee members are encouraged to openly discuss measures during the discussion portion of the committee meetings. This open dialogue allows members to share

insights, raise questions, and provide context that may be valuable to the committee's deliberations, even if they are recused from voting.

All committee members have an ongoing duty to monitor their own COI issues and those of fellow committee members and raise or disclose any issues either in a committee meeting, to the committee chair, or to the Battelle program team.

Appendix A. Disclosure of Interest Forms

Personal/Organizational Disclosure of Interest Form

1. Your Name:

   Your Organization Affiliation:

   Committee Name:

Describe any personal or organizational relationships subject to disclosure (e.g., disclosures may include relationships with employees of organizations developing or stewarding the measure, stock options in companies that may benefit from the measure).

2. If none, check here: ☐
3. Describe any personal or organizational financial interests subject to disclosure. If none, check here: ☐
4. Electronic Certification

By executing this Electronic Certification, I certify that I have reviewed the Personal/Organizational Disclosure of Interest Form, and the information provided is true to the best of my knowledge.

Name: _____ **Signature:** _____

Date: _____

You and all other persons and organizations must be free of any conflicts of interest for this effort. If at any time you believe a potential or actual conflict exists, you must notify Battelle immediately. “Conflict of interest” means any financial or other interest that could actually or be perceived to (1) significantly impede your objectivity or (2) create an unfair competitive advantage for you or an organization associated with you.

Measure Disclosure of Interest Form

1. Your Name:

   Your Organization Affiliation:

   Committee Name:

2. Describe any personal or organizational measure conflicts. If none, check here: ☐

   a. Measure Under Review:

MUC ID	Measure Title	Measure Developer/Steward

   i. If you have worked as an employee, collaborator, or consultant of the measure developers/stewards listed OR contributed to the development of the measures listed, in any capacity, in the past 5 years, check here: ☐

   b. Competing Measure:

MUC ID	Measure Title	Measure Developer/Steward

   i. If you have worked as an employee, collaborator, or consultant of the measure developers/stewards listed OR contributed to the development of the measures listed, in any capacity, in the past 5 years, check here: ☐

3. If you checked either box under 2a. or 2b., please provide a detailed description of the involvement. (Include MUC ID and measure title and measure developer/steward name:)

Electronic Certification

By executing this Electronic Certification, I certify I have reviewed this Form, and the information provided is true to the best of my knowledge.

Name: _____ **Signature:** _____

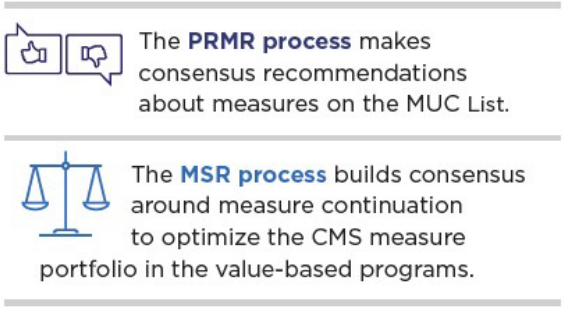
Date: _____

You and all other persons and organizations must be free of any conflicts of interest for this effort. If at any time you believe a potential or actual conflict exists, you must notify Battelle immediately. “Conflict of interest” means any financial or other interest that could actually or be perceived to (1) significantly impede your objectivity or (2) create an unfair competitive advantage for you or an organization associated with you.

Appendix B. Guidance on Evaluating PRMR and MSR Criteria

This appendix explains how committee members should apply evaluation criteria for two different processes:

- **PRMR (Pre-Rulemaking Measure Review)** reviews measures on the MUC List that are new, are currently active in a program but undergoing substantive changes or are being introduced to a new program to decide whether they should be **added** to select CMS Medicare quality programs.
- **MSR (Measure Set Review)** reviews current measures in use to determine whether they should be **retained** in select CMS Medicare quality programs.



Both processes rely on structured evidence-based evaluation criteria rooted in the frameworks provided by the CMS Measures Management System (MMS) Hub.

PRMR Evaluation Guiding Questions

When a developer submits a MUC, they are making claims about how the measure will improve care, close gaps in care, and function within a CMS program. PRMR groups evaluate whether evidence supports these claims and whether the measure is appropriate for program adoption.

PRMR committee evaluation is guided by questions across three criteria:

1. **Meaningfulness** – Does the measure address an important issue and add value for the program's population?
2. **Appropriateness of Scale** – Do expected benefits and burdens affect subpopulations within the program-target population in balanced ways?
3. **Time-to-Value Realization** – Will the measure produce value over both the short and long term?

Meaningfulness (PRMR)

Meaningfulness combines the importance of the measure's focus with how effectively the measure can be applied in the program. Meaningfulness looks at whether the measure addresses a gap in care and whether the measure can be implemented in a way that produces accurate, actionable results that support the program's goals.

When a committee reviews a measure, their primary question is: does this measure add value to the specific CMS program and the people it is intended to help? A measure may be well-designed overall, but it must also be important, useful, feasible, and scientifically sound within the context of the particular program. These criteria support the idea that the measure will

ultimately help improve care, reduce gaps in care, strengthen accountability, and/or inform decision-making.

If a measure has gone through the E&M process, the E&M committee will have reviewed the measure's meaningfulness for general accountability. PRMR will evaluate the measure for meaningfulness within a specific program context. The PRMR committee will take into account the E&M review findings as well as submitted materials.

Staff will assign endorsed measures a rating of "met" for criteria established through the endorsement process, with consideration for any changes to the measure, program, or population since last review that may impact how a measure performs within a program.

Our evaluation looks at two broad areas:

- **The Concept of Interest** – What the measure addresses and how the measure is constructed, without consideration of a specific CMS program population.
- **The Context of Use** – How the measure will work in the program where it is intended to be used and considerations for measure performance within the program population.

Concept of Interest

When considering meaningfulness of the concept of interest, committees should evaluate:

- Is there evidence that the measure focus is associated with a measurable and significant outcome or known gaps in care for persons and entities? **(Importance)**
- Do measure components and specifications align with the intent of the measure focus and target population? (**Conformance)**
- Are the tools, process, and people necessary to implement and report on the measure reasonably available? **(Feasibility)**
    - For electronic clinical quality measures (eCQMs), feasibility testing is required. More information can be found about eCQM testing at the MMS Hub.

Context of Use

When considering meaningfulness in the context of use, committees should evaluate:

- If using this measure in the quality program provides more benefits than burdens and barriers. **(Importance)**
- Did the developer show with data or reasoning that the measure accurately reflects quality of care in the program's setting? **(Validity[3])**
    - Validity addresses whether the measure truly captures differences in quality of care, rather than differences driven by factors outside a provider's control. In assessing validity, reviewers should consider two core questions:
        - **Rule-Out:** did the developer credibly rule out alternative explanations for observed performance differences (e.g., patient mix, random variation, data artifacts) that are unrelated to quality (or cost)?

[3] The MMS Hub provides minimum validity testing requirements for pre-rulemaking for new measures and measures already in use.

  - **Rule-In:** did the developer credibly demonstrate specific, identifiable ways in which provider/measured entity actions can influence measured performance on quality (or cost)?
  - Together, these considerations help assess the risk of misclassification (that is, the chance that providers/measured entities are incorrectly labeled as high or low performers due to factors other than true quality differences).
- Committee members should assess whether the type and level of testing are appropriate for the intended level of analysis and program use. The MMS Hub has additional guidance on validity testing.

- When appropriate, did the developer provide entity-level (measure score) testing appropriate to the measure type (e.g., signal-to-noise analysis, split-sample correlation) showing that performance differences reflect true differences instead of measurement error? **(Reliability[4])**
  - Low reliability increases the risk that providers/entities are misclassified--for example, labeled as lower performers when their true performance is average.
  - Reliability is considered acceptable when at least 70% of entities in the testing sample demonstrate reliability greater than 0.6.
  - To support interpretability, developers should translate reliability results into misclassification risk.
- Once implemented, will the measure provide actionable insights for improving quality of care and have all potential barriers to implementation or unintended consequences of use been identified? **(Usability)**

Appropriateness of Scale (PRMR)

Is the measure balanced and scaled to meet program and target population-specific goals?

Even when meaningful overall, a measure may affect segments of the program-target population in different ways. Some groups may see faster improvement, slower improvement, or different types of challenges.

Committee members review:

- How benefits and burdens may vary across identifiable subpopulations.
- Whether the measure may unintentionally widen or overlook gaps in care.
- Whether developers have identified strategies to reduce unnecessary burden or minimize negative effects.

This criterion helps ensure the measure supports improvement without creating or worsening gaps in care.

Time-to-Value Realization (PRMR)

Is there a plan for near- and long-term positive impacts of the measure on the program and population as the measure matures?

[4] The MMS Hub has minimum reliability testing requirements for pre-rulemaking for new measures and measures already in use.

Measures evolve as programs generate more data and organizations adapt to improvement methods.

Committee members consider:

- Short-term value: Will the measure show early, meaningful improvement to clinical practice or other targeted outcome/process?
- Long-term value: Will the measure continue to produce benefits as more entities become experienced in data collection and reporting of the measure, generating more data to assess performance and gaps in care?
- Shifts in benefits or harms: Could unintended consequences appear over time?
- Opportunities: Are there ways to extend benefits or reduce harms as the measure matures? Is this measure suitable for Fast Health Interoperability Resources® (FHIR®) implementation?

This ensures measures added to programs offer sustained quality improvement potential.

MSR Evaluation Guiding Questions

MSR evaluates measures already in use to determine whether they should be continued in the program. MSR groups rely on real-world performance data to evaluate whether a measure remains useful or whether another measure or revised approach would better address gaps in care.

MSR committee evaluation is guided by questions across three criteria:

1. **Meaningfulness** – Does the measure still address an important issue and continue to add value for the program's population?
2. **Alignment with the Patient Health Care Journey** – Does the measure align with how patients experience and prioritize care?
3. **Data Stream Burden Reduction** – When considered within the full measure set, does the measure avoid creating multiple parallel data streams, and have any redundancies been addressed to reduce overall reporting burden?

Unlike PRMR, which evaluates proposed new measures or those undergoing substantive changes, MSR draws on CMS performance data, program implementation and reporting history, and known challenges to determine whether a measure continues to add value and effectively addresses gaps in quality of care.

Meaningfulness (MSR)

Does the measure still address an important issue and continue to add value for the program's population?

When measures are initially added to programs, the decision to add the measure was potentially supported by either an endorsement process and/or pre-rulemaking process to review evidence in support of the core E&M criteria. Those criteria demonstrate the meaningfulness necessary for the measure to yield positive benefit. Often measure developers generated that evidence from pilot studies or review of the literature. However, since the initial measure adoption decision, CMS has implemented the measure in a program, and the

implementation experience enables consideration of additional or new information to inform whether the measure should remain in the program.

This criterion examines whether the measure continues to focus on an issue that truly matters within the program and whether it still supports identifying and reducing gaps in care. Over time, practice patterns, clinical evidence, and care delivery processes may change—making some measures less useful than they once were.

MSR committees should consider:

- Is the measure focus still associated with a material outcome or known gaps in care for persons and entities? Does current performance data show that the measure continues to highlight meaningful gaps in care or areas needing improvement? **(Importance)**
- Does the measure continue to function as intended when applied to current data sources, program populations, and settings? **(Conformance)**
- Are the tools, process, and people necessary to implement and report on the measure reasonably available? **(Feasibility)**
- Does the measure score accurately reflect quality of care? Are there still clear and effective ways for reporting entities to improve performance on the measure? See validity guidance outlined in PRMR section above. **(Validity)**
- Do differences in performance reflect true differences rather than random variation or measurement error? See reliability guidance outlined in the PRMR section above. **(Reliability)**
- Does the measure provide actionable insights for improving quality of care? Have any potential barriers to implementation or unintended consequences been identified and mitigated? **(Usability)**

This criterion ensures the measure remains relevant, useful, and scientifically sound based on current program experience.

Alignment with the Patient Health Care Journey (MSR)

Does the measure align with how patients experience and prioritize care?

Measures should fit naturally into the patient health care journey, the full path a person takes to get care, from first noticing a problem through appointments, tests, diagnosis, treatment, recovery, and follow-up. Each stage of this journey can be understood through the CMS prevention framework, with opportunities for primary prevention (avoiding disease onset), secondary prevention (early detection and intervention), and tertiary prevention (managing established disease to prevent complications). Measures should clearly align with the specific stage(s) of prevention they are intended to assess and reflect how providers/measured entities meaningfully influence outcomes at that point in the care pathway. A measure that once aligned with care pathways may no longer do so if clinical practices or program priorities have shifted.

Committees should consider:

- Does the measure address the right aspects of care for where patients typically are in their care journey?
  - For example, chronic disease quality measures should reflect ongoing management rather than one-time encounters. A measure that assesses HbA1c control in outpatient primary care settings over time would be more aligned with the patient health journey than one that only assesses long-term glucose control during acute hospitalizations or

emergency department (ED) visits.

- Does the measure continue to reflect current care pathways across relevant settings (e.g., home, outpatient, acute care, post-acute care)?
- Would removing the measure leave an important part of the patient journey unmeasured, or does another measure now better cover that point in care?
- Does the measure still help identify where gaps in care may occur along the care pathway?

This criterion helps ensure the overall measure set captures the most meaningful touchpoints in the patient experience.

Data Stream Burden Reduction (MSR)

When considered within the full measure set, does the measure avoid creating multiple parallel data streams, and have any redundancies been addressed to reduce overall reporting burden?

Even if a measure is feasible on its own, collecting and reporting its data may create unnecessary burden when combined with requirements from other measures in the same program or across multiple programs.

Committees should consider:

- Does the measure require data elements, definitions, or reporting processes that differ from other measures in ways that meaningfully increase burden?
- Is the measure duplicative of others in the set that assess similar gaps in care?
- Does the measure require additional data workflows, separate submission mechanisms, or unique extraction processes that could be streamlined or eliminated?
- Would removing the measure improve reporting efficiency without sacrificing the program's ability to monitor care quality?

This criterion helps ensure the entire measure set remains manageable, aligned, and supportive of meaningful improvement.

Appendix C. Consensus-Based Entity (CBE) Policy on Instrument-Derived Clinical Quality Measures

Overview

Instrument-derived clinical quality measures are measures that are derived from instruments or surveys, such as various versions of CAHPS, the Hospice Outcomes and Patient Evaluation (HOPE), or End-Stage Renal Disease (ESRD) Patient Life Goals Survey (PaLS).

Policy

The following is the policy of the CBE with respect to instrument-derived clinical quality measures:

- The CBE does not review or endorse instruments or surveys. Rather, the CBE reviews and endorses clinical quality measures derived from instruments or surveys.
- Clinical quality measures derived from instruments or surveys must be specified and tested at the accountable entity level (e.g., clinician or facility).
- There are no differences in the requirements or criteria for endorsement & maintenance between instrument-derived clinical quality measures and other clinical quality measures. Specifically, all measures are evaluated based on data element-level (i.e., person- or encounter-level) reliability and validity, and accountable entity-level reliability and validity.
- For data element-level reliability and validity, measure developers/stewards may cite existing literature to substantiate those properties.
- Measure developers/stewards should attest that they developed the instrument or survey using a best practice protocol (e.g., Holmbeck, 2009).
- The CBE separately reviews and endorses each clinical quality measure derived from an instrument or survey.
- Where appropriate, measure developers/stewards should, combine individual instrument or survey items into a person/respondent-level "composite," which may then be aggregated to the accountable entity level. The CBE would review and endorse such a measure as a single measure.
- CBE staff are available for technical assistance to measure developers/stewards in the application of this policy.

References

Holmbeck GN, Devine KA. Editorial: an author's checklist for measure development and validation manuscripts. J Pediatr Psychol. 2009 Aug;34(7):691-6. doi: 10.1093/jpepsy/jsp046. Epub 2009 May 31. PMID: 19487232; PMCID: PMC2735062. https://pubmed.ncbi.nlm.nih.gov/19487232/

Appendix D. Public Comment Posting Policy

Battelle hosts written public comment opportunities during PRMR and MSR cycles on the PQM website. Battelle will publicly post comments, as written, by the close of the public comment period. Commenters should include only details they are comfortable sharing. The PQM website describes information about comments that Battelle will not post.

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