Partnership for Quality Measurement
Powered by Battelle

Fall 2025 Cost and Efficiency Recommendation Group Endorsement Meeting

Mary Schramke | Patient Co-Chair
Steven Spivack | Technical Co-Chair
Jeff Geppert | Battelle
Matt Pickering | Battelle
Anna Michie | Battelle
Isaac Sakyi | Battelle

February 6, 2026

The analyses upon which this publication is based were performed under Contract Number 75FCMC23C0010, entitled, "National Consensus Development and Strategic Planning for Health Care Quality Measurement," sponsored by the Department of Health and Human Services, Centers for Medicare & Medicaid Services. Restricted: Use, duplication, or disclosure is subject to the restrictions as stated in Contract Number 75FCMC23C0010 between the Government and Battelle.

Partnership for Quality Measurement
Powered by Battelle

Welcome

Agenda

- Welcome and Review of Meeting Objectives and Ground Rules
- Roll Call with Disclosures of Interest
- Overview of Evaluation Procedures and Measures for Endorsement Consideration
- Test Vote
- Evaluation of Fall 2025 Measures
- Maintenance Measure Reconsideration
- Next Steps
- Adjourn

Meeting Objectives

The purpose of today's meeting is to:

- Review and discuss measures submitted to the Cost and Efficiency committee for the Fall 2025 cycle;
- Review public comments, Advisory Group feedback, and any corresponding developer/steward input for the submitted measures; and
- Render endorsement decisions for the submitted measures.

Housekeeping Reminders for Recommendation Group

- The system will allow you to mute/unmute yourself and turn your video on/off throughout the event.
- Please raise your hand and unmute yourself when called on.
- Please lower your hand and mute yourself following your question/comment.
- Please state your first and last name if you are a call-in user.
- We encourage you to keep your video on throughout the event.
- Feel free to use the chat feature to communicate with Battelle staff.
- If you are experiencing technical issues, please contact the project team via chat 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
- Be respectful and allow others to contribute
- Share your experiences
- Learn from others

Roll Call with Disclosures of Interest

Quorum

- Meeting quorum requires that 60% of the Recommendation Group members are present during roll call at the beginning of the meeting.

- The Recommendation Group renders endorsement decisions via a vote after the discussion. Voting quorum is at least 80% of active committee members (Recommendation Group only) who are not recused.

Cost and Efficiency Fall 2025 Cycle Committee – *Recommendation Group*

- Mary Schramke, PhD, MBA **(Patient Co-Chair)**
- Steven Spivack, PhD, MPH **(Technical Co-Chair)**
- Jacqueline Alikhaani, BS
- Sopida Andronaco, MSN, RN, PHN, CPHQ
- Alice Bell, PT, DPT
- Bijan Borah, PhD, MSc
- Amy Chin, DrPHc, MS
- Erin Crum, MPH
- Sandeep Das, MD, MPH
- Anne Deutsch, PhD, BSN, MS
- Marisa Elliott, BS
- Stephanie Fitzgerald, RN RAC-CTA
- Carrie I. Freeman-Wright, PhD
- Olga Gross-Balzano, BS
- Megan Guinn, MBA, BSN, RN
- Stephanie Hansen, DO, MBA
- Sharon Hibay, DNP, RN
- Kristal Higgins
- Sunny Jhamnani, MD
- Kim Tyree, MBA

Cost and Efficiency Subject Matter Experts*

- **Sepsis**
  - Raymund Dantes, MD, MPH
- **Dementia**
  - Annie Slye, MS, OTR/L, CDP

*Subject matter experts (SMEs) serve as non-voting participants to provide relevance and context to the committee's measure endorsement review and discussions.

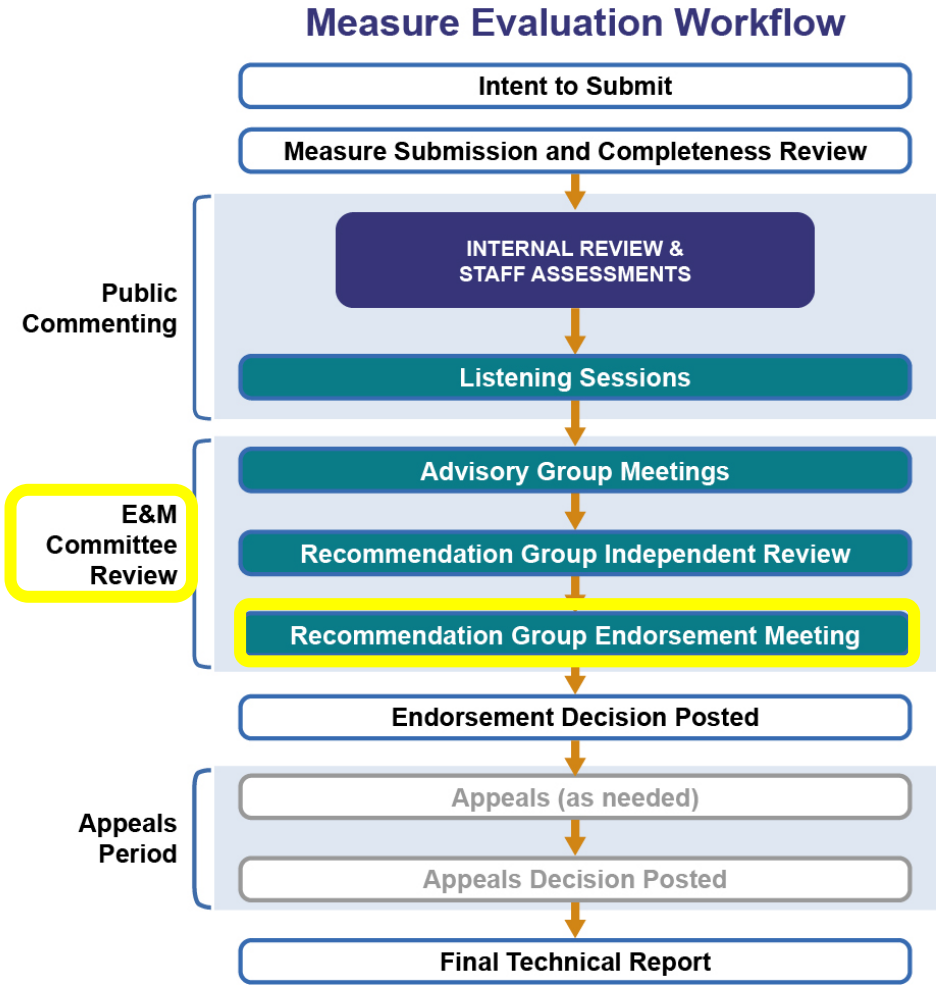
SMEs review the relevant measure(s) prior to the endorsement meeting and attend the endorsement meeting to provide input on and answer committee questions regarding the measure's clinical relevance, the supporting evidence, inclusion and exclusion criteria, measure validity, and risk-adjustment or stratification approach (if applicable).

Overview of Evaluation Procedures

E&M Process

Six major steps:

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



Recommendation Group Meeting

Measure Review Procedures

1. Measure Introduction by Battelle

- Battelle introduces the measure and salient points from discussion guide, staff assessments, and public comment.

2. Developer/Steward Comments

- Developers/stewards provide 3–5-minute commentary about the measure for committee consideration.

3. Recommendation Group Discussion

- Battelle conducts facilitated discussion by topic:
  - SME* input on relevant discussion items
  - Patient partner feedback
  - Advisory Group feedback
  - Recommendation Group discussion
  - Developer/steward response

4. Endorsement Vote

- Co-chairs recommend any conditions for consideration based on committee discussions.
- Recommendation Group votes.

** SME = subject matter expert*

Patient Partner Feedback

- As a patient or caregiver, do you have experience with the measure topic that you would like to share?
- Do you think the measure is meaningful to patients and will help to improve their care?
- Is the measure respectful of and responsive to individual patient preferences, needs, and values?
- Are there aspects about the measure that may be difficult for patients to understand?
- Are there aspects about the measure that may be burdensome to patients?

Developer Response

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

Facilitators will call upon developers to respond accordingly.

If you have questions for the developer, please raise your hand to verbalize your questions, rather than putting them in the chat, so the entire group can benefit from the information provided.

Guiding Questions for Endorsement Assessment

When reviewing the key themes, what core issues relating to endorsement stand out?

Do the issues pose a substantial risk to the measure's safety or effectiveness?

Do the issues impact your endorsement decision?

Can the developer implement feasible mitigation strategies to reduce residual risk by a future maintenance cycle?

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.

Consensus Voting for Final Determinations

Voting Choices	Endorse (A)	Endorse with Conditions (B)	Do Not Endorse/Remove Endorsement (C) *(Must provide rationale)*
Outcomes	**75% or more†** of the active voting members agree the measure **meets all the criteria** of endorsement, the committee votes to **Endorse.**	**75% or more** of the active voting members agree the measure can be endorsed as it meets the criteria **but also agree with any conditions identified for endorsement,** the committee votes to **Endorse with Conditions**.	**75% or more** of the active voting members agree the measure **does not meet the criteria of endorsement**, the committee votes to **Not Endorse/Remove Endorsement.**

75% or more votes **between** Endorse and Endorse with Conditions, the committee votes to **Endorse with Conditions**.

If no voting category reaches 75%, the committee vote is **No Consensus**.*

**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.*

†The consensus threshold is adjusted to 70% in cases where there are fewer than 20 voting members.

Overview of Fall 2025 Measures for Endorsement Consideration

Fall 2025 Measures for Committee Review

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

NUMBER OF MEASURES:

2

AREAS OF FOCUS

- Readmission Following Hospitalization for Sepsis
- Readmission Following Inpatient Psychiatric Hospitalization

NEW VS. MAINTENANCE

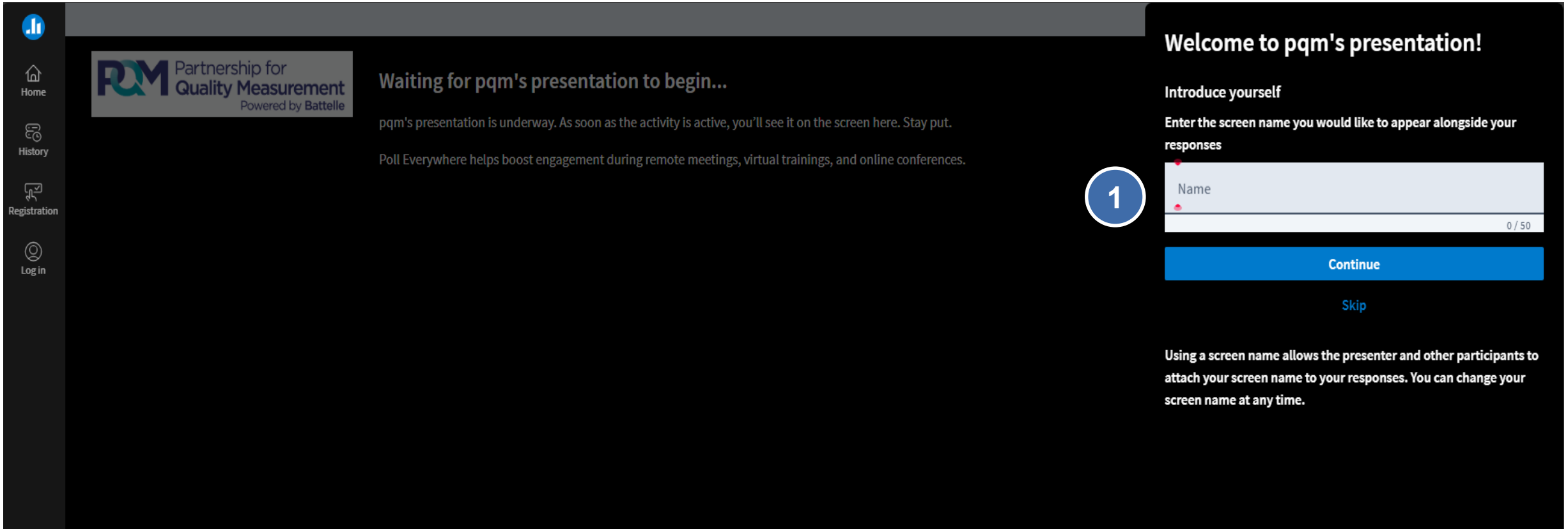
- **1** New Measure
- **1** Maintenance Measure

Fall 2025 Measures for Committee Review
(cont., 1)

CBE Number	Measure Title	New/ Maintenance	Developer/Steward
#2860	Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF Readmission)	Maintenance	Mathematica/Centers for Medicare & Medicaid Services (CMS)
#5275	Hospital-Level, Risk-Standardized 30-day All-Cause Readmission Following Hospitalization for Sepsis	New	Yale Center for Outcomes Research and Evaluation (CORE)/CMS

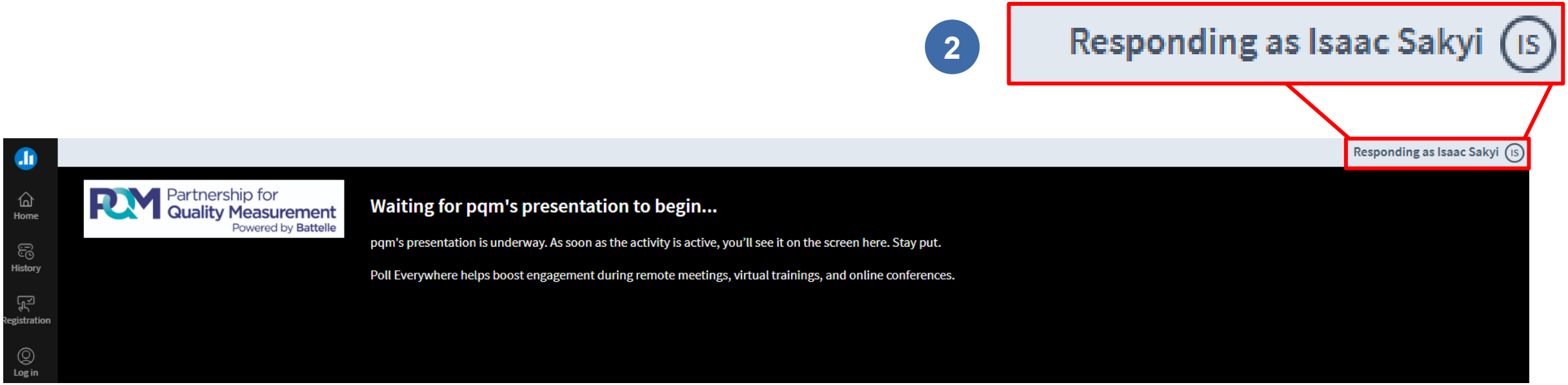
Test Vote

Using the Poll Everywhere Platform



1 Click the text box to enter your first and last name and then click continue.

Using the Poll Everywhere Platform *(cont., 1)*



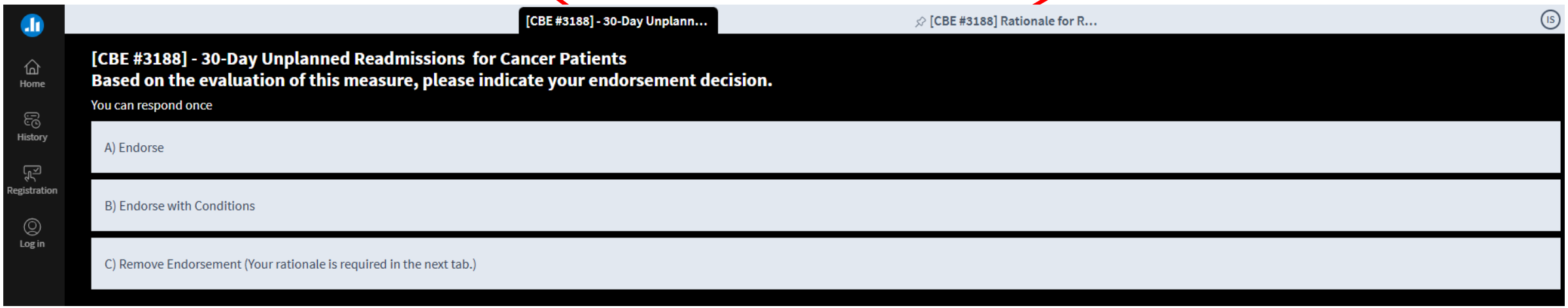
2 Once you enter your name you will see “Responding as First name Last name” followed by your initials.

Click the icon in the top right corner to change your name if the system assigned you a randomly generated name.

Using the Poll Everywhere Platform *(cont., 2)*

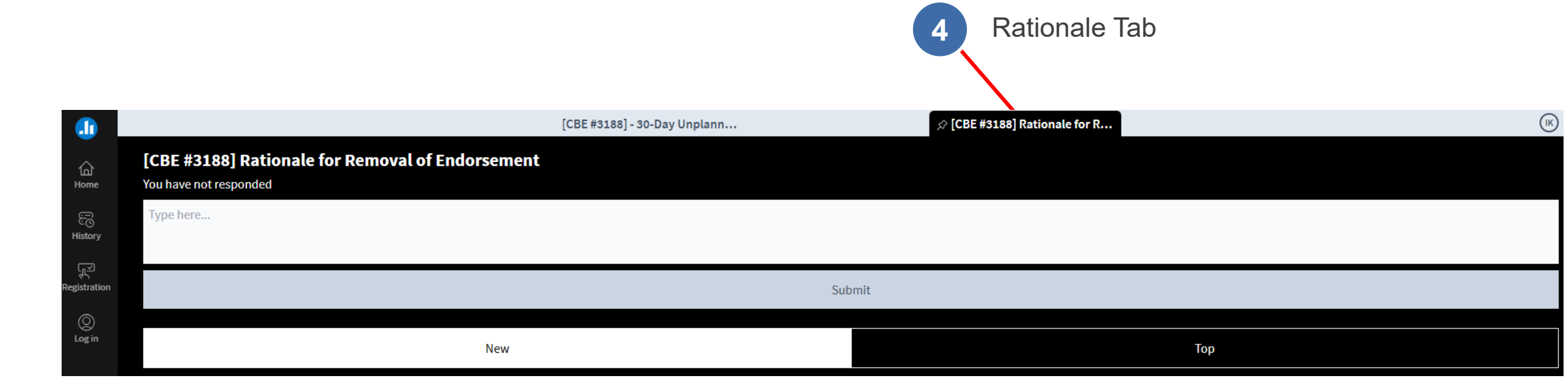
3 Select your vote

4 Rationale Tab



3 When voting not to endorse a measure or to remove endorsement, you are required to document your rationale in the next tab.

Using the Poll Everywhere Platform *(cont., 3)*



4 Click the tab with the pin icon, type your rationale, and then click "Submit."

Voting Considerations and Troubleshooting

A link to **Poll Everywhere** was sent to your email from "pqm@battelle.org."

- Do not share the voting link in the Zoom chat.
- If you cannot find the voting link, please direct message the "PQM Co-host" or let us know verbally.

⚠

If, at any point, you are having difficulties voting, try refreshing your page or opening the link in a different internet browser.

- If you are still having difficulties, please let us know.

Out-of-Scope Topics for Measure Endorsement

- Endorsement confirms a quality measure is safe and effective as specified.
- While committee members may suggest exploring other patient populations, care settings, or uses, these suggestions should not prevent endorsement if the measure meets the criteria.
- Endorsement should proceed if the measure is safe and effective as specified.

Evaluation of Fall 2025 Measures

CBE 2860 – Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF Readmission)

Item	Description
Measure 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.
Developer/ Steward	Mathematica/CMS
New or Maintenance	Maintenance
Current Use	Public Reporting; Payment Program
Initial Endorsement	Fall 2016 (Last Reviewed: Spring 2021)
Material Specification Changes	None

Measure Type

Outcome

Target Populations

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

Care Setting

Behavioral Health: Inpatient (e.g., Inpatient Psychiatric Facility)

Level of Analysis

Facility

CBE #2860 Public Comments

This measure did not receive any public comments during the public comment period.

CBE #2860 Advisory Group Feedback
Technical Feedback

Key Themes	Summary of Committee Comments	Summary of Developer Response
Measure Scope and Data Sources	• An “all-cause” approach may penalize facilities for events outside of their control (e.g., accidents).	• All unplanned readmissions are adverse events from the patient perspective, and including all such readmissions, rather than cause-specific ones, provide IPFs greater opportunity for quality improvement.
	• Questioned why the measure is limited to inpatient psychiatric facilities (IPFs) and excludes other settings (i.e., designated receiving facilities [DRFs]).	• There are no plans to expand the measure, but in 2027 CMS will add a complementary measure tracking emergency department visits post-discharge. This new measure will provide additional information on patient outcomes in other settings and will complement the readmission measure without double-counting.
	• Suggested a shift toward mutual accountability and whole-person care models, reflecting the complexity of patients with high comorbidity and accident rates. • Suggested employing cross-cutting metrics that capture overall utilization and integrated care.	• Many IPFs continue to have risk-standardized readmission rates (RSRRs) below the national rate, indicating room for improvement. There are no plans to update this measure to a cross-cutting measure.
	• Excluding Medicare Advantage (MA) is a major limitation that could widen care gaps and opportunities for gaming.	• MA data differ from fee-for-service (FFS) data, but they could consider adding this population in the future.
	• Facilities may be penalized twice: once under this IPF readmission measure and again under the hospital-wide readmission measure (CBE 2879e).	• Hospitals will not be penalized twice as this measure only attributes readmissions based on an index admission at an IPF.

CBE #2860 Advisory Group Feedback
Technical Feedback (cont., 1)

Key Themes	Summary of Committee Comments	Summary of Developer Response
Risk Adjustment and Methodology	• Requested more information about the risk adjustment methodology and model composition.	• The risk model includes age, sex, and psychiatric and non-psychiatric conditions that were associated with readmission as well as 22 non-psychiatric comorbidities (e.g., heart failure, liver disease, diabetes). • The model uses a hierarchical logistic regression to estimate a risk-standardized readmission rate (RSRR).
	• Suggested splitting the measure into severe mental illness and dementia/Alzheimer's tracks, with stratified performance data and calibration plots provided for each group.	• Individuals with dementia/Alzheimer's are included within the 15 psychiatric condition groups defined in the Agency for Healthcare Research and Quality's Clinical Classifications Software. • There are no plans to create separate measures for these populations. • The risk adjustment model accounts for the higher readmission risk in dementia patients, though model performance has not been tested separately for these groups.
Reliability	• Suggested using higher thresholds to improve accuracy as low case thresholds reduce reliability and cause shrinkage toward the mean.	• Reliability concerns will be noted for CMS, which sets volume thresholds for reporting.
Actionability for Facilities	• Facilities need actionable data, including patient-level readmission flags and actual versus expected readmission counts to support quality improvement.	• CMS provides a reporting dashboard for patient-level analysis of readmissions and supplies actual versus expected readmission counts, calculated as a risk-standardized ratio.

The Advisory Group (AG) highlighted these topics as key considerations for the Recommendation Group (RG).

CBE #2860 Key Discussion Themes

Discussion Category	Key Themes	Source of Comment	Summary of Comments
Supportive	Feasibility	• Staff Assessment • Committee Independent Review	• Staff rated this measure as “Met” and 100% of RG reviewers agreed.
	Reliability	• Staff Assessment • Advisory Group • Committee Independent Review	• Staff rated this measure as “Met” and 100% of RG reviewers agreed. • An AG member noted that low case thresholds reduce reliability and cause shrinkage toward the mean. Higher thresholds could improve accuracy.
Mixed	Importance	• Staff Assessment • Advisory Group • Committee Independent Review	• Staff rated this measure as “Not Met but Addressable” due to limited evidence relevance and mixed patient feedback, with only three out of eight patients on a developer-convened panel finding the measure meaningful. • AG members raised concerns that an “all-cause” approach may penalize facilities for events outside of their control. • 40% rating this domain as “Met,” while others agreed with staff assessment rating of “Not Met but Addressable,” citing limited evidence of meaningful improvement, strong concern about combining dementia/Alzheimer’s with serious mental illness, and a need for more patient/caregiver input.

AG: Advisory Group

CBE #2860 Key Discussion Themes *(cont., 1)*

Discussion Category	Key Themes	Source of Comment	Summary of Comments
Mixed	**Validity, Risk Adjustment, and Stratification**	• Staff Assessment • Advisory Group • Committee Independent Review	• Staff rated the measure "Not Met but Addressable" due to missing effect sizes, t-test results, and evidence of risk factor variation. While RG reviewers generally found validity testing and risk adjustment methods acceptable, they noted mixed correlation results, limited differentiation in the subgroup analyses, calibration limitations at the tails, and a need for diagnosis-specific results. • AG and RG members noted concerns about two distinct patient populations in the measure and suggested splitting the measure by severe mental illness vs. dementia/Alzheimer's and stratifying data accordingly.
	Use and Usability	• Staff Assessment • Committee Independent Review	• Staff rated this measure as "Not Met but Addressable" because the national performance rates show only modest improvement without a sufficient rationale for limited progress. • 40% of RG reviewers rated this domain as "Met," while others agreed with the staff assessment rating, citing limited performance improvement, the combination of distinct patient populations, and FFS-only applicability as MA enrollment grows.

AG: Advisory Group

Break

Meeting will resume at 11:45 AM ET

When returning from break, please type “Present” in the Zoom chat.

Evaluation of Fall 2025 Measures

CBE 5275 – Hospital-Level, Risk-Standardized 30-day All-Cause Readmission Following Hospitalization for Sepsis

Item	Description
Measure 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.
Developer/ Steward	Yale Center for Outcomes Research and Evaluation (CORE)/CMS
New or Maintenance	New
Planned Use	Public Reporting Program; Payment Program
Initial Endorsement	N/A
Material Specification Changes	N/A

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

CBE #5275 Public Comments

One comment received.

- The American Medical Association (AMA) noted that readmission measures may cause negative outcomes, including increased mortality, and requested analyses of correlations across timeframes and risk adjustment methods.
- The developer acknowledged the importance of monitoring unintended consequences and cited evidence showing no correlation between readmission rates and post-discharge mortality for sepsis.

Unintended Consequences: Post-Discharge Mortality **1**

- The AMA questioned whether the 30-day post-discharge period is appropriate. Additional analyses are needed to assess correlations between readmissions and mortality across different timeframes and outcome types.
- The developer cited empirical evidence that readmission risk remains elevated beyond 30 days and that the first 3 weeks post-discharge are the highest risk period.

Post-Discharge Timeframe Validity **1**

- The AMA raised concerns that reliance on risk-adjusted data may mask important associations and recommended examining both unadjusted and adjusted rates.
- The developer explained that risk adjustment is essential for fair hospital comparisons and confirmed their model is well-calibrated across patient subgroups.

Risk Adjustment **1**

CBE #5275 Public Comments *(cont., 1)*

One comment received.

- The AMA noted recent CMS readmission measure changes (ICD-10–based risk adjustment, MA inclusion, and a 2-year data period) and requested clarification on their impact on reliability and hospital performance.
- The developer clarified that this new measure was not based on prior readmission methodology, and testing demonstrated strong reliability and validity.

Impact of CMS Methodology Changes: 1

- The AMA criticized the lack of socioeconomic factors in risk adjustment, noting that hospitals serving poorer populations may be disadvantaged, and suggested community-level variables be considered.
- The developer stated testing results do not support poorer performance among hospitals with higher proportions of dual-eligible patients.

Socioeconomic Adjustment: 1

- The AMA recommended increasing the minimum sample size to achieve higher reliability and disagreed with current PQM guidance allowing only 70% of entities to meet this threshold.
- The developer stated that the measure meets PQM standards for publicly reported measures and showed strong reliability for hospitals with at least 25 cases.

Reliability and Minimum Sample Size: 1

CBE #5275 Advisory Group Feedback
Technical Feedback

Key Themes	Summary of Committee Comments	Summary of Developer Response
Coding Practices, Artificial Intelligence (AI) Influence, and Diagnostic Accuracy	• Raised concerns about how coding accuracy, AI-assisted coding, and clinical variability may inflate sepsis diagnoses, potentially affecting measure validity and biasing readmission rates.	• Analyses of 2022-2023 data found variation in A41.9 coding across hospitals by sepsis volume, with no association between coding intensity and unadjusted sepsis readmission or mortality rates, indicating no impact on the comparability of risk-adjusted outcomes.
	• 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.	• Sepsis readmissions are identified using claims-based diagnosis codes listed in the data dictionary, with CMS guidance on coding and sequencing under the Sepsis-2 definition.
	• Important to understand how changes in diagnostic practices and clinical and coding variability affect numerator and denominator inclusion, and recommended accounting for these trends to ensure accurate and reliable assessment.	• The measure relies on final-action claims after audits and coding denials. The risk model has shown reliable performance across sepsis subpopulations and can accommodate future coding changes, with specifications updated as needed based on CMS monitoring.
Risk Adjustment and Methodology	• Questioned whether the measure's risk adjustment model remains appropriate as diagnostic thresholds and coding practices evolve.	• The measure has a robust risk adjustment model with 160 variables (e.g., organism pathogenicity, immune suppression, organ compromise, sepsis severity, and source of sepsis) addresses case-mix differences across hospitals and was refined with input from a technical expert panel.
	• Asked if the risk adjustment model includes socioeconomic factors, such as income and housing, to avoid penalizing hospitals serving vulnerable populations.	• Risk adjustment testing did not support including dual eligibility, as existing clinical variables account for most associated readmission risk and the model was well calibrated for both dual- and non-dual-eligible patients. Adding dual eligibility had minimal impact on scores, and if implemented, the measure would be used in the Hospital Readmissions Reduction Program (HRRP), which accounts for dual eligibility in payment adjustments.

CBE #5275 Advisory Group Feedback
Technical Feedback (cont., 1)

Key Themes	Summary of Committee Comments	Summary of Developer Response
Measure Exclusions	• Questioned the exclusion of younger Medicare patients, dual-eligible individuals, and pneumonia-related sepsis cases.	• Like other CMS readmission measures, this measure excludes Medicare beneficiaries under 65 but not dually eligible patients. To avoid double penalties under HRRP, sepsis admissions captured by the pneumonia measure are excluded, as pneumonia is better assessed within its own measure.
Related Measures	• Questioned the need for a sepsis-specific readmission measure given existing sepsis measures and the Hybrid Hospital-Wide Readmission (HWR) measure (CBE #2879e), potential double-counting of sepsis patients, and concerns about diverting focus from identifying the primary diagnosis.	• This measure targets high-volume, high-cost sepsis readmissions, providing hospitals with data to guide improvements. It complements identifying and treating the primary infection. Sepsis admissions appear in both this measure and the HWR measure but serve different CMS programs. • HRRP uses only condition-specific measures, so CMS is considering this sepsis readmission measure for HRRP to address post-discharge care gaps.
	• Asked if better performance on the Severe Sepsis and Septic Shock measure (CBE #0500) correlates with this measure.	• The relationship between CBE #0500 and the sepsis readmission measure was considered. While the readmission measure targets post-discharge care coordination, CBE #0500 addresses in-hospital processes. They involve different care teams, and the link between CBE #0500 and readmission is complex.
Actionability and Impact	• Asked whether hospital-based interventions improve outcomes, noting that recent research suggests sepsis-specific efforts may not reduce readmissions and questioned if the measure supports actionable improvements.	• Structured discharge planning and early post-discharge follow-up can reduce sepsis readmissions, but mixed evidence and variation in study design, outcome definitions, adjustment variables, and inclusion criteria limit generalizability.
	• Asked if the developer saw a difference in how location (e.g., rural vs. urban) affects outcomes.	• Analyses did not assess location effects. While CMS does not adjust HRRP readmission measures for geography, payment adjustments are applied to Diagnosis-Related Group payments, which are geographically adjusted.

The Advisory Group highlighted these topics as key considerations for the Recommendation Group.

CBE #5275 Advisory Group Feedback
Technical Feedback (cont., 2)

Key Themes	Summary of Committee Comments	Summary of Developer Response
Unintended Consequences	• Expressed that hospitals might shift readmissions to emergency department (ED) or observation stays to avoid penalties, as seen in prior CMS programs.	• CMS monitors potential unintended consequences, including coding or care shifts, and may use balancing measures such as Excess Days in Acute Care. Although readmissions vary by diagnosis severity, hospital-level post-discharge mortality does not, suggesting no unintended consequences.

CBE #5275 Key Discussion Themes

Discussion Category	Key Themes	Source of Comment	Summary of Comments
Supportive	**Feasibility**	• Staff Assessment • Committee Independent Review	• Staff rated this measure as “Met.” • 100% of RG reviewers rated Feasibility as “Met.”
Mixed	**Reliability**	• Staff Assessment • Public Comment • Committee Independent Review	• While staff rated this measure as “Met,” the AMA recommended increasing minimum sample size to achieve higher reliability and disagreed with current guidance allowing only 70% of entities to meet the reliability threshold. • 100% of RG reviewers rated Reliability as “Met.”
	Use and Usability	• Staff Assessment • Committee Independent Review	• Staff rated this measure as “Met.” • The AMA and an AG member raised concerns that the measure could lead to unintended consequences, such as hospitals shifting readmissions to the ED or observation stays to avoid penalties. • 33% of RG reviewers agreed with staff, while others rated Use and Usability as “Not Met but Addressable” due to unclear value over existing measures, lack of CMS implementation, and limited real-world usability. Reviewers suggested an electronic clinical quality measure/Fast Health care Interoperability Resources (FHIR) version to improve timeliness.
	Importance and Related Measures	• Staff Assessment • Advisory Group • Committee Independent Review	• Staff rated the measure “Not Met but Addressable” due to lack of justification for combining with existing CMS readmission measures and unexplained incomplete patient survey responses. • AG members and the AMA questioned the need for a sepsis-specific measure, noting existing measures, limited impact on readmissions, and recommending review of the 30-day period. • 67% of RG reviewers agreed with the staff assessment, questioning redundancy with HWR, while 33% of reviewers rated Importance as “Met.”

CBE #5275 Key Discussion Themes *(cont., 1)*

Discussion Category	Key Themes	Source of Comment	Summary of Comments
Mixed	**Validity and Risk Adjustment**	• Staff Assessment • Public Comment • Advisory Group • Committee Independent Review	• Staff rated the measure “Not Met but Addressable” due to reliance on studies of uncertain relevance for data validity. • The AMA and AG members raised concerns about risk adjustment masking key associations, lack of socioeconomic factors, coding accuracy, sepsis definitions, and the 30-day window, suggesting alternative timeframes. • AG members further questioned the risk adjustment model given changing coding practices. • 33% of RG reviewers rating validity as “Met,” while 67% agreed with the staff assessment, citing face validity issues, lack of SEP-1 correlation, no early/late readmission analysis, insufficient calibration, and minimal consideration of social factors.

Maintenance Measure Reconsideration

Reconsideration Process for Maintenance Measures

During reconsideration...

- Battelle staff will lead a focused discussion aimed at resolving areas of disagreement.
- There will be a subsequent revote to determine whether the consensus threshold is met.
- Endorsement is removed if the measure does not reach the 75% consensus threshold at this stage.*

- Reconsideration is critical to ensuring that the committee's final decision reflects a comprehensive and balanced evaluation.
- This reconsideration approach **only applies to maintenance measures**.

**The consensus threshold will be adjusted to 70% in cases where there are fewer than 20 voting members.*

Next Steps

Next Steps for Fall 2025

Meeting Summary

- Meeting summary will be posted to the E&M committee project page by March 9, 2026.

Appeals Period

- **Appeals Period:** February 25-March 17
- The Appeals Committee will meet on March 31, 2026, if needed, to review eligible appeals. Please refer to the E&M Guidebook for more information about the appeals process.

Technical Report

- At the conclusion of the appeals period, a final technical report will be posted to the E&M committee project page in May 2026.

Partnership for Quality Measurement
Powered by Battelle

Thank You!

Have questions? Contact us at
PQMsupport@battelle.org

Partnership for Quality Measurement

Powered by Battelle