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National Consensus Development and Strategic Planning for Health Care Quality Measurement

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

COST AND EFFICIENCY

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This document is marked as a draft. CMS review is currently pending due to the federal government shutdown. Updates may be made following CMS review.

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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 differences 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).

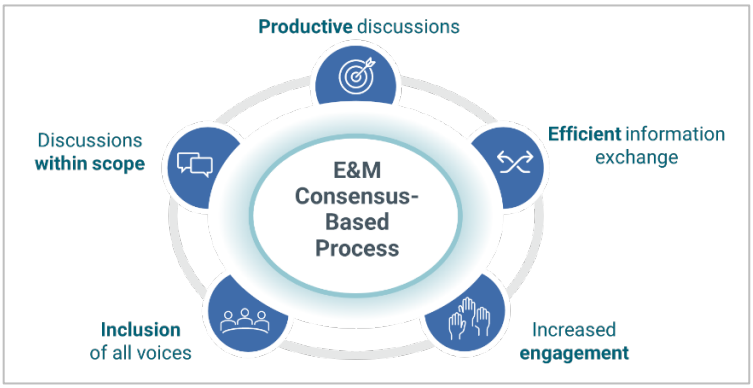

Figure 1. E&M Consensus-Based Process

One of those focus areas is cost and efficiency, which includes measures that focus on health care resource use, such as unplanned readmission for cancer patients and excess days in acute care following hospitalization for acute myocardial infarction (AMI). Cancer is the second leading cause of death in the United States.[3] In 2025, a projected 2,041,910 people will receive new cancer diagnoses, and 618,120 people will die from cancer. Cancer costs are estimated to increase 34% from $183 billion in 2015 to $246 billion by 2030.[4] Given the increasing prevalence of and costs associated with cancer, reducing hospital readmissions following initial discharge may be a means to minimize the cost burden of cancer and improve patient outcomes. Cardiovascular disease is also among the most costly health conditions in the U.S., with AMI hospitalizations making up a significant portion of annual health care costs.[5] Reducing hospital readmissions addresses both financial and patient care concerns, as frequent readmissions can negatively affect patients emotionally and physically and may diminish their confidence in the quality of care they receive.[6] A study of Medicare beneficiaries found that patients spent a median of 24 out of the first 30 days after discharge at home,[7] indicating that

many patients still face challenges that can lead to higher rates of acute care use post discharge.

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

Table 1. Measures Reviewed by the Cost and Efficiency Committee

CBE Number	Measure Title	New/Maintenance	Developer/Steward	Final Endorsement Decision
2881	Excess Days in Acute Care (EDAC) After Hospitalization for Acute Myocardial Infarction (AMI)	Maintenance	Yale Center for Outcomes Research and Evaluation (CORE)/Centers for Medicare & Medicaid Services (CMS)	Endorse with Conditions
3188	30-Day Unplanned Readmissions for Cancer Patients	Maintenance	Alliance of Dedicated Cancer Centers	Endorse with Conditions

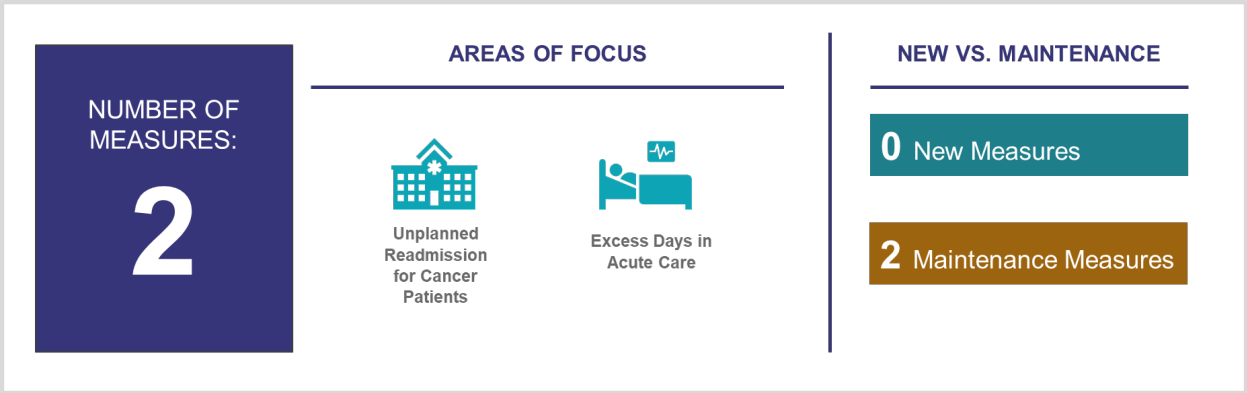

Figure 2. Spring 2025 Measures for Committee Review

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. These E&M committees are composed of diverse PQM members, representing all facets of the health care system. Each E&M committee is divided into an Advisory Group and a Recommendation Group (Figure 3).

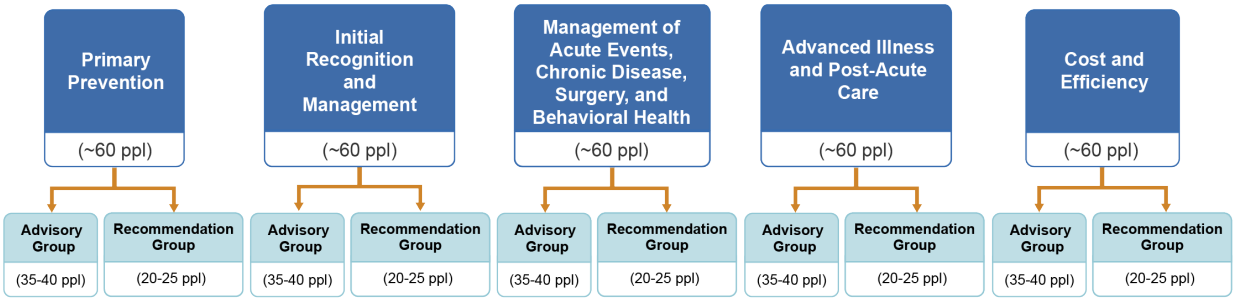

Figure 3. E&M Committee Structure

The goal is to create inclusive committees that balance experience, expertise, and perspectives. The E&M process convenes and engages interested parties throughout the cycle. The interested parties include those who are impacted or affected by quality and cost/resource use measures who come from a variety of places and represent multiple perspectives (Figure 4).

Figure 4. E&M Interested Parties

For the Cost and Efficiency committee, membership for the Spring 2025 cycle consisted of nine patient partners (i.e., patients, caregivers, advocates) and 15 clinicians, with specialties in quality improvement, health policy, data science, and occupational therapy, and others (Figure 5). The committee also included eight population health experts.

While a list of committee members is provided in

Appendix A, full committee rosters and bios are on the respective project pages on the PQM website.

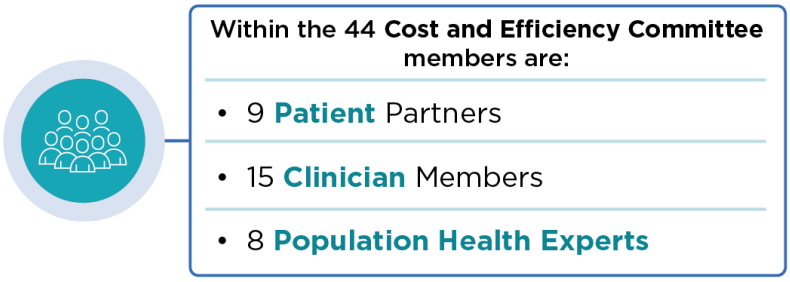

Figure 5. Cost and Efficiency Committee Members

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 p.m. (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. The intent of this 30-day comment period is to solicit 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). Prior to the close of the public comment period, we host a Public Comment Listening Session to gather additional public comments on the measures. Any interested party may attend to give a brief spoken statement on one or more of the measures.

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. A summary of the comments received for the measures submitted to the Cost and Efficiency committee for the Spring 2025 cycle is below.

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 are given the opportunity to share written responses to Advisory Group feedback after these meetings. They can also provide written responses to any public comments received directly on the measure's webpage. This process ensures comprehensive input and engagement from all

stakeholders involved. For the Cost and Efficiency committee, the Advisory Group convened on June 2, 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 preliminary assessments, 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 August 6, 2025. Brief summaries of the Recommendation Group deliberations and voting results are below, while a detailed meeting summary is available on the PQM website.

During the endorsement meeting, the Recommendation Group focuses their discussions on key themes identified from the public comments, the Advisory Group meetings, the associated developer/steward responses, independent reviews, and the staff preliminary assessments. 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 reached when there 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.** When 20 voting members or more: the E&M committee agrees by 75% or more to endorse the measure. When fewer than 20 voting members: the E&M committee agrees by 70% or more to endorse the measure.	Measures undergo maintenance of endorsement reviews every 5 years with a status report review at 3 years (*see Evaluations for Maintenance Endorsement 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 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 recommendations are not addressed, the developer/steward should provide a rationale for consideration by the E&M committee review.	Measures undergo maintenance of endorsement reviews every 5 years with a status report at 3 years, unless the condition requires the measure to be reviewed earlier (*see Evaluations for Maintenance Endorsement for more details*). The E&M committee evaluates whether conditions have been met, in addition to all other maintenance endorsement minimum requirements.
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.** • The E&M committee agrees by 75% or greater (when 20 members or more) or 70% or greater (when fewer than 20 voting members) to remove endorsement; or • A measure steward retires a measure (i.e., no longer pursues endorsement); or • A measure steward never submits a measure for maintenance, and the steward does not respond after targeted outreach; or • There is no longer a meaningful gap in care, or the measure has topped out (i.e., no significant change in measure results for accountable entities over time).	None

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

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

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

The "Endorsed with Conditions" category serves as a means of endorsing a measure but with conditions recommended 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, committee endorsement decisions are posted to the PQM website for 3 weeks, which serves as the appeals period. During this time, any interested party may request an appeal regarding any E&M committee endorsement decision. If a measure's endorsement, including an "Endorsed with Conditions" decision, is being appealed, 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 information that was available by the cycle's Intent to Submit deadline but was not considered by the E&M committee at the time of the endorsement decision, which 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 CBE's measure evaluation criteria were not applied appropriately. For this rationale, the appellant must specify the evaluation criteria they believe were misapplied.
- The CBE's E&M process was not followed. 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 of an appeal by voting to uphold (i.e., overturn a committee endorsement decision) or deny (i.e., maintain the endorsement decision) the appeal. Consensus is determined to be 75% or greater agreement via a vote among members.

For the Spring 2025 cycle, the appeals period opened on August 27, 2025, and closed on September 16, 2025. The measures reviewed by the 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 two measures undergoing maintenance review against standard measure evaluation criteria. During the Recommendation Group endorsement meeting, the committee voted to endorse two measures with conditions (Table 4).

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

	Maintenance	New	Total
Number of measures submitted for endorsement review	2	0	2
Number of measures withdrawn from consideration*	0	0	0
Number of measures reviewed by the committee	2	0	2
Number of measures endorsed	0	0	0
Number of measures endorsed with conditions	2	0	2
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.*

Public Comments Received Prior to Committee Evaluation

Battelle accepts comments on measures through the PQM website. For this evaluation cycle, the public comment period opened on May 20, 2025, and closed on June 15, 2025, during which time we hosted a Public Comment Listening Session on May 28, 2025. The measures received two public comments, and we published the comments to the respective measure pages on the PQM website. If the measure received any comments, the measure's evaluation summary includes a summary of these comments. Developer/steward responses to the public comments can be found under the "Comments" tab of each measure page on the PQM website.

Summary of Potential High-Priority Gap

During the committee's evaluation of the measures, committee members identified a gap area, which is summarized below for future development and endorsement considerations.

Generalizability Beyond Cancer Hospitals

The committee discussed the utility and generalizability of CBE #3188. Currently, 11 cancer hospitals in the CMS Prospective Payment System-Exempt Cancer Hospital Quality Reporting (PCHQR) Program report on the measure. Because the measure has not yet been evaluated or used outside this specific program and these hospitals, the current evidence for broader applicability is limited. The committee recognized the potential value of expanding measurement to other settings and suggested consideration of how CBE #3188 might perform or require adaptation if implemented in different hospital environments.

Summary of Major Concerns

The committee did not report any major concerns.

Summary of Methodological Issue

Risk Adjustment and Accounting for Unique Populations

The committee emphasized the importance of both measures adequately accounting for differences in specific populations.

For CBE #2881, the committee discussed the inclusion of Medicare Advantage (MA) patients and highlighted the need to empirically examine differences in follow-up care between MA and fee-for-service (FFS) patients. They also raised concerns about coding differences and their impact on risk scores.

For CBE #3188, the committee expressed concern that the measure may not fully account for the complexity of cancer care—especially for patients with frequent readmissions or those participating in clinical trials. They questioned whether the model sufficiently adjusts for patients in palliative care or with diminished functional status. The committee also highlighted challenges faced by rural populations, suggesting that the measure may not accurately reflect barriers to care in these settings.

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Measure Evaluation Summaries

CBE #2881 – Excess Days in Acute Care (EDAC) After Hospitalization for Acute Myocardial Infarction (AMI) [Yale CORE/CMS] – Maintenance

Specifications

Description: The Excess Days in Acute Care (EDAC) after Hospitalization for Acute Myocardial Infarction (AMI) (hereafter "AMI EDAC") measure assesses days spent in acute care within 30 days of discharge from an inpatient hospitalization for AMI. This measure is intended to improve the quality of care transitions provided to discharged patients hospitalized for AMI 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 calculated as the difference ("excess") between a hospital's "predicted days" and "expected days," per 100 discharges.

Committee Final Vote: Endorse with Conditions

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

- Empirically explored the differences with outpatient visits and post-hospitalizations for MA patients compared to fee-for-service patients.

Vote Count: Endorse (9 votes; 50%), Endorse with Conditions (7 votes; 39%), Remove Endorsement (2 votes; 11%); Recusals (0).

Summary of Public Comments: Battelle received one comment prior to the meeting. The commenter expressed concern that the measure's focus on unplanned readmissions might lead to negative unintended consequences for patients and fail to accurately capture the appropriate patient population due to its current structure and timeframe.

Summary of Measure Evaluation: This maintenance measure was last reviewed for endorsement in 2016. CMS's Inpatient Quality Reporting (IQR) Program currently uses it.

Discussion Topic/Theme	Committee Discussion Summary
Risk Adjustment	• The Advisory Group asked about risk adjustment for different types of myocardial infarction (MI), such as subendocardial versus transmural, as well as repeat MIs. The developer confirmed that the risk model includes history of AMI to account for repeat events and incorporates variables such as prior coronary artery bypass graft (CABG), stent placement, prior ST-segment elevation myocardial infarction (STEMI), heart failure, and other relevant procedures for different MI types.

Discussion Topic/Theme	Committee Discussion Summary
	• The Advisory Group also raised questions about including intensive care unit (ICU) and critical care unit (CCU) status and potential collinearity. The developer responded that ICU status was not included due to variability in hospital admission thresholds, which are under the control of individual hospitals. • The Advisory Group supported the inclusion of MA patients but questioned the choice of a binomial risk model over Poisson or negative binomial models, as well as the decision to use MA for risk adjustment rather than stratification. The Recommendation Group echoed concerns about the appropriateness of the MA risk adjustment variable and its effect on measure results. • The developer explained that the binomial model was selected for better performance and computational efficiency, and that MA was incorporated as a dummy-coded risk variable after comparing stratification and risk adjustment approaches. The committee raised additional concerns regarding potential coding differences between MA and FFS patients, particularly the risk of aggressive coding in MA plans inflating risk scores. • The developer acknowledged both coding discrepancies and the risk of overcoding in MA, noting that unadjusted rates for MA patients are higher, and requested feedback on how best to address this issue. They track dual eligibility and income but do not adjust for these factors. • A Recommendation Group member suggested the developer use claims data to empirically examine outpatient follow-up visit differences between MA and FFS patients to better understand factors driving acute care use. • The Recommendation Group also considered the risk model C-statistic, noting that it was like other readmissions measures that have previously been endorsed. A Recommendation Group member suggested that the committee should not rely on C-statistics of other performance measures to determine if the current measure's risk adjustment model C-statistic is acceptable. • *Battelle staff noted there is currently no standard for what constitutes an acceptable C-statistic for endorsement. As a result, developers have used C-statistics from similar endorsed measures to support the claim that their risk adjustment model performance is sufficient. Battelle is planning to work with the Scientific Methods Panel to develop risk adjustment guidance, which will include C-statistic considerations.* • Based on this discussion, the Recommendation Group voted to impose the following condition on the measure: **when the measure comes back for maintenance in 5 years, the developer should have empirically explored the differences with outpatient visits and post-hospitalizations for MA patients compared to fee-for-service patients.**
Measure Focus	• The public comment raised concerns that focusing solely on unplanned readmissions could result in unintended negative consequences for patients and may not accurately identify the appropriate patient population, given the measure's current structure and timeframe. • Both the Advisory and Recommendation Groups noted that the measure includes ED visits and observation stays. However, the Recommendation

Discussion Topic/Theme	Committee Discussion Summary
	Group was concerned that counting all acute care events, rather than only those related to AMI, might unfairly penalize hospitals, particularly those in areas with limited outpatient care options. • Additionally, the Recommendation Group noted that the measure does not account for mortality, which could make hospitals with higher death rates appear to perform better because those cases are not recorded as readmissions. In response, the developer clarified that mortality and readmissions are intentionally tracked as separate measures because they require different risk adjustment strategies and have distinct quality improvement implications. The developer also cited empirical evidence (Figure 4 and Table 7) indicating that most of post-discharge acute care events are cardiac related.
Measure Specifications and Overlap with Existing Measures	• The Advisory Group expressed concern about the conceptual overlap between the measure and other existing measures (such as readmission, complications, and mortality), and highlighted the potential for multiple penalties, particularly for rural providers. In response, the developer clarified that there is no overlap in outcomes—only in patient cohorts—and emphasized that the EDAC measure is intended for reporting purposes, not for payment. • The Advisory Group also asked why federal hospitals were excluded. The developer explained that currently only non-federal hospital claims data are available, but Veterans Affairs (VA) data will be included in the future. Additionally, the Advisory Group inquired about the continuous enrollment requirement for MA and FFS patients; the developer clarified that patients are included if they are enrolled in either MA or FFS at index admission or follow-up, regardless of switching within a 12-month period. • Additional questions from the Advisory Group focused on the inclusion of observation stays and the counting of multiple events. The developer explained that all inpatient, ED, and observation events occurring within 30 days are counted, which distinguishes this measure from traditional readmission metrics and helps prevent gaming. • The Recommendation Group sought clarification on how different types of acute care days—ED, inpatient, and observation—are weighted and distinguished. The developer stated that inpatient days are counted by the actual number of days, ED visits are counted as 1 day, and observation stays are rounded to the nearest whole day. • Finally, the Recommendation Group asked about the minimum case requirement for reporting. The developer responded that public reporting requires a minimum of 50 cases, although scores are calculated for all hospitals to support ongoing quality improvement.

Additional Recommendations for the Developer/Steward: None.

CBE #3188 – 30-Day Unplanned Readmissions for Cancer Patients [Alliance of Dedicated Cancer Centers] – Maintenance

Specifications

Description: 30-Day Unplanned Readmissions for Cancer Patients measure is a cancer-specific measure. It provides the rate at which all adult cancer patients covered as Fee-for-Service Medicare beneficiaries have an unplanned readmission within 30 days of discharge from an acute care hospital. The unplanned readmission is defined as a subsequent inpatient admission to a short-term acute care hospital, which occurs within 30 days of the discharge date of an eligible index admission and has an admission type of "emergency" or "urgent."

Committee Final Vote: Endorse with Conditions

Conditions: When the measure returns in 3 years for maintenance endorsement, the developer would have:

- Conducted an empirical exploration of the reasons for patients being readmitted, especially considering those unrelated to cancer, and the impact of those reasons on the measure's performance.

Vote Count: Endorse (2 votes; 12%), Endorse with Conditions (11 votes; 65%), Remove Endorsement (4 votes; 24%); Recusals (0).

Summary of Public Comments: Battelle received one comment prior to the meeting. The commenter expressed concern that the measure's focus on unplanned readmissions might lead to negative unintended consequences for patients and fail to accurately capture the appropriate patient population due to its current structure and timeframe. They also indicated that the measure specifications and definitions are not aligned with other readmission measures used in CMS programs.

Summary of Measure Evaluation: This maintenance measure was last reviewed for endorsement in the 2017 cycle. CMS's PCHQR Program currently uses it.

Discussion Topic/Theme	Committee Discussion Summary
Validity and Risk Adjustment	• The Advisory Group questioned the limited use of risk adjusters—particularly the reliance on a single comorbidity measure—and suggested that including individual comorbidities and longer data periods or cancer type distinctions could improve performance. The developer responded that variables were removed based on CMS preferences and expert advice; the Elixhauser index was retained per cancer literature and panel recommendations, and individual comorbidities did not enhance performance. Cancer type is included, but longer data periods are not. • The Recommendation Group raised concerns that the model may reduce variation between facilities, potentially impacting the measure's utility. The developer acknowledged the trade-off, stating all critical variables were added as advised by experts, which did reduce variation, but determining meaningful variation for cancer patients remains difficult. • Both groups noted limitations in claims data for risk adjustment, particularly regarding clinical characteristics and variable reliability. The Advisory Group

Discussion Topic/Theme	Committee Discussion Summary
	questioned whether the model sufficiently adjusts for unique clinical circumstances, such as surgery versus ongoing therapy, palliative care, or functional status. The developer acknowledged these challenges, used validated mitigation strategies, and explained that some variables (such as surgical admission and "do not resuscitate" status) were tested but did not improve the model. • The Recommendation Group further raised concerns about the measure's validity in complex care scenarios—particularly in rural settings, for patients with frequent readmissions, or those receiving experimental treatments. They argued that the measure reflects how complications are treated, rather than whether a complication occurred, which may undermine validity. • As a result, the Recommendation Group voted to impose a condition: **when the measure returns in 3 years for maintenance endorsement, the developer must empirically analyze reasons for patient readmissions—including those unrelated to cancer—and the impact on measure performance.**
Measure Focus and Misalignment	• The public comment raised concerns that focusing on unplanned readmissions may cause negative unintended consequences for patients and fail to accurately identify the appropriate population. • The Advisory Group emphasized the importance of including observation stays, noting that regional variation in their use could artificially lower readmission rates. • The Recommendation Group agreed, stating that excluding ED visits and observation stays could allow hospitals to game the measure and creates inconsistency with other CMS readmission measures. The public comment also highlighted misalignment with other CMS readmission measure specifications. • The developer responded that observation stays are not currently included, but they are open to exploring such as an inclusion to better align with other measures. • The Recommendation Group noted possible unfair penalties if patients are readmitted for conditions unrelated to cancer, due to complexities in diagnosis coding. The developer clarified that, as the measure is limited to cancer hospitals, patients are unlikely to be readmitted for reasons unrelated to cancer, and diagnosis coding should reflect this. • The Advisory Group sought clarification on how attribution works when patients are readmitted to different facilities. The developer indicated that the patient is attributed to the measured entity where the index admission occurred. • The Advisory Group also discussed how disease progression is determined for numerator inclusion, specifically questioning the use of metastatic codes. The developer explained that the specifications require a metastatic code at the time of readmission; however, if the index admission already had a

Discussion Topic/Theme	Committee Discussion Summary
	metastatic code, any subsequent admission within 30 days is considered a readmission.

Additional Recommendations for the Developer/Steward:

The developer may want to consider including ED visits and/or observation stays due to alignment with other readmissions measures that include these events and to address Recommendation Group concerns of potential gaming.

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Appendix A: Cost and Efficiency Committee Roster

Spring 2025 Cycle

Member	Affiliation/ Organization	Primary Perspective	Advisory/ Recommendation Group
Seth Morrison (Patient Representative Co-Chair)	--	Patient, Caregiver, and Patient Advocate	Recommendation Group
William Golden (Non-Patient Representative Co-Chair)	University of Arkansas for Medical Sciences; Arkansas Medicaid	Purchaser/Plan; Clinician; Population Health Expert	Recommendation Group
Jacqueline Alikhaani	--	Patient, Caregiver, and Patient Advocate	Advisory Group
Nishant Anand	Altais	Clinician	Advisory Group
Sopida Andronaco	Hoag Orthopedic Institute	Clinician; Facility/Institution	Recommendation Group
Melody Beaty	--	Clinician	Advisory Group
Alice Bell	American Physical Therapy Association	Clinician; Other Interested Parties	Recommendation Group
Bijan Borah	Mayo Clinic College of Medicine and Science	Researcher; Facility/Institution	Recommendation Group
Amy Chin	HSS Center for the Advancement of Value in Musculoskeletal Care	Researcher; Facility/Institution	Recommendation Group
Erin Crum	McKesson	Other Interested Parties	Advisory Group
Sandeep Das (Inactive)	UT Southwestern Medical Center; Parkland Health	Population Health Expert; Clinician; Facility/Institution; Researcher	Recommendation Group
Anne Deutsch	RTI International	Researcher	Advisory Group
Marisa Elliott	--	Facility/Institution; Population Health Expert	Recommendation Group
Lynn Ferguson	--	Patient, Caregiver, and Patient Advocate	Recommendation Group
Maria Fernandez	Emory Johns Creek Hospital	Population Health Expert	Advisory Group
Stephanie Fitzgerald	Blue	Clinician	Advisory Group
Carrie I. Freeman-Wright	--	Patient, Caregiver, and Patient Advocate	Recommendation Group

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Member	Affiliation/ Organization	Primary Perspective	Advisory/ Recommendation Group
Joan Gleason Scott	--	Other Interested Parties; Clinician	Recommendation Group
Beth Godsey (Inactive)	--	Other Interested Parties	Recommendation Group
Olga Gross-Balzano	--	Facility/Institution	Advisory Group
Megan Guinn (Inactive)	BJC Healthcare ACO; BJC Medical Group	Facility/Institution; Clinician; Other Interested Parties	Recommendation Group
Daniel Halevy	Healthfirst	Purchaser/Plan; Clinician	Recommendation Group
Michelle Hammer	Elevance Health	Purchaser/Plan	Advisory Group
Stephanie Hansen	--	Clinician	Advisory Group
Charles Hawley	National Association of Health Data Organizations	Other Interested Parties	Advisory Group
Sharon Hibay	Advanced Health Outcomes	Researcher	Recommendation Group
Kristal Higgins	--	Patient, Caregiver, and Patient Advocate	Advisory Group
Christina Hurst	--	Patient, Caregiver, and Patient Advocate	Advisory Group
Sunny Jhamnani	TriCity Cardiology	Clinician; Facility/Institution	Advisory Group
Robert Jones	Cleveland Clinic	Clinician	Advisory Group
John Martin	Premier	Other Interested Parties; Researcher	Recommendation Group
Harold Miller	Center for Healthcare Quality and Payment Reform	Researcher; Other Interested Parties	Recommendation Group
Jack Needleman	Department of Health Policy and Management, UCLA School of Public Health	Researcher	Recommendation Group
Jessica Peterson	Anatomy IT	Other Interested Parties	Advisory Group
Rosa Plasencia	ADvancing States	Population Health Expert; Other Interested Parties	Recommendation Group
Pamela Roberts	Cedars-Sinai Health System	Clinician; Facility/Institution; Researcher	Recommendation Group
Susan Roberts	--	Patient, Caregiver, and Patient Advocate	Advisory Group

Member	Affiliation/ Organization	Primary Perspective	Advisory/ Recommendation Group
Mary Schramke	--	Patient, Caregiver, and Patient Advocate	Recommendation Group
Lynden Schuyler	--	Population Health Expert	Advisory Group
Shalini Selvarajah	American College of Medical Genetics and Genomics	Researcher	Advisory Group
Trisha Jean Smith	--	Patient, Caregiver, and Patient Advocate	Advisory Group
Steven Spivack	Lewin Group	Other Interested Parties	Recommendation Group
Kim Tyree (Inactive)	Evergreen Family Medicine	Population Health Expert; Facility/Institution; Other Interested Parties	Recommendation Group
Margaret Woeppel	--	Population Health Expert; Clinician; Facility/Institution; Other Interested Parties	Recommendation Group

Partnership for Quality Measurement Organizations

Battelle

Measure Stewards

Alliance of Dedicated Cancer Centers

Centers for Medicare & Medicaid Services (CMS)

Measure Developers

Alliance of Dedicated Cancer Centers

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 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

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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

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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