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Spring 2026 Cost and Efficiency Endorsement and Maintenance (E&M) Advisory Group Meeting

Brenna Rabel | Battelle

Anna Michie | Battelle

Meridith Eastman | Battelle

Beth Jackson | Battelle

Elena Hughes | Battelle

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Agenda

- Welcome and Ground Rules
- Roll Call
- Overview of E&M Process and Advisory Group Meeting Procedures
- Public Comment
- Discussion of Spring 2026 Measures
- Next Steps
- Adjourn

Housekeeping Reminders

- State your first and last name if you are a call-in user.
- We encourage you to keep your video on; however, the system will allow you to turn your video off/on throughout the event.
- Use the raise hand button if you have a question/comment; when called on, unmute yourself.
- Lower your hand and mute yourself following your question/comment.
- If you are experiencing technical issues, please contact the project team via the chat feature on the virtual platform or at PQMsupport@battelle.org.

Meeting Ground Rules

- Respect all voices
- Remain engaged and actively participate
- Keep your comments concise and focused
- Allow others to contribute
- Share your experiences
- Learn from others

Roll Call

Cost and Efficiency Committee

Advisory Group Members

- Nishant Anand, MD, FACEP
- Melody Beaty, BSN, RN, CEN
- Jason Chen, DO, IFMCP
- Melissa Chen, MD
- Mary Ann Clark, MHA
- Rebecca Ekholm, DHA, BS, MBA
- Maria Fernandez, BA, MHA
- Nancy Garrett, PhD
- Kelci Hannan, BS, MS, PhD
- Charles Hawley, BS, MA
- Corey Hill, BS, MHA
- Allyson Hughes, PhD, MA, BS
- Christina Hurst^
- Veronica James, RN, RAC-CT, QCP
- Michael Kanter, MD
- Amy Lu, MD, MPH, MBA
- Kurt Mahan, PharmD, PhC, FASHP, FCCP
- Laura Morris, MS, BA, CPHQ
- Seth Morrison, MD, MACP ^
- Jack Needleman, PhD, FAAN
- Sonya Pease, MD, MBA
- Jessica Peterson, MD, MPH
- Pamela Roberts, PhD, MSHA, OTR/L, SCFES, FAOTA, CPHQ, FNAP, FACRM
- Susan Roberts, MS ^
- Lynden Schuyler, MPH, MBA
- Shalini Selvarajah, MD, MPH, MA, CPH, CPHQ, FRSPH
- Mary Smith, PhD, DNP, APRN, FAANP
- Trisha Jean Smith, MPH ^
- Jonathan Staloff, MD, MSc
- Dorothy Stanton, MS, CPC
- Linda Thomas Hemack, MD, FACP, FAAP
- Jackie Tran, MD

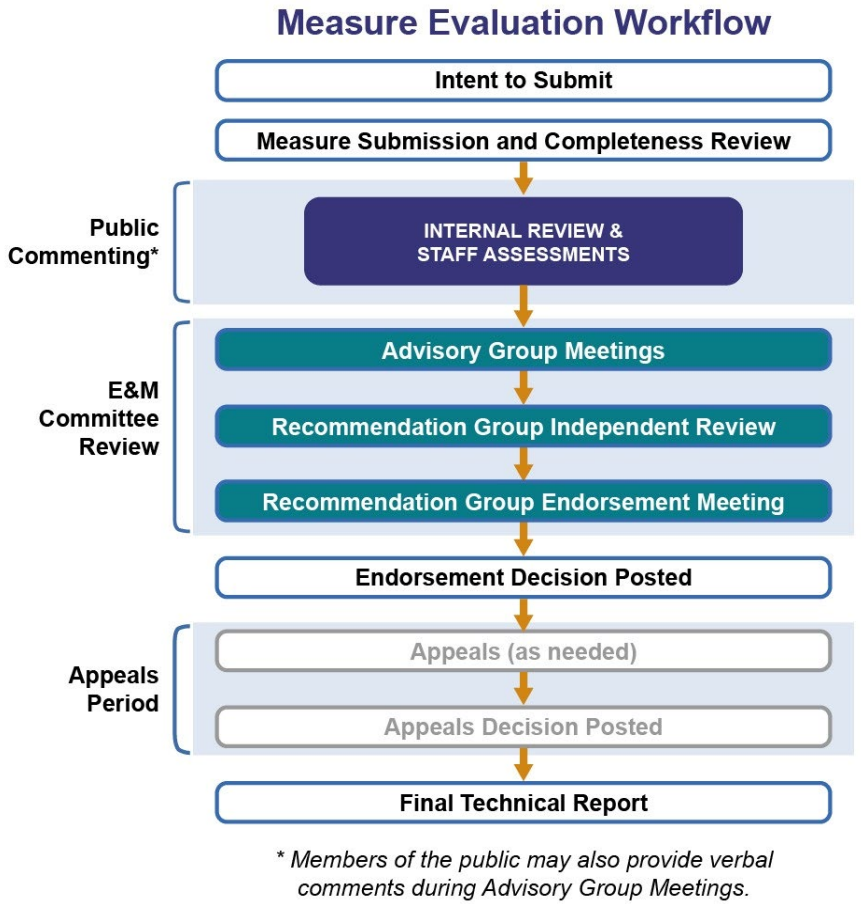
^Denotes committee member is a patient participant.

Overview of E&M Process and Meeting Procedures

E&M Process

Six major steps:

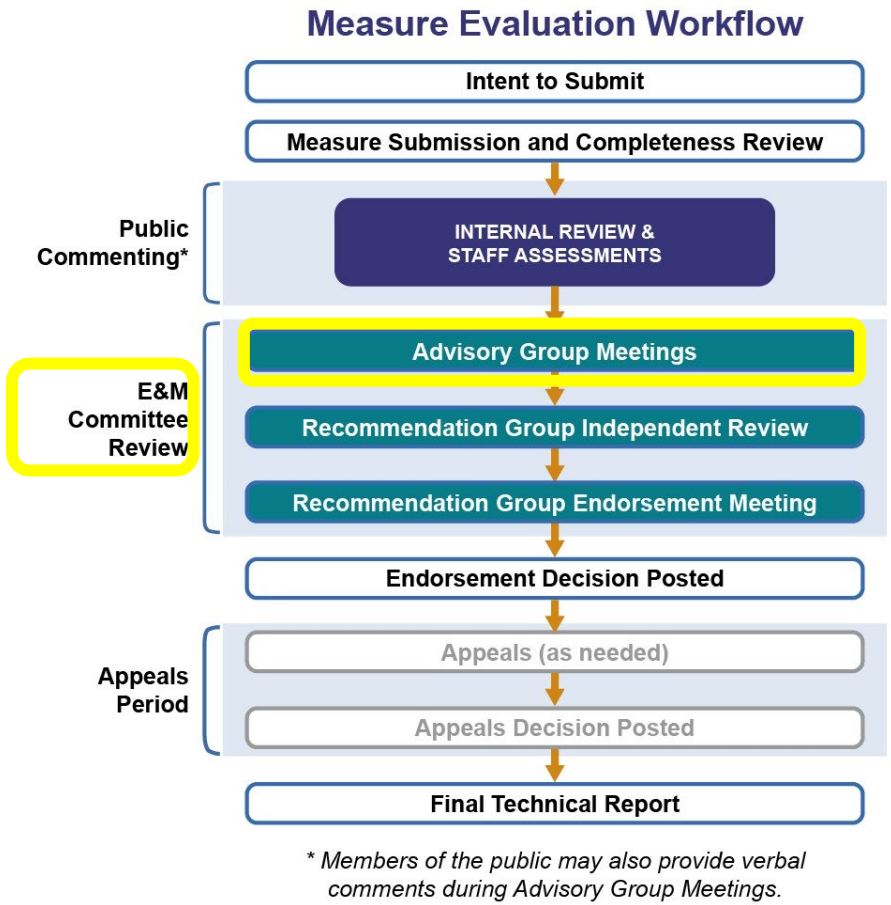
1. Intent to Submit
2. Full Measure Submission
3. Staff Internal Review and Measure Public Comment
   - Public Comment
4. E&M Committee Review
   - Advisory Group Meetings
   - Recommendation Group (RG) Independent Review
   - Recommendation Group Meetings
5. Appeals Period (as warranted)
6. Final Technical Report



** Members of the public may also provide verbal comments during Advisory Group Meetings.*

E&M Committee Review
Advisory Group Meeting

- **Steps:**
  - The Advisory Group from each E&M committee convenes to comment on strengths and limitations of submitted measure(s) and ask questions of developers.
  - We encourage developers to attend and respond to questions/feedback from the Advisory Group members.
- **Timing:**
  - Early January (Fall) and June/July (Spring)
- **Outputs:**
  - Summary of Advisory Group member feedback, questions, and developer/steward responses on the PQM website.



PQM Measure Evaluation Rubric

1

Importance - Extent to which the measure is evidence based AND is important for making significant gains in health care quality or cost where there is variation in or overall less-than-optimal performance.

2

Closing Care Gaps (optional) - Extent to which the measure can distinguish differences in care for certain patient subpopulations, which can be used to close gaps in care across those identified subpopulations.

3

Feasibility - Extent to which the measure specifications (i.e., numerator, denominator, exclusions) require data that are readily available OR could be captured without undue burden AND can be implemented for performance measurement.

4

Scientific Acceptability [i.e., Reliability and Validity] - Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented.

5

Use and Usability - Extent to which potential audiences (e.g., consumers, purchasers, providers, and policymakers) are using or could use measure results for both accountability and performance improvement to achieve the goal of high-quality, efficient health care for individuals or populations.

Advisory Group Meeting

Measure Review Procedures

1. Measure introduction by Battelle

- Battelle introduces the measure, highlighting basic information about the measure (e.g., description, measure type, target population, current/planned use).

2. Advisory Group discusses

- Patient partners have the floor first, then members assigned the relevant measure, and then the wider AG.
- We encourage members to note risks to the measure's safety and effectiveness for the RG to consider and discuss.

3. Developer/steward responds to feedback and questions

- Developer/steward respond to questions by topic.
- Before moving to next measure, developer/stewards provide final response to the discussion.

Patient Partner Feedback

- Have you had experiences related to this measure that you would like to share?
- Do you believe this measure is meaningful and can enhance patient care?
- Does this measure respect and respond to your individual preferences, needs, and values?
- Are there parts of this measure that might be hard to understand or burdensome?
- Would knowing your provider's performance on this measure be helpful to you?

Developer Response

Throughout the course of the measure discussion, developers will have the opportunity to respond to committee feedback and questions.

Developers may also choose to provide additional clarification or detail offline after the meeting.

If you have questions for the developer to address offline, you may share them in the chat following the discussion so they can provide detailed responses.

Advisory Group Meeting

Your Feedback in Action

Advisory Group

The Advisory Group raises potential major concerns about a measure.

Example: Maintenance measure shows minimal performance improvement (0.3 increase in performance scores from 2021-2022) despite multi-year use in a national accountability program.

Shared Feedback

The endorsement meeting materials flag the Advisory Group concerns.

The committee co-chairs present concerns as key discussion points to the RG.

Outcome

After RG discussion of major concern, if RG members agree, they may **place a condition on the measure**.

Example: When the measure returns for maintenance in 5 years, the developer should have worked with accountable entities to identify challenges and reasons for limited improvement over time as well as strategies to address them.

Public Comment

Public Comment Guidance

Public comment is now open. To comment on any of the project's measures:

✋ Raise hand — Use the **"raise hand"** feature to be recognized.

Please state your **name** and any **affiliation**. Please also state **the measure(s)** on which you intend to comment.

We kindly ask commenters to keep their comments to **2 minutes or less**.

Developers/stewards: Do not respond to commenters directly. You will have an opportunity to address feedback during the Advisory Group discussions.

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Discussion of Spring 2026 Measures

Spring 2026 Measures for Committee Review

The Cost and Efficiency committee received seven measures for endorsement consideration.

NUMBER OF MEASURES:

7

AREAS OF FOCUS

- Readmission
- Screening/Episode Cost Efficiency
- Post-Discharge Utilization

NEW VS. MAINTENANCE

- **5** New Measures
- **2** Maintenance Measures

Spring 2026 Measures for Committee Review
(cont., 1)

CBE Number	Measure Title	New/Maintenance	Developer/Steward
#3510	Screening/Surveillance Colonoscopy	Maintenance	Acumen PCMP/CMS*
#3566	Standardized Ratio of Emergency Department Encounters Occurring Within 30 Days of Hospital Discharge (ED30) for Dialysis Facilities	Maintenance	UM-KECC‡/CMS
#5110	Standardized Readmission Ratio (SRR) for Dialysis Facilities	New	UM-KECC/CMS
#5565	Excess Days in Acute Care (EDAC) After Isolated Coronary Artery Bypass Graft (CABG) Surgery	New	Yale CORE⊖/CMS
#5570	Excess Days in Acute Care (EDAC) After Hospitalization for Chronic Obstructive Pulmonary Disease (COPD)	New	Yale CORE/CMS
#5575	Excess Days in Acute Care (EDAC) After Hospitalization for Diabetes	New	Yale CORE/CMS
#5580	Excess Days in Acute Care (EDAC) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	New	Yale CORE/CMS

*Physician Cost Measures and Patient Relationship Codes (PCMP)/Centers for Medicare & Medicaid Services (CMS)
‡University of Michigan Kidney Epidemiology and Cost Center (UM-KECC)
⊖Yale Center for Outcomes Research and Evaluation (Yale)

CBE #3510 Screening/Surveillance Colonoscopy

Item	Description
Measure Description	The Screening/Surveillance Colonoscopy episode-based cost measure evaluates the risk-adjusted cost to Medicare for beneficiaries who receive this procedure. Performance is assessed at the clinician (Tax Identification Number-National Provider Identifier [TIN-NPI]) and group (Tax Identification Number [TIN]) levels. A measure score reflects the average risk-adjusted cost per episode across all episodes attributed to the clinician or group during the performance period. This measure includes costs of services clinically related to the attributed clinician's role in managing care from the day of the clinical event that triggers the episode through 14 days after the trigger. Beneficiaries eligible for this measure include Medicare beneficiaries enrolled in Medicare Parts A and B during the performance period.
Developer/ Steward	Acumen PCMP/CMS
Current Use	Public Reporting, Payment Program, Quality Improvement with Benchmarking
Measure Specification Changes	None

Measure Type

Cost/Resource Use

Target Populations

Older Adults (65 years and older)

Care Setting

Ambulatory Care: Office
Ambulatory Surgery Center
Hospital: Outpatient

Level of Analysis

Clinician: Group/Practice
Clinician: Individual

New or Maintenance

Maintenance

Initial Endorsement

Spring 2019

CBE #3510 Screening/Surveillance Colonoscopy
Staff Assessment

Domain	Importance	Closing Care Gaps*	Feasibility	Scientific Acceptability	Use and Usability
Staff Rating	*Met*	*Not Met*	*Met*	*Met*	*Met*
Strengths	• High impact measure with long-standing use supporting engagement and potential for cost savings.	• The developer did not address this optional domain.	• Measure components are derived from administrative claims and enrollment data. • Data elements are based on structured and coded fields. • Entity burden for data collection and reporting is minimal.	• Used large sample of patients across clinicians and clinician groups to support reliability analysis. • Meets signal-to-noise reliability thresholds across all entities. • Developer conducted appropriate validity testing using large Medicare datasets, demonstrating expected associations with cost and quality outcomes, supported by the well-grounded logic model.	• Measure is in use and developer explicitly articulates clinician-modifiable factors and associated resources for improvement.
Limitations	• Focuses more on potential causal factors and general cost drivers than on the association between the measure focus and the outcome, • Logic model mainly represents implementation of the measure and does not represent competing factors counter-acting mechanisms, and adverse effects.	• The developer did not address this optional domain.	• Some trade-off between the timeliness of the data and the completeness of claims. • Requirements for look-back periods may exclude patients with worse than expected outcomes due to coverage interruptions.	• Did not describe how complications and repeat procedures are linked with each episode of care. • Did not report the denominator for the mean event share shown in the tables in 5.3.4.	• Structural barriers to improvement are not fully addressed • Logic model does not account for key factors such as anesthesiologist involvement or monitoring for adverse events.

*Currently optional.

CBE #3566 Standardized Ratio of Emergency Department Encounters Occurring Within 30 Days of Hospital Discharge (ED30) for Dialysis Facilities

Item	Description
Measure Description	The Standardized Ratio of Emergency Department Encounters Occurring Within 30 Days of Hospital Discharge for Dialysis Facilities (ED30) is the ratio of the observed number of index hospital discharges that are followed by an emergency department encounter within 30 days for adult Medicare dialysis patients treated at a particular facility to the number of ED encounters that would be expected given the characteristics of the dialysis facility's patients and the national event rate for dialysis facilities. The time period for the measure calculation is two years. Medicare patients include those with traditional Fee for Service (FFS) Medicare and those with Medicare Advantage. Note that for this measure an "ED encounter" always refers to an outpatient encounter that does not end in a hospital admission but does include observation stays. This measure is calculated as a ratio but can also be expressed as a rate.
Developer/ Steward	UM-KECC/CMS
Current Use	Public Reporting
Measure Specification Changes	• Denominator: The measure now includes Medicare Advantage (MA) patients who had previously been excluded due to lack of outpatient claims data. • Risk Adjustment: The measure includes MA status at the time of index discharge as a covariate in the risk adjustment model.

Measure Type

Outcome

Target Populations

Adults (18-64 years)
Older Adults (65 years and older)

Care Setting

Dialysis Facility

Level of Analysis

Facility

New or Maintenance

Maintenance

Initial Endorsement

Spring 2020

CBE #3566 Standardized Ratio of Emergency Department Encounters Occurring Within 30 Days of Hospital Discharge (ED30) for Dialysis Facilities

Staff Assessment

Domain	Importance	Closing Care Gaps*	Feasibility	Scientific Acceptability	Use and Usability
Staff Rating	*Met*	*Not Met*	*Met*	*Reliability: Not Met, but Addressable* *Validity: Met*	*Met*
Strengths	• Provided a clear logic model. • Measure addresses a major public health issue and demonstrates a performance gap, indicating variation in measure performance.	• The developer did not address this optional domain.	• All required data elements are routinely generated. • Transparent handling of patient confidentiality, burden, licensing, and fees.	• Data for reliability testing were sources from EQRS clinical and administrative data for 2023. • Developer performed required validity testing and testing results support a strong inference for validity.	• Measure has a clear plan for use in at least one accountability application and provides actionable information for improvement. • Developer reported that no potential unintended consequences were identified.
Limitations	• Literature and patient input presented are dated.	• The developer did not address this optional domain.	• None identified.	• Accountability entity-level reliability is limited, with many entities below acceptable thresholds due to small sample sizes. • Developer did not provide an interpretation for the lack of significant association between ED30 and STrR.	• None identified.

*Currently optional.

Break

Meeting Resumes at 12:15 PM ET

CBE #5110 Standardized Readmission Ratio (SRR) for Dialysis Facilities

Item	Description
Measure Description	The Standardized Readmission Ratio (SRR) for a dialysis facility is the ratio of the number of observed index discharges from acute care hospitals to that facility that resulted in an unplanned readmission to an acute care hospital within 4-30 days of discharge, to the expected number of readmissions given the discharging hospital's and patient's characteristics, and based on a national event rate. Note that the measure applies exclusively to Medicare covered ESRD chronic dialysis patients enrolled in either Fee-for-Service (FFS) or Medicare Advantage (MA) programs.
Developer/ Steward	UM-KECC/CMS
Current Use	Public Reporting, Payment Program
Measure Specification Changes	N/A

Measure Type
Outcome
Target Populations
Children (0-17 years) Adults (18-64 years) Older Adults (65 years and older)
Care Setting
Dialysis Facility
Level of Analysis
Facility
New or Maintenance
New

CBE #5110 Standardized Readmission Ratio (SRR) for Dialysis Facilities

Staff Assessment

Domain	Importance	Closing Care Gaps*	Feasibility	Scientific Acceptability	Use and Usability
Staff Rating	*Not Met, but Addressable*	*Not Met*	*Met*	*Reliability: Met* *Validity: Not Met, but Addressable*	*Met*
Strengths	• Provided a clear logic model. • Measure addresses a major public health issue and demonstrates a performance gap, indicating variation in measure performance.	• The developer did not address this optional domain.	• All required data elements are routinely generated. • Transparent handling of patient confidentiality, burden, licensing, and fees.	• Developer provided the required evidence for this measure to demonstrate sufficient reliability at the data element-level. • Risk adjustment methods used are appropriate and model performance is acceptable. • Developer performed optional accountable entity-level testing for validity.	• Measure is actively used in at least one accountability application, with a systematic feedback approach that allows for continuous updates based on stakeholder feedback.
Limitations	• Evidence is dated and does not address anticipated measure impact. • Submission lacks information regarding potential competing measures.	• The developer did not address this optional domain.	• None identified.	• Data element validity testing results partially support an inference of validity, suggesting that the measure somewhat accurately reflects performance on quality and can distinguish good from poor performance to a limited extent. • The c-statistic of 0.683 indicates moderate model discrimination.	• Optional performance trend data shows that readmission rates have largely remained steady from 2014 to 2023.

*Currently optional.

CBE #5565 Excess Days in Acute Care (EDAC) After Isolated Coronary Artery Bypass Graft (CABG) Surgery

Item	Description
Measure Description	The Excess Days in Acute Care (EDAC) After Isolated Coronary Artery Bypass Graft (CABG) Surgery (hereafter “CABG EDAC") measure assesses days spent in acute care within 30 days of discharge from an inpatient hospitalization for an isolated CABG procedure. This measure is intended to capture the quality of care (during and after discharge) for patients undergoing CABG surgery by collectively measuring a set of adverse acute care outcomes that can occur post-discharge: emergency department (ED) visits, observation stays, and unplanned readmissions at any time during the 30 days post-discharge. To aggregate all three events, each event is measured in terms of days. The outcome is adjusted to account for age, sex, and comorbidities, and incorporates exposure time to account for survival times shorter than 30 days (for patients who die within 30 days of discharge). The measure cohort includes admissions for patients who are 65 years or older, are enrolled in Medicare Fee-For-Service (FFS) or Medicare Advantage (MA) and are hospitalized in non-federal short-term acute care hospitals. The final risk-adjusted measure score is based on two years of data and is calculated as the difference (“excess”) between a hospital’s “predicted days” and “expected days,” per 100 discharges.
Developer/ Steward	Yale CORE/CMS
Planned Use	Public Reporting, Quality Improvement with Benchmarking
Measure Specification Changes	N/A

Measure Type

Outcome

Target Populations

Older Adults (65 years and older)

Care Setting

Hospital: Inpatient

Level of Analysis

Facility

New or Maintenance

New

CBE #5565 Excess Days in Acute Care (EDAC) After Isolated Coronary Artery Bypass Graft (CABG) Surgery

Staff Assessment

Domain	Importance	Closing Care Gaps*	Feasibility	Scientific Acceptability	Use and Usability
Staff Rating	*Met*	*Not Met*	*Met*	*Met*	*Met*
Strengths	• Provided clear logic model. • Evidence from guidelines and empirical studies shows that targeted, evidence-based interventions can reduce post-discharge acute care use.	• The developer did not address this optional domain.	• All required data elements are routinely generated. • No feasibility issues found requiring adjustment of the final measure specifications. • Transparent handling of burden, licensing, and fees.	• Developer provided the required evidence for this measure to demonstrate sufficient reliability at the data element-level. • Provided adequate support for validity of measure's data elements. • Risk adjustment methods used are appropriate and model performance is acceptable. • Provided results from optional accountable entity level testing.	• Clear plan for use in public reporting and quality improvement.
Limitations	• Overlap with existing measure #2515 and #2879e.	• The developer did not address this optional domain.	• None identified.	• The 2016 study cited to support the validity of CABG procedure codes may have limited applicability to claims data.	• Though post-discharge mortality is a conceptual concern, this is mitigated by accounting for survival time.

*Currently optional.

Break

Meeting Resumes at 1:30 PM ET

CBE #5570 Excess Days in Acute Care (EDAC) After Hospitalization for Chronic Obstructive Pulmonary Disease (COPD)

Item	Description
Measure Description	The Excess Days in Acute Care (EDAC) After Hospitalization for Chronic Obstructive Pulmonary Disease (COPD) (hereafter “COPD EDAC") measure assesses days spent in acute care within 30 days of discharge from an inpatient hospitalization for COPD. This measure is intended to improve care transition quality for discharged patients hospitalized for COPD by collectively measuring a set of adverse acute care outcomes that can occur post-discharge: emergency department (ED) visits, observation stays, and unplanned readmissions, at any time during the 30 days post-discharge. To aggregate all three events, each event is measured in terms of days. The outcome is adjusted to account for age and comorbidities and incorporates exposure time to account for survival times shorter than 30 days (for patients who die within 30 days of discharge). The measure cohort includes admissions for patients who are 65 years or older, are enrolled in Medicare Fee-For-Service (FFS) or Medicare Advantage (MA) and are hospitalized in non-federal short-term acute care hospitals. The final risk-adjusted measure score is based on two years of data and is calculated as the difference (“excess”) between a hospital’s “predicted days” and “expected days,” per 100 discharges.
Developer/ Steward	Yale CORE/CMS
Planned Use	Public Reporting, Quality Improvement with Benchmarking
Measure Specification Changes	N/A

Measure Type
Outcome
Target Populations
Older Adults (65 years and older)
Care Setting
Hospital: Inpatient
Level of Analysis
Facility
New or Maintenance
New

CBE #5570 Excess Days in Acute Care (EDAC) After Hospitalization for Chronic Obstructive Pulmonary Disease (COPD)

Staff Assessment

Domain	Importance	Closing Care Gaps*	Feasibility	Scientific Acceptability	Use and Usability
Staff Rating	*Met*	*Not Met*	*Met*	*Reliability: Met* *Validity: Not Met, but Addressable*	*Met*
Strengths	• Provided clear logic model. • Measure addresses a major health issue, making it essential for addressing excess days in acute care.	• The developer did not address this optional domain.	• All required data elements are routinely generated. • No feasibility issues found requiring adjustment of the final measure specifications. • Transparent handling of burden, licensing, and fees.	• Developer provided the required evidence for this measure to demonstrate sufficient reliability at the data element-level. • Provided evidence which partially supports an inference of validity. • Risk adjustment methods used are appropriate and model performance is acceptable. • Provided results from optional accountable entity level testing.	• Clear plan for use in public reporting and quality improvement.
Limitations	• Overlap with existing measures #1891 and #2879e.	• The developer did not address this optional domain.	• None identified.	• The cited 2012 article potentially indicates that coding algorithms may not identify all admissions due to COPD.	• Though post-discharge mortality is a conceptual concern, this is mitigated by accounting for survival time.

*Currently optional.

CBE #5575 Excess Days in Acute Care (EDAC) After Hospitalization for Diabetes

Item	Description
Measure Description	The Excess Days in Acute Care (EDAC) After Hospitalization for Diabetes (hereafter “Diabetes EDAC") measure assesses days spent in acute care within 30 days of discharge from an inpatient hospitalization for diabetes. This measure is intended to improve care transition quality for discharged patients hospitalized for diabetes by collectively measuring a set of adverse acute care outcomes that can occur post-discharge: emergency department (ED) visits, observation stays, and unplanned readmissions at any time during the 30 days post-discharge. To aggregate all three events, each event is measured in terms of days. The outcome is adjusted to account for age and comorbidities and incorporates exposure time to account for survival times shorter than 30 days (for patients who die within 30 days of discharge). The measure cohort includes admissions for patients who are 65 years or older, are enrolled in Medicare Fee-For-Service (FFS) or Medicare Advantage (MA) and are hospitalized in non-federal short-term acute care hospitals. The final risk-adjusted measure score is based on two years of data and is calculated as the difference (“excess”) between a hospital’s “predicted days” and “expected days,” per 100 discharges.
Developer/ Steward	Yale CORE/CMS
Planned Use	Public Reporting, Quality Improvement with Benchmarking
Measure Specification Changes	N/A

Measure Type
Outcome
Target Populations
Older Adults (65 years and older)
Care Setting
Hospital: Inpatient
Level of Analysis
Facility
New or Maintenance
New

CBE #5575 Excess Days in Acute Care (EDAC) After Hospitalization for Diabetes

Staff Assessment

Domain	Importance	Closing Care Gaps*	Feasibility	Scientific Acceptability	Use and Usability
Staff Rating	*Met*	*Not Met*	*Met*	*Reliability: Met* *Validity: Not Met, but Addressable*	*Met*
Strengths	• Provided a clear logic model. • Measure addresses a major health issue, making it essential for addressing excess days in acute care.	• The developer did not address this optional domain.	• All required data elements are routinely generated. • No feasibility issues found requiring adjustment of the final measure specifications. • Transparent handling of burden, licensing, and fees.	• Developer provided the required evidence for this measure to demonstrate sufficient reliability at the data element-level. • Provided evidence which partially supports an inference of validity. • Risk adjustment methods used are appropriate and model performance is acceptable. • Provided results from optional accountable entity level testing.	• Clear plan for use in public reporting and quality improvement.
Limitations	• Overlap with existing measure #2879e.	• The developer did not address this optional domain.	• None identified.	• Cited articles show ICD-10 codes may not identify all admissions for diabetes.	• Though post-discharge mortality is a conceptual concern, this is mitigated by accounting for survival time.

*Currently optional.

CBE #5580 Excess Days in Acute Care (EDAC) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)

Item	Description
Measure Description	Excess Days in Acute Care (EDAC) Following Elective Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (hereafter, "THA/TKA EDAC") measure assesses days spent in acute care within 30 days of discharge from a hospitalization for an elective primary inpatient THA/TKA. This measure is intended to capture the quality of care (during and after discharge) for patients undergoing elective inpatient THA and/or TKA arthroplasty by collectively measuring a set of adverse acute care outcomes that can occur: emergency department (ED) visits, observation stays, and unplanned readmissions, at any time during the 30 days post-discharge. To aggregate all three events, each event is measured in terms of days. The outcome is adjusted to account for age and comorbidities and incorporates exposure time to account for survival times shorter than 30 days (for patients who die within 30 days of discharge). The measure cohort includes admissions for patients who are 65 years or older, are enrolled in Medicare Fee-For-Service (FFS) or Medicare Advantage (MA) and are hospitalized in non-federal short-term acute care hospitals. The final risk-adjusted measure score is calculated as the difference ("excess") between a hospital's "predicted days" and "expected days," per 100 discharges.
Developer/ Steward	Yale CORE/CMS
Planned Use	Public Reporting, Quality Improvement with Benchmarking
Measure Specification Changes	N/A

Measure Type
Outcome
Target Populations
Older Adults (65 years and older)
Care Setting
Hospital: Inpatient
Level of Analysis
Facility
New or Maintenance
New

CBE #5580 Excess Days in Acute Care (EDAC) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)

Staff Assessment

Domain	Importance	Closing Care Gaps*	Feasibility	Scientific Acceptability	Use and Usability
Staff Rating	*Met*	*Not Met*	*Met*	*Met*	*Met*
Strengths	• Provided a clear logic model. • Measure addresses a major health issue, making it essential for addressing excess days in acute care.	• The developer did not address this optional domain	• All required data elements are routinely generated. • No feasibility issues found requiring adjustment of the final measure specifications. • Transparent handling of burden, licensing, and fees. .	• Developer provided the required evidence for this measure to demonstrate sufficient reliability at the data element-level. • Provided adequate support for validity of measure's data elements. • Risk adjustment methods used are appropriate and model performance is acceptable. • Provided results from optional accountable entity level testing.	• Clear plan for use in public reporting and quality improvement.
Limitations	• Overlaps with existing measure #1551 and #2879e	• The developer did not address this optional domain	• None identified.	• Unclear how moderate model discrimination was calculated.	• Though post-discharge mortality is a conceptual concern, this is mitigated by accounting for survival time.

*Currently optional.

Next Steps

Next Steps for Spring 2026 E&M Cycle

Compiled Comments

- We will post all comments from today to the respective measure pages on the PQM website.
- We will share all public comments, Advisory Group feedback and questions, along with developer/steward clarifications, publicly and with the Recommendation Group in advance of the endorsement meetings.

Upcoming Meetings

- **Endorsement Meeting:** August 6, 2026
- **Appeals Committee Meeting (if needed):** September 30, 2026

Upcoming Webinars

- **Enhancements to the Endorsement and Maintenance (E&M) Guidebook and Processes:** July 2026

Questions:

Contact us at p4qm.org/contact
or by emailing PQMsupport@battelle.org

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