



National Consensus Development and Strategic Planning
for Health Care Quality Measurement

Fall 2025 Cycle Endorsement and Maintenance (E&M) Comment Summary Guide (Advisory Group Feedback)

**ADVANCED ILLNESS AND
POST-ACUTE CARE**

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Overview of Fall 2025 Measures for Review

During this measure review cycle, developers and stewards submitted five measures to the Advanced Illness and Post-Acute Care committee for endorsement consideration ([Table 1](#)). Table 1 lists measures in the order the Advisory Group reviewed them.

Table 1. Overview of Measures Under Endorsement Review

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

Advisory Group Feedback

The Advisory Group convened on [December 3, 2025](#). Twenty-two of 34 (65%) active Advisory Group members attended to share feedback and ask questions regarding the measures under endorsement review. Developers/stewards of the respective measures also attended and provided responses to the Advisory Group questions. After the meeting, developers/stewards had the opportunity to submit additional written responses to Advisory Group member feedback and questions. The measure evaluation summaries in this document include overviews of the Advisory Group discussions and developer/steward responses.

To contextualize public comments and Advisory Group summaries, Battelle represents the number of comments received or number of individuals who shared similar comments, feedback, and/or questions as “a few” (two to three individuals), “several” (four to six individuals), and “many” (more than six individuals).

Measures Under Endorsement Review

CBE 0369: Standardized Mortality Ratio for Dialysis Facilities [UM-KECC/CMS]

Advisory Group Feedback

Feedback/Questions	Summary of Developer Response
Expected Death Rate: A patient partner sought clarification about why public reporting was limited to facilities with at least three expected deaths.	The threshold of three expected deaths is used to maintain patient confidentiality, particularly in small facilities, and to ensure statistical precision. To estimate a facility's mortality rate for a given year, the developer uses a statistical model that accounts for the facility's patient demographics and comorbid conditions.
Exclusions: A patient partner inquired about the exclusion of deaths unrelated to treatment such as from accidents or drug overdoses.	Deaths related to specific diagnosis codes for illicit drug overdose and trauma are rare (less than 1% of the United States [US] Medicare dialysis population is excluded). The exclusion is intended to demonstrate fairness and ensure that facilities are not held responsible for deaths that are out of their control, such as accidents or drug overdoses.
Facility Actions to Impact Mortality: A patient partner asked what actions dialysis facilities can take to reduce mortality that are reflected in the measure.	The Battelle facilitator noted that the measure submission cited several such actions including optimizing dialysis adequacy, managing cardiovascular risk factors, infection prevention, nutrition and metabolic support, improving vascular access, and enhancing care coordination. The developer affirmed these points and indicated the submission materials provide several concrete examples.
Data Collection and Patient Privacy: A committee member inquired about how patient data are collected, stored, and protected.	The data to calculate the measure come from various sources maintained by the federal government including Medicare claims, administrative data, and End Stage Renal Disease Quality Reporting System (EQRS) facility reports. The developer is required to follow federal regulations around personally identifiable information (PII) and protected health information (PHI), including maintaining Federal Information Security Modernization Act (FISMA) moderate-secure sites and reporting only at the facility level so there are no patient identifiers. They also migrated the entire production system to the CMS Central Data Repository (CDR), a highly secure, cloud-based enclave.

Feedback/Questions	Summary of Developer Response
Quality-of-Life Considerations: A few committee members asked whether quality of life is incorporated or adjusted for in the measure given its importance to patients.	Under the Medicare Conditions for Coverage (CFC), facilities must assess patients' quality of life at least annually and adjust care plans accordingly. Quality of life is not included in the risk adjustment model as it may mask facility-related impacts on mortality.
Handling of Hospice and Dialysis Withdrawal: A committee member asked whether the mortality rate accounts for deaths following patient-initiated dialysis withdrawal or hospice enrollment.	Withdrawals from dialysis are reported on the CMS Death Form. The measure does not exclude withdrawal decisions because such decisions are multifactorial and facility care may influence them. Hospice involvement among Medicare dialysis patients before death is under 1%; thus, the measure excludes hospice enrollment for parsimony because it does not affect the facility-level model.
Selection Bias: A few committee members expressed concern that facilities may avoid accepting patients who are at high risk for adverse outcomes to improve expected-to-observed mortality ratios, potentially biasing outcomes.	Selection bias occurs everywhere in health care and is a limitation of many outcome measures. Although the measure does not directly address this bias, dialysis facilities may have financial incentives to keep all chairs occupied, which could encourage patient acceptance.
Reliability Concerns for Small Facilities: A committee member noted their concerns with the reported inter-unit reliability (IUR) of 0.47 against a threshold of 0.60 and sought clarity on compensatory mechanisms for small facilities.	Reliability is constrained by small facility sizes and fewer events in dialysis facilities compared to hospitals. While reliability is low, this measure is still an important survival metric. In addition, they apply statistical techniques (e.g., broader confidence intervals) to reduce the likelihood that small facilities are unfairly flagged as outliers. The minimum expected-death thresholds and modeling choices are intended to preserve fairness while capturing meaningful differences in facility-level performance.
Performance Trends Over Time: A committee member inquired whether there has been improvement over time (i.e., a decline in actual compared to expected deaths over the measure's 17-year history).	Mortality among chronic dialysis patients generally declined until 2020. The COVID-19 pandemic significantly impacted end-stage renal disease (ESRD) patients; however, the measure mitigates the impact of systemic changes by evaluating performance relative to the national dialysis population. The developer also noted a historical example from 2011, when policy changes related to medications were associated with declines in mortality. Overall, the gradual decline in mortality likely reflects multiple factors, including provider efforts, policy changes, and public reporting initiatives.
Target Population: A few committee members asked whether the measure includes patients older than 65 and requested clarification on the proportion of pediatric and non-Medicare patients.	The target population includes birth through advanced ages with age-based risk adjustment. The pediatric ESRD population is small (15,000-18,000) compared to about 500,000 adults. About half of pediatric patients receive dialysis in adult facilities; the remainder are

Feedback/Questions	Summary of Developer Response
	treated in mixed settings or in one of roughly 40-50 pediatric-exclusive dialysis facilities in the US. Because the measure relies on Medicare data, non-Medicare patients are excluded (roughly half of pediatric patients), reflecting data availability constraints rather than intentional omission. <i>Note: Battelle staff worked with the developer after the meeting to add “Older Adults (65 years and older)” to the target population (1.15d Age Group) within the measure submission.</i>

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

Advisory Group Feedback

Feedback/Questions	Summary of Developer Response
Reliability and Selection Bias: Committee members shared similar methodological concerns about reliability and selection bias as for CBE #0369 .	The discussion for CBE #0369 is applicable to this measure.
Impact of Advance Care Planning and Directives: A committee member asked whether SHR accounts for completion of health care directives or portable medical orders (Medical/Provider Orders for Life-Sustaining Treatment [POLST/MOLST]) and whether such planning influences hospitalization rates. They asked whether differences could be tested between patients with and without advanced care planning processes.	The measure does not adjust for advanced care planning or patient directives, as such an approach may mask facility-related impacts on hospitalization. Pre-ESRD advance care planning is outside the scope of this measure, which focuses on care delivered in dialysis facilities rather than pre-dialysis care. The measure also excludes patients for the first 90 days of dialysis to create a buffer from the influence of pre-dialysis care when attributing hospitalizations to the dialysis facility.
Reasons for Hospitalization: A few committee members inquired whether the measure captures reasons for hospitalization. They also discussed the usefulness of capturing all-cause hospitalizations versus cause-specific or potentially avoidable hospitalizations. One committee member suggested that focusing on potentially avoidable hospitalizations might better support clinical pathways and care coordination, acknowledging that today’s broader value-based programs reduce opportunities to game via coding compared to a decade ago.	When the measure was originally developed, the developer considered focusing on cause-specific hospitalization, but the technical expert panel favored an all-cause approach to reduce potential gaming. They have maintained the all-cause approach for longitudinal continuity to compare results over time.
Data Sources and Target Population: A patient partner inquired	The measure uses Medicare administrative data and EQRS portal

Feedback/Questions	Summary of Developer Response
whether the data captured for the measure are part of standard practice and whether they are required for pediatric or non-Medicare patients.	submissions (which all dialysis providers are required to use) to capture admissions, discharges, and other relevant information. Pediatric and non-Medicare patients are excluded. <i>Note: Battelle staff worked with the developer after the meeting to remove “Children (0-17 years)” from the target population (1.15d Age Group) within the measure submission.</i>
Threshold for Public Reporting and Confidentiality: A committee member asked for clarification on conflicting thresholds referenced in materials: minimum sample size of 5 patient-years at risk (1.26 Minimum Sample Size) versus 11 eligible index discharges for confidentiality (4.1c Confidentiality).	The developer acknowledged a typographical error and confirmed the public reporting minimum is 5 patient-years at risk. <i>Note: Battelle staff worked with the developer after the meeting to edit 4.1.c (Confidentiality) within the measure submission to: “Public reporting on Dialysis Facility Care Compare would be restricted to facilities with least 5 patient-years at risk to comply with restrictions on reporting potentially identifiable information related to small cell size.”</i>
Length of Stay vs Admission Count: The subject matter expert (SME) noted that each hospitalization is counted as a single event, regardless of length of stay, and asked the committee to consider under what circumstances insensitivity to length of stay is acceptable. A patient partner shared real-world experiences that highlighted the significance of prolonged hospitalizations and comorbidities.	When the measure was initially developed, the developer considered two versions: admissions and days. The admissions-based SHR became the primary approach because hospital financial incentives to reduce length of stay could potentially affect the days-based version, making the measure biased and less usable. The measure counts only full acute care hospitalizations (excluding observation stays).
Dialysis Facility: A committee member asked whether in-house dialysis programs in long-term care facilities are considered dialysis facilities or whether that designation is reserved for freestanding dialysis facilities.	An ESRD facility is one certified under Medicare Conditions for Coverage (CFC Part 494) and identified by a CMS certification number (CCN) within a range defining it as a chronic dialysis facility. For in-house dialysis performed in nursing homes by dialysis companies, SHR is attributed to the dialysis provider, not the nursing home, unless the nursing home has established a certified in-center program with its own CCN.
Socioeconomic and Systemic Factors Affecting Hospitalization: A committee member noted non-clinical drivers of hospitalization (e.g., medication access, transportation, caregiver dynamics, and socioeconomic stress) and suggested exploring incentives for dialysis facilities to play a broader role beyond clinical care, given frequent patient contact.	The developer did not specifically address this comment during the meeting.

CBE 2979: Standardized Transfusion Ratio for Dialysis Facilities [UM-KECC/CMS]

Advisory Group Feedback

Feedback/Questions	Summary of Developer Response
Reliability: Committee members shared similar methodological concerns about reliability as for CBE #0369 .	The discussion for CBE #0369 is applicable to this measure.
Minimum Reporting Threshold: A patient partner asked about the statement that results are reported only for facilities with at least 10 patient-years at risk, seeking clarity on what “patient-years at risk” means and how it relates to other minimums seen in previous measures.	Due to small facility sizes, different ESRD measures set minimum thresholds in slightly different ways (e.g., expected events, patient counts, patient-years) but with the same aims: protecting privacy and improving statistical stability. The “10 patient-years at risk” criterion is the applicable reporting threshold for this measure.
Accountability: A few committee members discussed whether dialysis facilities “manage” or “monitor” anemia, and how the roles of nephrologists and advanced practice providers intersect with facility responsibilities. Committee members described typical operations (e.g., monthly labs, protocol-driven adjustments, medical director oversight), emphasizing that clinicians make day-to-day treatment decisions but within a facility accountability framework. Patient partners highlighted real-world practice where providers make treatment decisions using data gathered by the facility.	ESRD and Medicare payment regulations place anemia management responsibility on the dialysis facility, implemented via interdisciplinary teams and protocols. The measure focuses on outcomes (i.e., transfusions avoided) rather than direct observation of care processes or individualized decision-making. Success is measured via avoidance of transfusions.
Transplant Trajectory and Advanced Care Planning: A committee member asked whether the measure accounts for where a patient is on their clinical trajectory (e.g., bridging to transplant) and whether advanced care planning affects anemia/transfusion management decisions.	The measure does not consider patient trajectory or advanced care planning because the available data do not capture those discussions. While such factors may inform internal targets, they are not part of the metric.
Current Relevance: The SME noted that transfusions often occur in the inpatient setting for reasons such as gastrointestinal bleeding or cancer and questioned the measure’s present-day relevance. The co-chair noted the measure’s role in reinforcing the importance of appropriate anemia management despite changing incentives (e.g., payment bundling).	Accountability resides with dialysis facilities under ESRD regulations, while anemia management is shared with prescribing physicians through facility protocols. The financial impacts of bundling primarily affect facilities rather than individual nephrologists.
Adherence to Transfusion Guidelines: A committee member asked how the measure monitors adherence to transfusion guidelines and whether the measure directly captures guideline adherence versus	The measure does not directly assess guideline adherence. Transfusion guidelines are public and assiduously followed in hospitals, but the measure captures the result (i.e., transfusion event),

Feedback/Questions	Summary of Developer Response
counting transfusion events.	not adherence process. The developer will review the referenced logic model and confirm guideline adherence language post-meeting. <i>Note: To clarify the short-term outcomes in the logic model and that the measure does not evaluate adherence to transfusion guidelines, the developer revised the text to read “increased awareness of transfusion practices.” Battelle uploaded the updated logic model to the measure submission.</i>

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

Advisory Group Feedback

Feedback/Questions	Summary of Developer Response
Rising Long-Term Catheter Rates and Potential Causes: A patient partner asked why long-term catheter use has increased markedly (nearly 50% between 2018 and 2022) and whether factors such as surgeon availability or shared decision-making contributed. The SME observed that the trend predated COVID-19 and suggested shared decision-making/patient preferences as a plausible contributor. A few committee members discussed whether rising catheter use may be partly due to the aging dialysis population and patients exhausting vascular access options as mortality decreases. They raised rural access and insurance acceptance as practical barriers potentially affecting catheter persistence. A committee member noted that financial factors (e.g., coverage, patient portions, co-payments, co-insurance) and access to specialists may influence catheter decisions and persistence, complicating measure design.	While they could only speculate, the developer noted the concern and suggested that guideline changes emphasizing patient choice and life-plan considerations coincided with the rise.
Definition of Long-Term Catheter Use: A patient partner inquired about the definition of long-term catheter use.	Long-term catheter use is defined as a catheter present for greater than 3 months within a particular facility. The “1,000 days on dialysis plus sole catheter for last 12 months” exclusion is intended as a reasonable proxy for patient choice or exhausted access options in the absence of direct data fields capturing those conditions.
Updated Exclusions: A few committee members discussed new	Observational evidence links catheters to infection and other

Feedback/Questions	Summary of Developer Response
exclusions intended to reflect patient choice, limited access options, and data limitations for non-Medicare beneficiaries. A committee member expressed concerns that expanding exclusions and moderate evidence strength could affect the measure's long-term usability. The SME suggested the exclusions serve to offer fairness and protection against coercion.	complications (e.g., thrombosis, access failure). Expanding exclusions is a necessary trade-off to address current limitations, such as the lack of patient-choice data, Medicare-only terminal-condition information, and the inability to detect exhausted access, which improves accuracy at the cost of excluding approximately 5-6% of cases. Patients over age 84 comprise a small, single-digit percentage of the dialysis population (approximately 2-3%) and are excluded.
Accountability and Care Coordination Roles of Dialysis Facilities: A committee member considered whether the facility (medical director/nephrologist) should be considered the accountable entity for vascular access quality metrics, noting that achieving optimal access depends on coordinated and timely referrals among the facility, vascular surgeons, and transplant surgeons. Structured coordination across providers is essential to ensure appropriate access placement. The SME underscored the importance of avoiding coercion while proactively supporting patient-centered transitions away from catheter use.	Effective practice includes coordinating referrals to vascular or transplant surgeons for permanent access when appropriate. Primary care providers outside the dialysis setting are not accountable for dialysis access decisions within this measure.

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

Advisory Group Feedback

Feedback/Questions	Summary of Developer Response
Data Source and Performance Gap: A committee member asked whether EQRS data are used for the measure, why large differences are observed between low- and high-performing facilities, and whether only monthly phosphorus measurements are reported and from what source.	The measure is all-patient and uses EQRS portal data for administrative and clinical intermediate outcomes (e.g., vascular access, serum phosphorus). Risk adjustment does not explain facility variation, and differences likely reflect facility-level emphasis and expertise (dietitian/physician management) and other factors. The original (2008) measure only evaluated whether facilities were monitoring phosphorus on a regular basis; the current measure assesses achievement based on monthly phosphorus.
Threshold Selection and Rolling Average Rules: A few committee members asked why 6.5 mg/dL was chosen for the adult population and 7 mg/dL for the pediatric population and how many values form the rolling average, citing concerns about nutrition and unintended	Extensive observational literature links prolonged hyperphosphatemia to mortality. The signal rises around 5.5 or 6 mg/dL and increases with higher phosphorus. The technical expert panel (TEP) recommended 6.5 mg/dL to retain statistical power and reflect stronger signal. For

Feedback/Questions	Summary of Developer Response
consequences of strict thresholds.	children, the developer chose 7 mg/dL due to growth and nutrition concerns. The rolling average is 6 months; is reported monthly, including the 5 prior months; and allows for some degree of missingness for hospitalizations or labs. To be included in the calculation for the numerator, each patient must have at least four phosphorus values in the six-month rolling period.
Facility Actions to Reduce Hyperphosphatemia and Patient Burden/Choice: A few committee members discussed facility levers (e.g., dialysis adequacy/prescription, diet counseling, and phosphate binders) against patient pill burden and nutrition trade-offs. A patient partner shared their preference for taking the simpler choice, eating less rather than taking multiple pills to reduce stress.	Management of secondary hyperparathyroidism is another important factor influencing serum phosphorus levels; the impact depends on the drugs used, the intensity of treatment (including overtreatment), and the presence of low turnover bone disease.
Outcome versus Lab Metric: A committee member asked why the metric focuses on lab reduction rather than a reduction in cardiovascular or bone disease onset.	While the presence of cardiovascular disease and vascular calcification are common, using imaging or stroke presence as endpoints is difficult. The TEP considered parathyroid hormones but did not encourage such an approach due to methodological problems and threshold debates. The current metric is a pragmatic improvement with a strong association.
Percentage of Dialysis Population Above 6.5: A committee member asked what percentage of the dialysis population is chronically above 6.5 mg/dL.	Approximately 20% are chronically above 6.5 mg/dL, and the monthly prevalence is higher.

Appendix A: Acronyms

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

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

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

Acronym	Definition
HOQR	Hospital Outpatient Quality Reporting
HQMF	Health Quality Measurement Format
HQR	Hospice Quality Reporting
HQRP	Hospice Quality Reporting Program
HRRP	Hospital Readmission Reduction Program
HSAG	Health Services Advisory Group
HTML	Hypertext Markup Language
HVBP	Hospital Value-Based Purchasing
IAW	In Accordance With
ICD	International Classification of Diseases (International Statistical Classification of Diseases and Related Health Problems)
IHI	Institute for Healthcare Improvement
IMPACT Act	Improving Medicare Post-Acute Care Transformation Act
IPF	Inpatient Psychiatric Facilities
IPF QRP	Inpatient Psychiatric Facility Quality Reporting Program
IPPS	Inpatient Prospective Payment System
IQR	Inpatient Quality Reporting
IR	Initial Recognition
IRF	Inpatient Rehabilitation Facilities
IRF QRP	Inpatient Rehabilitation Facility Quality Reporting Program
IT	Information Technology
ITS	Intent to Submit
LLMs	Large Language Models
LTACH	Long-Term Acute Care Hospitals
LTCH	Long-Term Care Hospital
LTCH QRP	Long-Term Care Hospital Quality Reporting Program
MA	Medicare Advantage
MACRA	Medicare Access and CHIP Reauthorization Act
MACS	Medicaid: Adult Core Set
MAQIP	Medicare Advantage Quality Improvement Program
MAT	Measure Authoring Tool
MCCS	Medicaid: Child Core Set
MCO	Managed Care Organization
MERIT	Measures Under Consideration Entry/Review Tool

Acronym	Definition
MIPPA	Medicare Improvement for Patients and Providers Act of 2008
MIPS	Merit-based Incentive Payment System
MLTSS	Managed Long-Term Service and Support
MMS	Measures Management System
MS-DOI	Measure-Specific Disclosure of Interest
MSR	Measure Set Review
MSSP	Medicare Shared Savings Program
MUC	Measures Under Consideration
n	Sample Size
NCDC	National Consensus Development and Strategic Planning for Health Care Quality Measurement Contract
NCQA	National Committee for Quality Assurance
NHDNG	Novel Hybrid Delphi and Nominal Groups
NHQI	Nursing Home Quality Initiative
NLP	Natural Language Processing
NQF	National Quality Forum
NQS	CMS National Quality Strategy
NTTAA	National Technology Transfer and Advancement Act
OMB	Office of Management and Budget
OP	Option Period
OY	Option Year
PA	Preliminary Assessment
PAC/LTC	Post-Acute Care/Long-Term Care
PaLS	Patient Life Goals Survey
PAM	Patient Activation Measure
PCHQR	PPS-Exempt Cancer Hospital Quality Reporting
PDF	Portable Document Format
PIE Form	Pre-Meeting Initial Evaluation Form
PL	Project Leader
PM	Project Manager
PMP	Project Management Plan
POC	Point of Contact
PPS	Prospective Payment System
PQA	Pharmacy Quality Alliance

Acronym	Definition
PQM	Partnership for Quality Measurement
PRA	Paperwork Reduction Act
PRMR	Pre-Rulemaking Measure Review
PRO	Patient-Reported Outcome
PROM	Patient-Reported Outcome Measure
PRO-PMs	Patient-Reported Outcome Performance Measures
Q&A	Question & Answer
QC	Quality Control
QCDR	Qualified Clinical Data Registries
QDM	Quality Data Model
QI	Quality Improvement
QMDSA	Quality Measure Developer and Steward Agreement
QPP	Quality Payment Program
REHQR	Rural Emergency Hospital Quality Reporting (Program)
SDOH	Social Determinants of Health
SES	Socioeconomic Status
SLIN	Subline Item Number
SMEs	Subject Matter Experts
SMP	Scientific Measures Panel
SNF	Skilled Nursing Facilities
SNF QRP	Skilled Nursing Facility Quality Reporting Program
SNF VBP	Skilled Nursing Facility Value-Based Purchasing
SOP	Standard Operating Procedure
SOW	Statement of Work
SSA	Social Security Administration
STAR	Submission Tool and Repository
SUD	Substance Use Disorder
TBD	To Be Determined
TEP	Technical Expert Panel
TL	Task Lead
UMLS	Unified Medical Language System
USCDI	United States Core Data for Interoperability
VSAC	Value Set Authority Center

Acronym	Definition
Yale CORE	Yale Center for Outcomes Research and Evaluation

