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National Consensus Development and Strategic Planning for Health Care Quality Measurement

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

COST AND EFFICIENCY

April 2026

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Executive Summary

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

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

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

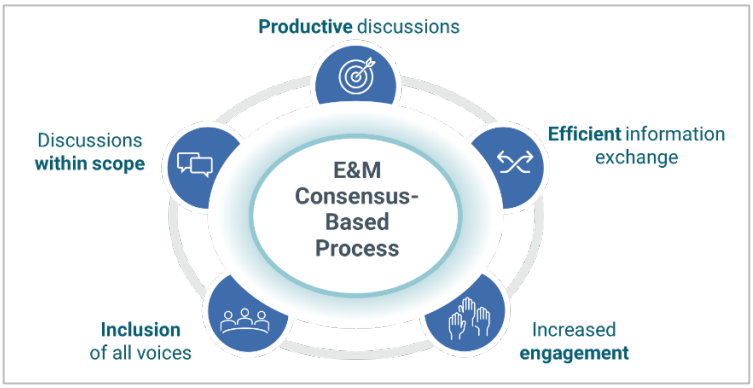

Figure 1. E&M Consensus-Based Process

One of those focus areas is Cost and Efficiency, which includes measures that focus on health care resource use, such as unplanned readmission following hospitalization for sepsis and readmission following inpatient psychiatric hospitalization. In 2021, U.S. hospitals recorded approximately 2.5 million sepsis-related inpatient stays (nearly 40% more than in 2016) accounting for $52.1 billion in aggregate costs. Sepsis was associated with almost one in three in-hospital patient deaths.[3] The high rate of readmission among sepsis survivors represents a major burden on patients and the health care system, with approximately one in five patients readmitted within 30 days of discharge and nearly 40% readmitted within 90 days. The readmissions consume substantial health care resources and significantly diminish survivors' quality of life.[4,5]

Similarly, hospital readmissions are a major cost driver in the treatment of severe psychiatric conditions.[6] Given the substantial burden and rising health care costs associated with mental illness, reducing hospital readmissions after psychiatric hospitalization is a critical strategy to improve patient outcomes and control costs. Unplanned readmissions following inpatient psychiatric care are common. Patients hospitalized for mental, behavioral, and

neurodevelopmental conditions experience relatively high 30-day readmission rates compared to the overall inpatient population.[7]

For this measure review cycle, developers submitted two measures to the Cost and Efficiency committee for endorsement consideration (Figure 2). Of the two measures reviewed by the committee, the committee endorsed one measure and endorsed the other with conditions (Table 1) based on the PQM Measure Evaluation Rubric within version 2.1 of the E&M Guidebook.

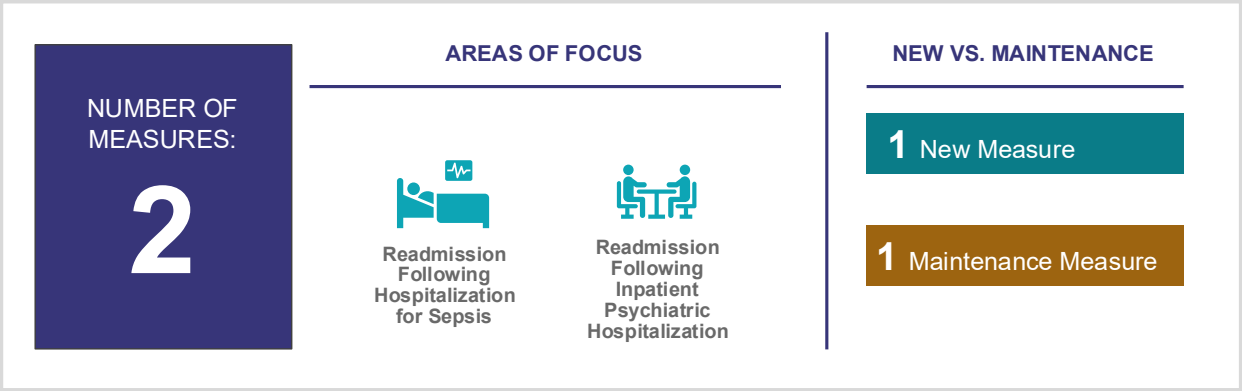

Figure 2. Fall 2025 Measures for Committee Review

Table 1. Measures Reviewed by the Cost and Efficiency Committee

CBE Number	Measure Title	New/Maintenance	Developer/Steward	Final Endorsement Decision
2860	Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF Readmission)	Maintenance	Mathematica/CMS	Endorse with Conditions
5275	Hospital-Level, Risk-Standardized 30-day All-Cause Readmission Following Hospitalization for Sepsis	New	Yale Center for Outcomes Research and Evaluation (CORE)/CMS	Endorse

Endorsement and Maintenance (E&M) Overview

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

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

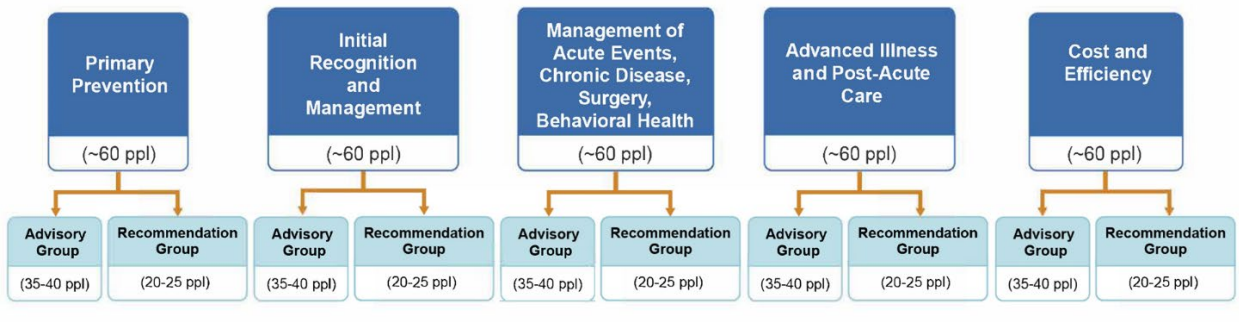

Figure 3. E&M Committee Structure

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

Figure 4. E&M Interested Parties

For the Fall 2025 cycle, the Cost and Efficiency committee had eight patient partners (i.e., patients, caregivers, advocates) and eight clinicians, with specialties in orthopedics, internal medicine, health policy, quality improvement, and others (Figure 5). The committee also included 12 population health experts.

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

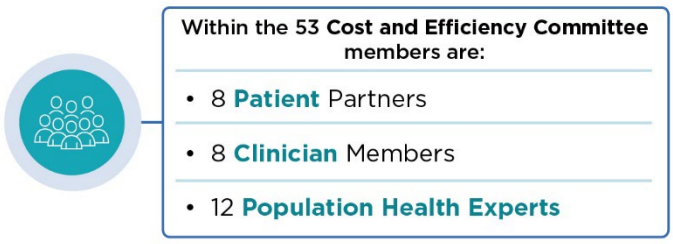

Figure 5. Cost and Efficiency Committee Members

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

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

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

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

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

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

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

We post all public comments received during this 30-day period, including those shared during the Public Comment Listening Session, to the respective measure page on the PQM website. We received one public comment for the measures this cycle. If a measure received any comments, the measure's evaluation summary includes a summary of these comments.

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Following the Public Comment Listening Session, we convene the Advisory Group of each E&M project during a public virtual meeting. The purpose of these meetings is to gather initial feedback and questions about the measures under endorsement review. Developers/stewards can share written responses to Advisory Group feedback after these meetings. This process ensures comprehensive input and engagement from all stakeholders involved. For the Cost and Efficiency committee, the Advisory Group convened on December 4, 2025, and we published a summary of the member feedback and developer/steward responses on the PQM website.

Prior to the Recommendation Group endorsement meeting, we share the full measure submission details, including all attachments, the PQM Measure Evaluation Rubric, the staff PAs, the public comments, Advisory Group feedback, and the developer/steward responses with the Recommendation Group for review. The Cost and Efficiency Recommendation Group convened on February 6, 2026. The Measure Evaluation Summaries section of this report includes brief summaries of the Recommendation Group deliberations and voting results, and the PQM website has a detailed meeting summary.

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

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

Table 3. Endorsement Decision Outcomes

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

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

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

** The E&M committee determines the conditions, with the consideration of what is feasible and appropriate for the developer/steward to execute by the time of maintenance endorsement review.*

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

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

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

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

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

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

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

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

For the Fall 2025 cycle, the appeals period opened on February 25 and closed on March 17, 2026. The measures reviewed by Cost and Efficiency committee did not receive any appeals.

Cost and Efficiency Measure Evaluation

For this measure review cycle, the Cost and Efficiency committee evaluated one new measure and one maintenance measure review against standard measure evaluation criteria. During the Recommendation Group endorsement meeting, the committee voted to endorse one measure and to endorse one measure with conditions (Table 4).

Table 4. Number of Fall 2025 Cost and Efficiency Measures Submitted and Reviewed

-	Maintenance	New	Total
Number of measures submitted for endorsement review	1	1	2
Number of measures withdrawn from consideration*	0	0	0
Number of measures reviewed by the committee	1	1	2
Number of measures endorsed	0	1	1
Number of measures endorsed with conditions	1	0	1
Number of measures not endorsed/ endorsement removed	0	0	0

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

Summary of Potential High-Priority Gap

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

Medicare Advantage (MA) Data

Committee members questioned the exclusion of MA data in the IPF Readmission measure, given growing MA enrollment. The committee cited concerns that excluding MA could worsen care gaps and opportunities for gaming.

Summary of Methodological Issues

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

Risk Adjustment

Committee members raised concerns that CBE #2860 may hold IPFs accountable for system-level factors outside their control, specifically the availability and strength of community-based post-discharge services. As a result, the committee placed a condition on CBE #2860 requiring the developer to explore whether the risk adjustment model should incorporate community resource availability.

The committee also emphasized the need for risk adjustment to better reflect population heterogeneity and imposed a condition on the measure requiring the developer to explore two separate models, one for dementia/Alzheimer's and one for severe mental illness.

Across both measures, the committee signaled the need for risk adjustment to be better aligned with clinical pathways, incorporate population-specific differences, and consider how socioeconomic status intersects with readmissions.

Additional Patient Populations

Committee members emphasized that patients with dementia/Alzheimer's differ clinically from patients with severe mental illness, noting that grouping these sub-populations together may obscure important differences in care needs and outcomes. The committee suggested separating the two groups within CBE #2860, as these sub-populations follow different care pathways with divergent trajectories that may warrant distinct models.

Measure Necessity

Regarding CBE #5275, several committee members questioned whether a condition-specific sepsis readmission measure adds meaningful value beyond existing hospital-wide readmission measures, specifically CBE #2879e (Hybrid Hospital-Wide Readmission). The committee expressed concern that the measure may duplicate outputs already captured by broader readmission measures rather than identifying unique improvement opportunities.

Addressing the committee's concern, the developer noted that this sepsis readmission measure addresses both a quality gap and a measurement gap, as there are no sepsis-specific outcome measures currently in any federal program.

As outlined in the E&M Guidebook, measure developers/stewards are expected to demonstrate why existing measures or quality improvement programs do not sufficiently address the specific need targeted by their new measure.

Coding Accuracy and Unintended Consequences

For CBE #5275, the committee had significant concerns regarding coding accuracy and the measure's validity. The committee expressed worry that artificial intelligence- (AI-) assisted coding tools may inflate sepsis diagnoses rates. Committee members also expressed concern over the lack of specificity in sepsis definitions and severity levels, suggesting the need for clearer criteria and a focus on severe sepsis to improve usability. Additionally, the committee shared that if measures incentivize reporting distortion or gaming behavior, improvements in reported "performance" do not correspond to enhancements in patient outcomes.

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Measure Evaluation Summaries

CBE #2860 – Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF Readmission) [Mathematica/CMS] – Maintenance

Specifications | Comment Summary Guide

***Substantive Changes: None**

Description: The IPF Readmission measure is a facility-level measure that estimates an unplanned, 30-day, risk-standardized readmission rate for adult Medicare fee-for-service (FFS) patients discharged from an inpatient psychiatric facility with a principal discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease. The performance period used to identify cases in the denominator is 24 months. Data from 12 months prior to the start of the performance period through the performance period are used to identify risk factors.

Committee Final Vote: Endorse with Conditions

Conditions: When the measure returns for maintenance in 5 years, the developer will have:

- Explored the feasibility of two risk adjustment models: one for dementia and Alzheimer's patients and one for patients with severe mental illness
- Explored whether community resources should be considered for risk adjustment

Vote Count: Endorse (8 votes; 42%), Endorse with Conditions (9 votes; 47%), Remove Endorsement (2 votes; 11%), Recusals (0).

Summary of Public Comments: This measure did not receive any public comments.

Summary of Measure Evaluation: An endorsement committee last reviewed this maintenance measure during the Spring 2021 cycle. CMS's Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program and Home Health Star Ratings Program currently use the measure.

Discussion Topic/Theme	Committee Discussion Summary
All-Cause Readmission and Accountability	• The Advisory Group raised concerns about using an "all-cause" approach, noting that this approach could penalize facilities for events unrelated to the quality of care (e.g., car accidents). • The developer asserted that all-cause readmissions represent adverse patient outcomes regardless of etiology, and including all unplanned readmissions, rather than focusing on a specific cause of readmission, allows IPFs more opportunity for quality improvement. • The Recommendation Group continued the Advisory Group's discussion with several members supporting the all-cause approach because such an approach is holistic and patient centered. However, some Recommendation Group members expressed concern that the measure

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Discussion Topic/Theme	Committee Discussion Summary
	holds facilities accountable for systemic issues outside the facilities' control, such as community resource availability after discharge. • The developer clarified that although community resources are an important factor, facilities retain some control through processes such as discharge planning. • Based on this discussion, the Recommendation Group imposed a condition upon the measure for the developer to **explore whether community resources should be considered for risk adjustment when the measure returns for maintenance (5 years).**
Differences in Psychiatric Sub-Populations	• The Advisory Group expressed concern that patients with dementia/Alzheimer's disease differ clinically from patients with severe mental illness. The Advisory Group suggested separating the measure into two tracks: severe mental illness and dementia/Alzheimer's. The Advisory Group noted that grouping these sub-populations together may obscure important differences in care needs and outcomes. They requested the developer provide additional stratified performance data and calibration plots comparing dementia/Alzheimer's patients with those with severe mental illness. • The patient co-chair supported maintaining a single combined measure, noting that grouping patients together provides a more holistic view. The subject matter expert supporting the Recommendation Group's deliberation agreed that, although care pathways differ, analyzing data collectively may still offer value for inpatient psychiatric facilities, especially given the expected growth of dementia and Alzheimer's populations. • The developer noted the risk adjustment model includes dementia/Alzheimer's disease, as these patients are more likely to be readmitted. The developer reported that patients with dementia/Alzheimer's disease account for approximately 11% of the measure's population and may consider revising the risk adjustment strategy if this percentage increases. • The Recommendation Group acknowledged the Advisory Group's concerns that patients with dementia/Alzheimer's and patients with severe mental illness represent distinct sub-populations with different care pathways. • Based on this discussion, the Recommendation Group imposed a condition upon the measure for the developer to **explore the feasibility of two risk adjustment models (one for dementia and Alzheimer's patients and one for patients with severe mental illness) when the measure returns for maintenance (5 years).**
Medicare Advantage (MA) Exclusion	• The Advisory Group expressed concern that excluding MA population from the measure could widen care gaps and allow opportunities for gaming.

Discussion Topic/Theme	Committee Discussion Summary
	• The developer noted that they would need to conduct additional testing to include MA patients because MA data differ from FFS data. • The Advisory Group recommended adding MA data, a suggestion the Recommendation Group acknowledged.

Appeals: None.

CBE #5275 – Hospital-Level, Risk-Standardized 30-day All-Cause Readmission Following Hospitalization for Sepsis [Yale CORE/CMS] – New

Specifications | Comment Summary Guide

Description: The Hospital-Level, Risk-Standardized 30-day All-Cause Readmission measure is a risk-adjusted measure that assesses the readmission rate within 30 days following an index hospitalization for sepsis. The target population for this measure are Medicare Fee-For-Service (FFS) and Medicare Advantage (MA) beneficiaries that are 65 years and older.

Committee Final Vote: Endorse

Vote Count: Endorse (16 votes; 84%), Not Endorse (3 votes; 16%), Recusals (0).

Summary of Public Comments: Battelle received one comment from the American Medical Association (AMA) prior to the meeting. The AMA noted that readmission measures may cause negative outcomes, questioned if the 30-day post-discharge period is appropriate, raised concerns that risk-adjusted data may mask important associations, requested clarification on the impact of recent CMS methodology changes, and criticized the lack of socioeconomic factors in the risk adjustment. In addition, the AMA also recommended increasing the minimum sample size, stating that PQM's current guidance to have 70% of entities achieve an intraclass correlation coefficient of 0.6 is not acceptable.

Summary of Measure Evaluation: The committee reviewed this new measure for initial endorsement. The developer noted that the measure is planned for use in public reporting and a payment program.

Discussion Topic/Theme	Committee Discussion Summary
Coding Accuracy and AI Influence	• The Advisory Group raised concerns that coding accuracy, AI-assisted coding, and clinical variability in sepsis diagnoses may inflate sepsis diagnosis rates, which could bias readmission rates, thereby affecting the validity of the measure. • The developer reported that analysis of coding variation using 2022-2023 data showed no meaningful variation in the use of ICD-10 code A41.9 across hospitals, even after stratifying facilities by sepsis volume. They found no association between coding intensity and unadjusted readmission or mortality rates within volume quartiles, suggesting that coding variation does not impact the comparability of risk-adjusted outcomes across hospitals.

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Discussion Topic/Theme	Committee Discussion Summary
	• The Recommendation Group agreed that AI-assisted coding is an emerging concern. They asked how the developer would monitor the aforementioned issues. • The developer found no impact of coding variation on the measure and will continue to monitor changes in clinical and coding practices and adjust the measure as needed. • A Recommendation Group co-chair noted that because the measure uses sepsis-specific ICD-10 codes, some of which are more heavily weighted; therefore, monitoring the frequency of those codes is critical to detect potential gaming. • The developer indicated that the measure uses sepsis ICD-10 codes that are highly specific and granular, which the developer asserted should make them more difficult to game.
Measure Necessity and Related Measures	• The Advisory Group questioned the added value of a sepsis-specific measure in light of existing sepsis measures and the Hybrid Hospital-Wide Readmission (HWR) measure (CBE #2879e), which includes sepsis readmissions. The Advisory Group inquired about the specific care gap that this measure addresses. • The developer stated that the sepsis readmission measure can improve quality and lower costs by addressing the high volume and high cost of sepsis readmissions among patients aged 65 and older, highlighting that sepsis readmissions result in substantial aggregate hospital costs ($26.3 billion). They noted a wide variation in hospital-level readmission rates (13% to 25%) after case-mix adjustment, indicating room for improvement. • The Recommendation Group continued this discussion, expressing concern that the proposed measure may not yield improvements beyond what existing measures and hospital programs achieve. They cautioned that the measure could instead create additional tracking and reporting burden for providers. • The developer clarified that CMS needs a condition-specific measure for use in the Hospital Readmissions Reduction Program (HRRP), which is limited to condition- and procedure-specific measures. This sepsis readmission measure is the first sepsis-specific outcome measure developed for potential inclusion in HRRP.
Socioeconomic Factors	• The Advisory Group sought clarification regarding the inclusion of socioeconomic variables, such as income and housing, in the risk adjustment model to ensure that the measure does not penalize hospitals serving vulnerable populations. • The developer confirmed that they considered risk adjustment for sociodemographic risk factors, such as dual eligibility (DE); however, they found that clinical variables accounted for most of the associated risk of readmission. The DE variable had little impact on measure scores when included in the risk model.

Discussion Topic/Theme	Committee Discussion Summary
	• The developer explained that readmission measures aim to balance fairness for hospitals serving communities with limited resources with accurately reflecting true differences in the quality of care for different populations. • The developer highlighted that risk adjusting for socioeconomic status may inadvertently normalize higher readmission rates among patients with a low socioeconomic status, potentially hindering improvement rates for these individuals.

Appeals: None.

References

1. Claxton G, Cox C, Gonzales S, Kamal R, Levitt L. Measuring the quality of healthcare in the U.S. Kaiser Family Foundation. September 10, 2015. Accessed September 18, 2024. https://www.healthsystemtracker.org/brief/measuring-the-quality-of-healthcare-in-the-u-s/

2. Quality Measurement and Quality Improvement. Centers for Medicare & Medicaid Services. Updated 09/10/2024. Accessed September 18, 2024. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Quality-Measure-and-Quality-Improvement-

3. Owens PL, Miller MA, Barrett ML, Hensche M. Overview of Outcomes for Inpatient Stays Involving Sepsis, 2016– 2021. HCUP Statistical Brief #306. April 2024. Agency for Healthcare Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/reports/statbriefs/sb306.pdf.

4. Franco Palacios, C., Solenkova, N., & Gorostiaga, F. (2020). Among sepsis survivors, readmissions due to infections occur sooner and are associated with increased mortality. Anaesthesiology intensive therapy, 52(2), 105–109. https://doi.org/10.5114/ait.2020.95070

5. Ackermann, K., Lynch, I., Aryal, N., Westbrook, J., & Li, L. (2025). Hospital readmission after surviving sepsis: A systematic review of readmission reasons and meta-analysis of readmission rates. Journal of Critical Care, 85, 154925. https://doi.org/10.1016/j.jcrc.2024.154925

6. Akram, F., Rosales, M., Chaudhuri, S., Mansouripour, S. M., Sharif, U., Maqsood, A., Wadhawan, A., Mohyuddin, F., & Mukhtar, F. (2020). Predictors of civil and forensic inpatient psychiatric readmissions at a Public Mental Health Hospital. Psychiatry research, 293, 113447. https://doi.org/10.1016/j.psychres.2020.113447

7. Jiang, H. J., & Hensche, M. S. (2023). Characteristics of 30-day all-cause hospital readmissions, 2016–2020 (HCUP Statistical Brief No. 304). Agency for Healthcare Research and Quality. https://hcup-us.ahrq.gov/reports/statbriefs/sb304-readmissions-2016-2020.jsp

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Appendix A: Cost and Efficiency Committee Roster

Fall 2025 Cycle

Member	Affiliation/Organization	Primary Perspective	Advisory or Recommendation Group
Mary Schramke *(Patient Representative Co-Chair)*	Sutter Health	Patient	Recommendation
Steven Spivack *(Technical Co-Chair)*	Lewin Group	Other Interested Party	Recommendation
Jacqueline Alikhaani	--	Patient	Recommendation
Nishant Anand	Altais	Clinician	Advisory
Sopida Andronaco	Hoag Orthopedic Institute	Clinician	Recommendation
Melody Beaty	--	Clinician	Advisory
Alice Bell	American Physical Therapy Association	Clinician	Recommendation
Bijan Borah	Mayo Clinic College of Medicine	Researcher	Recommendation
Jason Chen	Vibrant Health	Population Health Expert	Advisory
Melissa Chen	MD Anderson Cancer Center	Facility/Institution	Advisory
Amy Chin	HSS Center for the Advancement of Value in Musculoskeletal Care	Researcher	Recommendation
Mary Ann Clark	W.L Gore & Associates	Population Health Expert	Advisory
Erin Crum	McKesson	Other Interested Party	Recommendation
Sandeep Das	UT Southwestern Medical Center	Population Health Expert	Recommendation
Anne Deutsch	RTI International	Researcher	Recommendation
Rebecca Ekholm	--	Population Health Expert	Advisory
Marisa Elliott	--	Facility/Institution	Recommendation
Maria Fernandez	Emory Johns Creek Hospital	Population Health Expert	Advisory
Stephanie Fitzgerald	Blue	Clinician	Recommendation
Carrie I. Freeman-Wright	--	Patient	Recommendation

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Member	Affiliation/Organization	Primary Perspective	Advisory or Recommendation Group
Nancy Garrett	Highmark Health	Purchaser/Plan	Advisory
Olga Gross-Balzano	--	Facility/Institution	Recommendation
Megan Guinn	BJC Medical Group	Facility/Institution	Recommendation
Kelci Hannan	Gateway Business Health Coalition	Purchaser/Plan	Advisory
Stephanie Hansen	--	Clinician	Recommendation
Charles Hawley	National Association of Health Data Organizations	Other Interested Party	Advisory
Sharon Hibay	Advanced Health Outcomes	Researcher	Recommendation
Kristal Higgins	--	Patient	Recommendation
Corey Hill	--	Researcher	Advisory
Allyson Hughes	Ohio University Heritage College of Osteopathic Medicine	Population Health Expert	Advisory
Christina Hurst	--	Patient	Advisory
Veronica James	--	Other Interested Party	Advisory
Sunny Jhamnani	TriCity Cardiology	Clinician	Recommendation
Robert Jones	Cleveland Clinic	Clinician	Advisory
Michael Kanter	Kaiser Permanente School of Medicine	Facility/Institution	Advisory
Amy Lu	University of California San Francisco Health	Facility/Institution	Advisory
Kurt Mahan	University of New Mexico	Facility/Institution	Advisory
Laura Morris	--	Facility/Institution	Advisory
Seth Morrison	Patient Centered Outcomes Research Institute	Patient	Advisory
Jack Needleman	UCLA School of Public Health	Researcher	Advisory
Sonya Pease	Cleveland Clinic Florida	Population Health Expert	Advisory
Jessica Peterson	Anatomy IT	Other Interested Party	Advisory
Pamela Roberts	Cedars Sinai Health System	Other Interested Party	Advisory
Susan Roberts	--	Patient	Advisory

Member	Affiliation/Organization	Primary Perspective	Advisory or Recommendation Group
Lynden Schuyler	--	Population Health Expert	Advisory
Shalini Selvarajah	American College of Medical Genetics and Genomics	Researcher	Advisory
Mary Smith	--	Population Health Expert	Advisory
Trisha Jean Smith	--	Patient	Advisory
Jonathan Staloff	University of Washington	Researcher	Advisory
Dorothy Stanton	Radiology Partners	Other Interested Party	Advisory
Linda Thomas Hemack	The Wright Center	Population Health Expert	Advisory
Jackie Tran	Madonna Rehabilitation Hospitals	Population Health Expert	Advisory
Kim Tyree	Evergreen Family Medicine	Population Health Expert	Recommendation

Partnership for Quality Measurement Organizations

Battelle

Measure Stewards

Centers for Medicare & Medicaid Services

Measure Developers

Mathematica

Yale Center for Outcomes Research and Evaluation (CORE)

Appendix B: Acronyms

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

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

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

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

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

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

Acronym	Definition
USCDI	United States Core Data for Interoperability
VSAC	Value Set Authority Center
Yale CORE	Yale Center for Outcomes Research and Evaluation

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