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National Consensus Development and Strategic Planning for Health Care Quality Measurement

Spring 2025 Cycle Endorsement Meeting Summary

MANAGEMENT OF ACUTE EVENTS AND CHRONIC CONDITIONS COMMITTEE

SEPTEMBER 2025

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Spring 2025 Management of Acute Events and Chronic Conditions Endorsement Meeting Summary

Overview

Battelle, the consensus-based entity (CBE) for the Centers for Medicare & Medicaid Services (CMS), convened the Recommendation Group of the Management of Acute Events and Chronic Conditions committee on August 4 and 5, 2025, for discussion and voting on measures under endorsement consideration for the Spring 2025 cycle. Meeting participants joined virtually through a Zoom meeting platform. Measure stewards/developers and members of the public also attended.

The objectives of the meeting were to:

- Review and discuss measures submitted to the committee for the Spring 2025 cycle;
- Review staff preliminary assessments, Advisory and Recommendation Group feedback, public comments, and developer responses regarding the measures under endorsement review; and
- Render endorsement decisions using a virtual voting platform.

The Recommendation Group voted to endorse four measures and to endorse five measures with conditions (Table 1). This summary provides an overview of the meeting, the Recommendation Group deliberations, and the endorsement decision outcomes. Full measure information, including all public comments, staff preliminary assessments, Advisory Group feedback, and committee independent reviews can be found on the project committee's webpage on the Partnership for Quality Measurement (PQM) website.

After the endorsement meeting, measures and endorsement decisions enter an appeals period for 3 weeks, from August 27-September 16, 2025. Any interested party may submit an appeal, which Battelle will review for eligibility according to the criteria within the Endorsement and Maintenance (E&M) Guidebook. If eligible, the Appeals Committee, consisting of all co-chairs from the five E&M project committees, will convene to evaluate the appeal and determine whether to maintain or overturn an endorsement decision.

Welcome, Roll Call, and Disclosures of Interest

Brenna Rabel, PQM deputy director, welcomed the attendees to the meeting and introduced her co-facilitators, Matt Pickering, E&M task lead, and Anna Michie, E&M deputy task lead. Ms. Rabel also introduced the committee co-chairs, Kurt Mahan, the non-patient co-chair, and Florence Thicklin, the patient co-chair. Dr. Mahan provided welcoming remarks. The role of the co-chairs during the meeting is to summarize feedback from the Advisory Group to ensure the Recommendation Group takes it into account during their deliberations. Additionally, the co-chairs confirm the proposed conditions placed on measures. They also actively engage with and support patient representatives on the committee. Battelle facilitators summarize the deliberations of the Recommendation Group before proceeding to an endorsement vote.

Isaac Sakyi, social scientist, then conducted roll call, and members disclosed any perceived conflicts of interest regarding the measures under review. Four members were recused from

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voting based on Battelle's conflict of interest policy. Lisa Suter was recused from voting on CBE #3493 because she is one of the developers. Similarly, David Clayman was recused from voting on CBE #3503e due to working for the developer. Ben Shirley was recused from voting on CBE #3558 because he is one of the stewards, and Eleni Theodoropoulus was recused from voting on the same measure because her organization licenses measures from the Pharmacy Quality Alliance (PQA) for incorporation into their accreditation program.

After roll call, Battelle staff established whether quorum was met and outlined the procedures for discussing and voting on measures. The discussion quorum requires the attendance of at least 60% of the active Recommendation Group members (n=12). Voting quorum requires at least 80% of active Recommendation Group members who have not recused themselves from the vote (n=16). Both discussion quorum and voting quorum were established and maintained throughout the meeting. During the meeting, some committee members stepped away temporarily, so Battelle collected voting counts for each measure to ensure that each vote met quorum.

Evaluation of Candidate Measures

Ms. Michie provided an overview of the nine measures under review. For Spring 2025, the Management of Acute Events and Chronic Conditions committee received no new measures and nine measures undergoing maintenance endorsement review (Figure 1). The measures focused on surgical outcomes, medication and management safety, cardiac care, and standardized infection ratios.

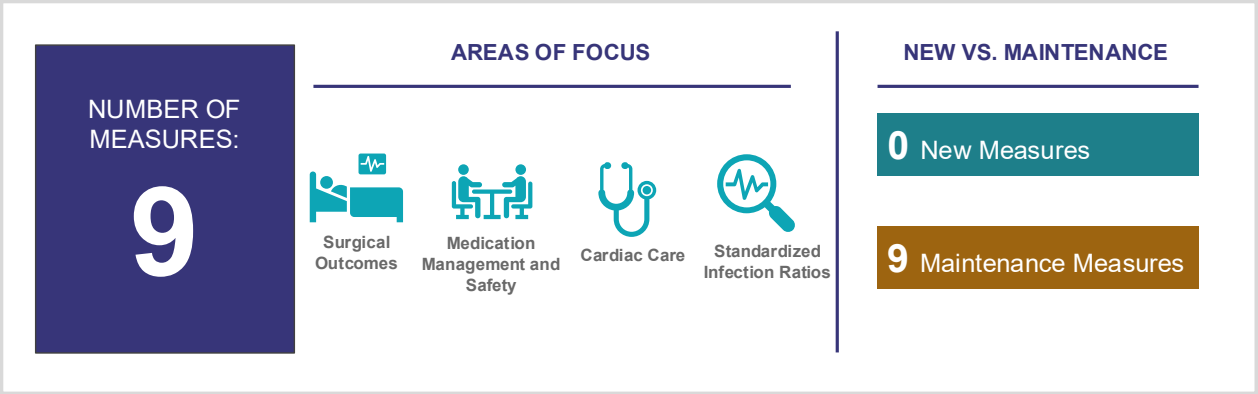

Figure 1. Management of Acute Events and Chronic Conditions Measures for Spring 2025

Battelle convened a public Advisory Group meeting on June 9, 2025, to gather initial feedback and questions about the measures under endorsement review. Developers had the opportunity to provide additional clarifications following the Advisory Group meetings. Battelle then shared the Advisory Group feedback and questions, along with the developer/steward responses, with the Recommendation Group a week prior to the endorsement meeting.

On July 28, 2025, Battelle provided Recommendation Group members the full measure submission details for each measure up for review, including all attachments, the PQM Measure Evaluation Rubric, the public comments received for the measures under review, and the staff preliminary assessments.

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Recommendation Group members conducted independent reviews for each measure against the PQM Measure Evaluation Rubric. Recommendation Group members assigned a rating of "Met," "Not Met but Addressable," or "Not Met" for each domain of the PQM Measure Evaluation Rubric. In addition, Recommendation Group members provided associated rationales for each domain rating, which were based on the rating criteria listed for each domain. Battelle staff aggregated and summarized the results and distributed them back to the Recommendation Group, and to the respective measure developers/stewards, for review within 1 week of the endorsement meeting.

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Table 1. Spring 2025 Management of Acute Events and Chronic Conditions Measure Endorsement Decisions[1]

CBE ID	Measure Title	New/ Maintenance	Endorsement Decision	Endorse | n (%)	Endorse with Conditions | n (%)	Not Endorse/ Remove Endorsement | n (%)	Recusals
0642	Cardiac Rehabilitation Patient Referral from an Inpatient Setting	Maintenance	Endorse	16 (100%)	N/A	0 (0%)	0
0964	Therapy with Aspirin, P2Y12 Inhibitor, and Statin at Discharge Following PCI in Eligible Patients	Maintenance	Endorse	17 (100%)	N/A	0 (0%)	0
3493	Risk-standardized Complication Rate (RSCR) following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) for Eligible Clinicians and Eligible Clinician Groups	Maintenance	Group/Clinician Level: Endorse Individual Level: Endorse	16 (94%) 15 (94%)	N/A N/A	1 (6%) 1 (6%)	1 1
3503e	Rate of Severe Hypoglycemia Among Hospitalized Patients	Maintenance	Endorse with Conditions	5 (31%)	10 (63%)	1 (6%)	1
0138	Catheter-Associated Urinary Tract Infection (CAUTI) Standardized Infection Ratio	Maintenance	Endorse with Conditions	3 (18%)	14 (82%)	0 (0%)	0
0139	Central Line-Associated Bloodstream Infection (CLABSI) Standardized Infection Ratio	Maintenance	Endorse with Conditions	6 (33%)	12 (67%)	0 (0%)	0
0753	30-Day Post-Operative Colon Surgery (COLO) and Abdominal Hysterectomy (HYST) Surgical Site Infection (SSI) Standardized Infection Ratio (SIR)	Maintenance	Endorse with Conditions	2 (13%)	14 (88%)	0 (0%)	0

[1] Note: Percentages may not add up to 100% due to rounding.

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CBE ID	Measure Title	New/ Maintenance	Endorsement Decision	Endorse | n (%)	Endorse with Conditions | n (%)	Not Endorse/ Remove Endorsement | n (%)	Recusals
3558	Initial Opioid Prescribing for Long Duration (IOP-LD)	Maintenance	Endorse with Conditions	4 (27%)	11 (73%)	0 (0%)	2
1879	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Maintenance	Group/Clinician Level: Endorse Individual Level: Endorse	16 (100%) 16 (100%)	N/A N/A	0 (0%) 0 (0%)	0 0

CBE #0642 – Cardiac Rehabilitation Patient Referral from an Inpatient Setting [American College of Cardiology]

Specifications | Comment Summary Guide

Description: Percentage of patients aged 18 years and older admitted to a hospital with a primary diagnosis of an acute myocardial infarction or chronic stable angina or who during hospitalization have undergone coronary artery bypass (CABG) surgery, a percutaneous coronary intervention (PCI), cardiac valve surgery (CVS), or cardiac transplantation who are referred to an early outpatient cardiac rehabilitation/secondary prevention program.

Committee Vote: Endorse

Vote Count: Endorse (16 votes; 100%), Remove Endorsement (0 votes; 0%); Recusals (0).†

Advisory Group Comments: The Advisory Group said the measure either needed to reflect the reality of patient experience or have a balancing measure that did so by capturing what occurred once a patient has a referral. They highlighted access issues, such as living in rural or urban areas, being in health care deserts, and long wait times, as well as the importance of patient-centered care. A few committee members added that, given the length of time the measure has been in use, they would have expected improvements to be stronger. Some committee members also suggested the measure include telehealth.

Public Comments: Battelle received one comment prior to the meeting. The commenter shared personal challenges in accessing cardiac rehab and emphasized that referrals alone are not enough. They also suggested that, given the growth of Medicare Advantage plans, quantitative access to rehabilitation facilities should be reported at the plan level.

Measure Discussion:

Discussion Topic/Theme	Recommendation Group Discussion
Patient Experience	• Several Recommendation Group members, including patient representatives, agreed with the Advisory Group's feedback and public comment that the measure needs a balancing measure that reflects patient experience and access after a referral. A committee member pointed out that attending the rehabilitation appointment is what will yield long-term stability and enhanced quality of life. • The developer said the measure is currently undergoing review and updates with a task force. • The developer emphasized that the current measure focuses on what is in the locus of control for physicians in the hospital setting; they pointed out that patients may not follow through with a referral for a variety of factors that are outside physicians' control. However, a Recommendation Group member responded by saying that while

† A committee member initially voted to endorse the measure with conditions; however, the committee did not attach any conditions to the measure. Upon clarification, the committee member revised their vote to endorse the measure.

Discussion Topic/Theme	Recommendation Group Discussion
	a physician cannot control the patient's decision, they can influence it. • The developer also stated that, in terms of a potential new measure, they face feasibility issues with data access and linkage across different insurance programs and hospital systems. One Recommendation Group member said they still believed the burden for collecting such data would be minimal. • The Recommendation Group strongly encouraged the developer to consider what a new measure that advances care and is meaningful to patients would look like.
Gap in Care	• A few Recommendation Group members commented that while the measure as specified may be more of a "checkbox" measure, a gap in care still exists. • The developer agreed that this is still an important measure and is not yet topped out.
Validity	• The Advisory Group expressed concerns about the strong reliance on face validity, to which the developer said no comparable measures existed for them to conduct analysis on. A few Recommendation Group members acknowledged that while no outcome measures could be analyzed, they asked if the developer could compare the measure to other process measures. • The developer stated that while they could correlate with other process measures, such as those that focus on discharge medications, they were not clear what this would accomplish. • The developer also highlighted technical and logistical barriers to more robust validity testing. For example, linking registry data to Medicare claims restricts the validity analysis to older patients, excluding about half of the measure's overall population. • Another Recommendation Group member agreed that such an analysis would not improve the validity data. They believed the developer's current approach, of providing data from many randomized controlled trials, is the most appropriate.

CBE #0964 – Therapy with Aspirin, P2Y12 Inhibitor, and Statin at Discharge Following PCI in Eligible Patients [American College of Cardiology]

Specifications | Comment Summary Guide

Description: This is a process measure of the annual proportion of eligible patients ≥ 18 years of age, who were prescribed aspirin, P2Y12 inhibitor, and statin at discharge following PCI with or without stenting.

Committee Vote: Endorse

Vote Count: Endorse (17 votes; 100%), Remove Endorsement (0 votes; 0%); Recusals (0).

Advisory Group Comments: The Advisory Group expressed concern that the measure does not address the real gaps affecting patient outcomes, such as the ability to travel to a pharmacy, insurance coverage, and pharmacy resources. A committee member acknowledged that tracking actual medication distribution is challenging and potentially costly but noted that methodologies exist to do so. Another committee member asked why the developer chose to use split-half methodology and Cronbach's alpha for agreement between the samples, believing there are better methods for the developer's intended purposes.

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

Measure Discussion:

Discussion Topic/Theme	Recommendation Group Discussion
Importance	• Patient representatives felt this measure is important as is and emphasized the clinical importance of tracking medications in preventing stent thrombosis. They believed another measure that looks at what is done with the prescription may be beneficial.
Reliability	• A Recommendation Group member said that while reporting the interclass correlation coefficient (ICC, which looks at agreement and correlation) is typical with split-sample testing, reporting the correlation coefficient is acceptable. They commented that the correlation coefficient of 0.82 the developer reported for this measure is quite good and the testing is appropriate. However, they would like to see the distribution of entity scores. • The developer noted that based on the Advisory Group feedback they should look beyond split-sample testing, they performed permutation with bootstrapping and looked at signal-to-noise ratios, and the results appeared favorable. • The Battelle facilitator asked if the developer had additional information on the percentage of entities at the accepted value of 0.6. • The developer said they achieved an ICC split by first and second half of 0.8259. The confidence interval is narrow, 0.81 to 0.84, which suggests reliability is strong and consistent across the dataset.
Performance Gap	• A Recommendation Group member asked the steward for their viewpoint on the value of a measure that has steady rates, with little improvement, because it is close to being topped out. • The developer said that while overall adherence rates are high (~94%) and opportunity for improvement is limited, the measure captures important aspects of care and can identify if a hospital's performance changes. In addition, the cost of the measure is minimal because the hospitals are already collecting the data. • A few other Recommendation Group members agreed that while the measure is close to being topped out, using the measure is still valuable because these drugs are critical, the gap for socially

Discussion Topic/Theme	Recommendation Group Discussion
	vulnerable individuals is wider, and without the measure hospitals and clinicians may not focus on this issue as much.
Patient Population	• A Recommendation Group member expressed concern about the measure including patients who receive stents versus those who undergo balloon angioplasty only since medication needs differ. • The developer said that for a balloon angioplasty, they drop the requirement for the P2Y12. However, they acknowledged that the measure could be adjusted further. • A patient representative also said they firmly believe this measure applying to individuals 18 and older is important.

CBE #3493 – Risk-standardized Complication Rate (RSCR) following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) for Eligible Clinicians and Eligible Clinician Groups [Yale Center for Outcomes Research (CORE)/CMS]

Specifications | Comment Summary Guide

Description: The primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) complication measure assesses risk-standardized complication rates (RSCRs) for individual clinicians or groups of clinicians to improve the quality of care delivered to their patients.

This re-specified measure includes THA/TKA procedures performed in both inpatient and outpatient (hospital outpatient department and Ambulatory Surgery Centers [ASC]) settings among eligible Medicare Fee-For-Service (FFS) beneficiaries who are at least 65 years of age.

The measure captures specific coded complications that occur at the index admission/encounter or during a readmission, observation stay, emergency department (ED) visit, or ASC encounter.

Committee Vote for Group/Clinical Level: Endorse

Committee Vote for Individual Level: Endorse

Vote Count for Group/Clinician Level: Endorse (16 votes; 94%), Remove Endorsement (1 vote; 6%); Recusal (1).

Vote Count for Individual Level: Endorse (15 votes; 94%), Remove Endorsement (1 vote; 6%); Recusals (1).

Advisory Group Comments: A few patient representatives said they considered this measure to be important and encouraged the inclusion of Medicare Advantage patients and patient-reported outcomes.

Public Comments: Battelle received one public comment for this measure from the American Medical Association (AMA). The AMA expressed concern that the measure testing occurred during the COVID-19 pandemic and questioned whether the data reflect typical care. In addition, the AMA recommended requiring a minimum of 20 admissions to ensure sound reliability.

Measure Discussion:

Discussion Topic/Theme	Recommendation Group Discussion
Medicare Advantage	• Several Recommendation Group members, including patient representatives, echoed the Advisory Group feedback that the measure should include Medicare Advantage patients and, if able to do so, expand the age range to include younger patients. They cited that more individuals are on Medicare Advantage plans and that FFS only covers about 50% of older individuals. In addition, they encouraged PQM and other measure developers to take this into consideration. • The developer said they have begun expanding some of their measures to include Medicare Advantage patients. They will discuss this recommendation with CMS.
Validity	• A Recommendation Group member expressed concern that the construct validity scores are around 0.2, which indicates less-than-moderate validity. • The developer assessed construct validity using the known-groups approach, examining the volume-outcome relationship, which is based on the theory and supporting evidence that higher-volume providers tend to achieve better outcomes due to greater experience and the use of standardized care processes. The developer said the overall correlations are on the lower side because the volume-outcome relationship only becomes evident among the highest-volume providers. They pointed out that in their data, a volume over 200 is where they begin to see an outcome relationship. • A Recommendation Group member expressed concern about the face validity, because the question focused on hospital quality, but the measure's level of analysis is for clinicians and clinician groups. • The developer said when the original measure was endorsed, the face validity focused on the clinician level. They included the hospital-level face validity at maintenance because of the addition of the outpatient setting. Data element validity was also supported through a code-level review of complications.
Minimum Case Volume	• In response to the AMA's comment about case volume, a Recommendation Group member emphasized the importance of clearly specifying the minimum case volume in the public measure specifications, noting its relevance to understanding the measure's reliability. They asked PQM if they collect minimum case volume as part of the measure submission process. The Battelle facilitator confirmed that they do, although it may not always be captured in the specifications the public sees.

Committee members who chose to remove endorsement cited the following key concerns:

- Poor validity results.

CBE #3503e – Rate of Severe Hypoglycemia Among Hospitalized Patients [Mathematica/CMS]

Specifications | Comment Summary Guide

Description: This electronic clinical quality measure (eCQM) assesses the proportion of inpatient hospitalizations for patients aged 18 years and older who were administered at least one medication known to cause hypoglycemia (hypoglycemic medication) during their hospitalization, and who suffered a severe hypoglycemic event (blood glucose less than 40 mg/dL) during the hospitalization.

Committee Vote: Endorse with Conditions

Conditions: By measure maintenance (5 years), the developer will have considered the potential for risk adjustment through empirical analysis.

Vote Count: Endorse (5 votes; 31%), Endorse with Conditions (10; 63%) Remove Endorsement (1 vote; 6%); Recusal (1).

Advisory Group Comments: A committee member expressed concern about the measure focusing on the initial 24 hours of hospitalization. The group also asked about which patients are included or excluded and how the measure accounts for different patient conditions. Committee members asked if a non-electronic version exists, about demonstrated improvement over time, and about the feasibility of the measure as an eCQM.

Public Comments: Battelle received one public comment for this measure. The commenter argued that requiring a re-draw of glucose after 5 minutes is not feasible due to lab processing times.

Measure Discussion:

Discussion Topic/Theme	Recommendation Group Discussion
Importance	• Several patient representatives said they believed this was an important measure, with one sharing a personal story of how they nearly died while hypoglycemic.
Evidence	• While the staff assessment rated Importance as “Not Met but Addressable” due to incomplete and low-quality evidence, a few Recommendation Group members explained the measure is supported by strong logic and clinical consensus. Hospitals can take clear actions, such as having protocols and monitoring high-risk patients, to prevent hypoglycemia.
Risk Adjustment	• The Recommendation Group discussed whether the measure should be risk adjusted. A few Recommendation Group members stated that the measure should consider hospital case mix, because hospitals that serve patients who are sicker or have more complicated illnesses that make them more prone to hypoglycemia may be at a disadvantage when compared to hospitals that serve healthier patients. They pointed out that a “never event” is

Discussion Topic/Theme	Recommendation Group Discussion
	subjective. The member recommended exploring whether adjusted vs. unadjusted rates differ significantly. • The developer said they discussed risk adjustment in depth with their expert workgroup. The workgroup believed that the measure should not be risk adjusted because if an individual is sicker and more prone to hypoglycemia, they should be monitored more closely. The American Diabetes Association (ADA) and Endocrine Society supported this decision. • A few Recommendation Group members agreed that the measure should not be risk adjusted and considered the measure reasonable, particularly because the threshold (40 mg/dL) and lack of risk adjustment are supported by the ADA and Endocrine Society. One patient representative added that risk-adjusting for conditions such as sepsis would have excluded her case, which could be life-threatening and unjust. • Based on this discussion, the Recommendation Group imposed a condition upon the measure for the developer to explore the potential for risk adjustment through empirical analyses.

Committee members who chose to remove endorsement cited the following key concerns:

- The proposed conditions do not resolve concerns and five years is too long for the measure to remain safe and effective.

CBE #0138 – Catheter-Associated Urinary Tract Infection (CAUTI) Standardized Infection Ratio [Centers for Disease Control and Prevention (CDC)/National Healthcare Safety Network]

Specifications | Comment Summary Guide

Description: Annual risk-adjusted standardized infection ratio (SIR) of catheter-associated urinary tract infections (CAUTI) among adults and children hospitalized as inpatients at acute care hospitals, oncology hospitals, long-term acute care hospitals, and acute care rehabilitation hospitals. SIR is reported annually and is calculated by dividing the number of observed CAUTIs into the number of predicted CAUTIs.

Committee Vote: Endorse with Conditions

Conditions: When the measure returns for maintenance (3 years), the measure developer should have explored the possibility of using other all-payer data sources to expand the use of patient-level factors in the risk adjustment model and reduce reliance on facility-level factors.

Vote Count: Endorse (3 votes; 18%), Endorse with Conditions (14; 82%) Remove Endorsement (0 votes; 0%); Recusals (0).

Advisory Group Comments: The Advisory Group highlighted the measure's importance for patient safety and outcomes, particularly for vulnerable populations. They raised concerns around the potential for facility-level variables to obscure quality of care. They asked clarifying

questions about what type of catheters are included in the measure and asked the developer to speak on how the measure impacts spinal cord injury patients.

Public Comments: Battelle received three public comments regarding this measure. Encompass Health and the American Medical Rehabilitation Providers Association (AMRPA) said the measure is not meaningful or actionable for many rehabilitation facilities, is not properly validated outside of acute care, and misrepresents facility performance in public reporting. AMPRA, the American Spinal Injury Association, the Academy of Spinal Cord Injury Professionals, and the United Spinal Association asked for the measure to adjust for or exclude the spinal cord injury population due to increased harm and adverse events from premature or aggressive catheter removal in this group.

Measure Discussion:

Discussion Topic/Theme	Recommendation Group Discussion
Importance	• Patient representatives said they agreed with the Advisory Group that this measure is important, citing that CAUTIs are often a top safety concern. • A few Recommendation Group members highlighted that although they believe the measure is imperfect due to the risk adjustment concerns, they also felt the measure was too important to remove its endorsement.
Risk Adjustment	• A few Recommendation Group members agreed with the Advisory Group that a performance measure should not use facility-level factors (e.g., hospital bed size), as such variables can mask poor care by "crediting" facilities for factors that actually reflect poor quality rather than patient risk, thus misleading the public and regulators as to the reality of an entity's true performance. • A few Recommendation Group members also highlighted that the measure should look at patient-level factors such as age, sex, and comorbidities. • The developer said that while they understand the issue with facility-level factors, they are restricted by what data they have access to; for CAUTI, they do not have access to patient-level data (and never have). Rather, they can use facility size as a surrogate for severity of illness and are able to discriminate and identify differences in performance as measured by standardized infection ratio. • Despite the developer's response, some Recommendation Group members expressed concern that the measure still accidentally adjusts away important findings and that this could be a "fatal flaw" in the measure. • One Recommendation Group member recommended the developer test two versions of the measure—one using current methods and one incorporating patient-level Medicare Provider Analysis and Review (MedPAR) data for older adults—to assess agreement in hospital performance classification. If there is considerable disagreement, the committee member said the developer should

Discussion Topic/Theme	Recommendation Group Discussion
	then more seriously consider how to access all-payer data to incorporate patient-level factors. • The developer said they have to balance several aspects when potentially accessing new data. As a federal agency, they must go through an Office of Management and Budget (OMB) process that reviews the potential burden and cost of the data collection. In addition, they are bound by budget constraints. When integrating a new data source, they must also ensure the data have a sufficient level of completeness and are immediately available. (In that regard, the developer said they were not familiar with the details of MedPAR.) They highlighted that they are interested in improving their risk-adjustment methodologies and incorporating patient-level characteristics but that they want to do so in a way that is systematic while taking into consideration burden, cost, and resources. • A Recommendation Group member commended the developer for their thoughtful responses on this measure, as well as on CBE #0139 and #0753, saying they communicated the limitations and challenges around data sources well while still showing a motivation to improve on these measures. • Based on the discussion, the Recommendation Group included a condition that when the measure returns for maintenance (on a shortened timeline of 3 years), the measure developer should have explored the possibility of using other all-payer data sources to expand the use of patient-level factors in the risk adjustment model and reduce reliance on facility-level factors.
Reliability	• A Recommendation Group member asked the developer to speak to the measure's reliability, as it falls below 0.6, when the measure is widely used and impacts payment. The member raised concerns about low reliability for hospitals with small case volume. • The developer said they have used signal-to-noise methodology to assess reliability, which is sensitive to exposure volume (i.e., number of catheter days). They work to balance the statistical methods with the practical challenges (i.e., measuring over a longer period would gather more exposure incidents but reduce the actionability of the results). While they would like to explore other methodologies, they are working within the constraints and resources available to them. However, they are also working to address reliability through other measures as well, such as a new adjusted ranking metric, which would account for both risk and reliability.
Spinal Cord Injury Patients	• A Recommendation Group member echoed the concern from the public comments that this measure may drive catheter removal in patients with spinal cord injury even when the removal is contraindicated. • As of January 2025, the developer has introduced a new measure field to identify CAUTI events in patients with spinal cord injury-

Discussion Topic/Theme	Recommendation Group Discussion
	associated neurogenic bladder to enhance their understanding of CAUTI occurrences in this vulnerable population. Currently, the field is optional but will become mandatory. This will not exclude this patient population, but once the developer has sufficient data, they will present their findings and recommendations. The developer emphasized that patients with neurogenic bladder require careful monitoring for CAUTI due to their increased risk, which is associated with prolonged indwelling catheterization, to ensure high-quality, safe care.

CBE #0139 – Central Line-Associated Bloodstream Infection (CLABSI) Standardized Infection Ratio [CDC/National Healthcare Safety Network]

Specifications | Comment Summary Guide

Description: Annual risk-adjusted standardized infection ratio (SIR) of central line-associated bloodstream infections (CLABSI) among adults and children hospitalized as inpatients at acute care hospitals, critical access hospitals, oncology hospitals, and long-term acute care hospitals. SIR is reported annually and is calculated by dividing the number of observed CLABSIs by the number of predicted CLABSIs.

Committee Vote: Endorse with Conditions

Conditions: When the measure returns for maintenance (3 years), the measure developer should have explored the possibility of using other all-payer data sources to expand the use of patient-level factors in the risk-adjustment model and reduce reliance on facility-level factors.

Vote Count: Endorse (6 votes; 33%), Endorse with Conditions (12; 67%) Remove Endorsement (0 votes; 0%); Recusals (0).

Advisory Group Comments: The Advisory Group highlighted the measure's importance for patient safety and outcomes, particularly for vulnerable populations, although they questioned if the measure is too broad. They raised concerns around the potential for facility-level variables to obscure quality of care and about the reliability for smaller hospitals.

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

Measure Discussion:

Discussion Topic/Theme	Recommendation Group Discussion
Importance	• A patient representative shared their personal experience having 7 central lines and said they agreed with the Advisory Group on the measure's importance.

Discussion Topic/Theme	Recommendation Group Discussion
Risk Adjustment	• A few Recommendation Group members expressed the same concerns as CBE #0138 that facility-level variables should be removed from the measure and patient-level variables should be used. • The developer explained that the same patient-level data limitations explained for CBE #0138 apply to this measure. • Based on the discussion, the Recommendation Group included a condition that when the measure returns for maintenance (on a shortened timeline of 3 years), the measure developer should have explored the possibility of using other all-payer data sources to expand the use of patient-level factors in the risk-adjustment model and reduce reliance on facility-level factors.
Benchmark	• A Recommendation Group member asked for more information about how SIRs are interpreted over time. They pointed out that because the SIR is calculated based on the national benchmark derived from historical data, observed improvements might reflect changes to the benchmark rather than actual reductions in raw infection rates. They suggested also examining unadjusted event counts to assess whether meaningful progress has occurred. • The developer explained that benchmarks are not updated annually to maintain comparability over time. The benchmarks are revised periodically to raise performance expectations in line with national progress and were recently updated from 2015 national data to 2022 data.
Reliability	• A few Recommendation Group members echoed the Advisory Group's concern that measures need to be accurate for hospitals that serve smaller populations, particularly rural hospitals. These hospitals often have less-reliable scores due to small sample sizes and limited resources to meet benchmarks that are calibrated to high-performing, larger institutions. • The developer explained the same reliability mitigations and trade-offs explained for CBE #0138 apply to this measure.

CBE #0753 – 30-Day Post-Operative Colon Surgery (COLO) and Abdominal Hysterectomy (HYST) Surgical Site Infection (SSI) Standardized Infection Ratio (SIR) [CDC]

Specifications | Comment Summary Guide

Description: Annual risk-adjusted standardized infection ratio (SIR) of observed over predicted deep incisional primary and organ/space surgical site infections (SSIs), over a 30-day post-operative surveillance period, among hospitalized adults who are >=18 year of age with a date of admission and date of discharge that are different calendar days, and the patient underwent a colon surgery (COLO) or abdominal hysterectomy (HYST) at an acute care hospital or oncology hospital. The 30-day postoperative surveillance period includes SSIs detected upon admission

to the facility or a readmission to the same facility or a different facility (other than where the procedure was performed) and via post-discharge surveillance.

Committee Vote: Endorse with Conditions

Conditions: When the measure returns for maintenance (3 years), the measure developer should have:

- Explored the possibility of using other all-payer data sources to expand the use of patient-level factors in the risk-adjustment model and reduce reliance on facility-level factors.
- Explored the exclusion of the patient-level factors such as procedure duration and American Society of Anesthesiologists (ASA) score, while also considering the inclusion of procedure complexity and patient comorbidities.
- Explored stratification of trauma cases rather than include as a risk-adjustment variable.

Vote Count: Endorse (2 votes; 13%), Endorse with Conditions (14; 88%) Remove Endorsement (0 votes; 0%); Recusals (0).

Advisory Group Comments: A patient representative said the measure was important. The Advisory Group asked about the high rates of HYST surgeries and how the measure considers patients with pre-existing immunocompromised statuses. They expressed concern over the inclusion of trauma cases as well as the methods, reliability, and validity. They debated whether the risk adjustment should include facility-level variables.

Public Comments: Battelle received two comments regarding this measure. AMA expressed concerns that the measure's reliability is insufficient and suggested applying a case minimum. The Memorial Hermann Texas Medical Center/McGovern Medical School University of Texas Health Houston argued that including high-risk trauma-related colon surgeries in SSI metrics disproportionately inflates infection rates for trauma centers. They recommend excluding these cases or creating a separate category for fair and effective surveillance. The AMA also believed that trauma cases should be excluded because these cases have different factors to consider compared to elective cases.

Measure Discussion:

Discussion Topic/Theme	Recommendation Group Discussion
Rates of Hysterectomy Surgery	• The Recommendation Group asked the developer to respond to the Advisory Group's inquiry about whether the incidence of HYST surgeries is higher than appropriate. • The developer said that the incidence of HYST surgeries is outside of their scope as a developer. They agreed that if the surgery is performed in a space when they should not be, that is a concern; however, they do not collect information as to why the procedure is performed.
Importance	• A patient representative with lived experience said they believed this is an important measure to lower infection rates and ensure patient safety.

Discussion Topic/Theme	Recommendation Group Discussion
Risk Adjustment	• A few Recommendation Group members echoed feedback from some of the Advisory Group and earlier discussions from CBE #0138 and #0139 that facility-level variables need to be removed from the risk adjustment. • A Recommendation Group member praised the measure for including patient-level characteristics in the risk adjustment but believed the developer needed to consider them more closely. In particular, they highlighted procedure length and the ASA physical status score. • The developer noted that such changes are reliant on access to appropriate data. (The developer discussed potential challenges to access as part of CBE #0138.) *Procedure Duration* • For procedure duration, the Recommendation Group member noted that while the risk of infection increases with the length of the procedure, risk adjusting this factor may mask the skill or performance of the surgeon, as a surgeon may be slower due to being less technically proficient. • The developer said they extensively discussed the inclusion of procedure duration, including with an American College of Surgeons representative. Because it was such a significant factor, the developer included it in the measure and noted that it has been useful in discriminating case complexity. • The Recommendation Group member replied that simply because a variable has a strong association with the outcome of interest does not mean it should be included in the model. They suggested replacing procedure duration with procedure complexity, using CPT or ICD-10 codes, which better reflect case difficulty and are less provider dependent. *ASA Score and Gaming* • For the ASA score, the Recommendation Group member pointed out that the score may be gameable; because a surgeon knows how important the score is, they may pressure the anesthesiologist to assign a higher score to make patients appear sicker than they are. • In terms of gaming, the developer said that individuals could fabricate data for many factors if they desired, so the developer relies on people to submit truthful, valid data. • The Recommendation Group member responded that certain types of data are less likely to be gameable, such as patient comorbidities. They recommended using data that are not coded by the entity or person being measured.

Discussion Topic/Theme	Recommendation Group Discussion
	• The developer noted they can explore enhancements to risk adjustment but currently do not collect the data necessary to assess procedure complexity and comorbidities. • Based on the discussion, the Recommendation Group imposed the following conditions on the measure: when the measure returns for maintenance (3 years), the measure developer should have: explored the possibility of using other all-payer data sources to expand the use of patient-level factors in the risk adjustment model and reduce reliance on facility-level factors; and explored the exclusion of the patient-level factors such as procedure duration and ASA score, while also considering the inclusion of procedure complexity and patient comorbidities.
Trauma Cases	• Echoing the public comment and Advisory Group discussion, a few Recommendation Group members also expressed concern over the inclusion of trauma cases, believing that trauma should be stratified and considered separately and that the current risk-adjustment approach is too difficult. One member noted that trauma cases differ fundamentally from elective procedures, making comparison problematic. • The developer stated that trauma cases make up a small proportion of cases (approximately 3%) and are likely concentrated in specific hospitals (e.g., trauma centers), making risk adjustment difficult. They believe these cases should be included because infection-prevention strategies are still important for them. They noted that trauma is risk adjusted for COLO surgeries so that trauma hospitals will not be unfairly penalized. • Based on this discussion, the Recommendation Group imposed the following condition on the measure: when the measure returns for maintenance (3 years), the measure developer should have: explored stratification of trauma cases rather than include as a risk adjustment variable.
Reliability	• A Recommendation Group member referred to the AMA's public comment about the low reliability of the measure. They agreed that if the measure is not considered reliable until the fourth decile, that is when the measure should be used, and a case minimum should reflect that. • The Battelle facilitator clarified that 70% of entities are above the CBE reliability threshold of 0.6 and the Reliability domain was "Met" according to the staff assessment.

CBE #3558 – Initial Opioid Prescribing for Long Duration (IOP-LD) [Pharmacy Quality Alliance (PQA, Inc.)]

Specifications | Comment Summary Guide

Description: The percentage of individuals ≥18 years of age with ≥1 initial opioid prescriptions for >7 cumulative days' supply during the measurement year.

Committee Vote: Endorse with Conditions

Conditions: When the measure returns for maintenance (5 years), the measure developer should have explored how to address nuances based on the complexity of certain medical procedures (e.g., through stratification or exclusions).

Vote Count: Endorse (4 votes; 27%), Endorse with Conditions (11; 73%) Remove Endorsement (0 votes; 0%); Recusals (2).

Advisory Group Comments: The Advisory Group discussed balancing opioid access against historical issues of overuse. They highlighted that this measure is important for closing care gaps. They expressed concern over who the measure might miss, including those who receive opioids from dentists, individuals who pay for their medications out-of-pocket, and teenagers. One Advisory Group member suggested removing the continuous Medicare D enrollment requirement, as individuals with unstable jobs or income are less likely to be continuously enrolled and more likely to be at risk for opioid use.

Public Comments: Battelle received three public comments regarding this measure. UnitedHealthcare and the AMA raised concerns that this measure could restrict access to necessary pain medications, lacks adequate clinical exclusions, and may not align with current evidence or guidelines. The AMA highlighted the risk of patient harm, specifically for vulnerable populations. Prime Therapeutics voiced support for continued endorsement of the measure, stating that it is feasible, actionable, evidence based, and can improve patient safety.

Measure Discussion:

Discussion Topic/Theme	Recommendation Group Discussion
Importance	• A patient representative commended the developer for the measure, saying they believed it is well balanced and will protect patients.
Use and Usability	• A Recommendation Group member asked for clarification on whether health plans that use the measure must pay a fee. • The developer clarified that any Part D plan would receive the specifications for free from CMS. A fee is associated with commercial use or services but not for the government or any measured entities.
Medical Complexity	• A few Recommendation Group members suggested the developer consider tiering procedures for medical complexity rather than having a blanket 7-day rule for every patient. For example, minor (e.g., dental work, scopes), moderate (e.g., colectomy, rotator cuff repair), and major/complex (e.g., joint replacement, thoracotomy, lumbar fusion). Patients receiving major surgeries or burn victims may need more than 7 days of opioids and may not have timely follow-up access, especially vulnerable populations. • The developer said they follow evidence and guidelines (e.g., Johns Hopkins consensus on postoperative prescribing and the Michigan

Discussion Topic/Theme	Recommendation Group Discussion
	Overdose Prevention Engagement Network [OPEN]) to make determinations and believed it would be reasonable to revisit those and consider tiers or exclusions. They noted that they understand that the measure may need to be sometimes overridden to reflect the nature of patient care when some patients will clearly need a longer-than-7-day supply. • Based on the discussion, the Recommendation Group imposed a condition on the measure that: when the measure returns for maintenance (5 years), the measure developer should have explored how to address nuances based on the complexity of certain medical procedures (e.g., through stratification or exclusions).
Public Comment	• A co-chair and a patient representative said they did not agree with the AMA's and UnitedHealthcare's concerns regarding the measure potentially restricting opioid access.
Day 1 Definition	• A Recommendation Group member asked for clarification on whether the day a patient is discharged from the hospital is considered day 1 regardless of what medications they received while in hospital. • The developer confirmed that is correct. They acknowledged that is a limitation of the data but noted that most studies are designed in a similar fashion.

CBE #1879 – Adherence to Antipsychotic Medications for Individuals with Schizophrenia [American Institutes for Research (AIR)/CMS]

Specifications | Comment Summary Guide

Description: Percentage of individuals at least 18 years of age as of the beginning of the performance period with schizophrenia or schizoaffective disorder who had at least two prescriptions filled for any antipsychotic medication and who had a Proportion of Days Covered (PDC) of at least 0.8 for antipsychotic medications during the performance period.

Committee Vote for Group/Clinician Level: Endorse

Committee Vote for Individual Level: Endorse

Vote Count for Group/Clinician Level: Endorse (16 votes; 100%), Remove Endorsement (0 votes; 0%); Recusals (0).

Vote Count for Individual Level: Endorse (16 votes; 100%), Remove Endorsement (0 votes; 0%); Recusals (0).

Advisory Group Comments: A few committee members, including a patient representative, emphasized the importance of the measure, especially because it includes interventions to improve medication adherence. Another committee member noted that adherence is crucial for reducing mortality and hospitalizations; they emphasized that the measure should not lose endorsement as a result of the measure being difficult to implement because this patient

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population can be challenging to care for. The Advisory Group asked for more information on improvement, noted that the measure may be burdensome and costly, and asked how the measure captures depot medications (long-acting injectables) and how information returns to the clinician.

Public Comments: Battelle received one public comment regarding this measure. The AMA recommends requiring a case minimum of 20 individuals to ensure the measure's minimum reliability is close to 0.7, which the AMA believes should be the standard for endorsed measures.

Measure Discussion:

Discussion Topic/Theme	Recommendation Group Discussion
Importance	• A few Recommendation Group members, including patient representatives, said they thought the measure is important, well thought out, and has high public health significance.
Patient Input	• One Recommendation Group member said they believed the measure's technical expert panel (TEP) needed more patient representatives, particularly around the topic of consent or coercion related to medication adherence and individuals with schizophrenia. • The same committee member also asked the patient representatives on the Recommendation Group if they considered the topics of consent and coercion during their independent reviews; the Recommendation Group patient representatives said they had not. • The developer agreed they could have stronger patient representation on their TEP. To mitigate consent concerns, they highlighted that the measure focuses on adults receiving care primarily in ambulatory, home-based settings—excluding environments like hospitals, correctional facilities, or long-term care where coercion might be more prevalent.
Setting of Care	• A Recommendation Group member expressed concern that the measure may not be effective in all locations of care because patients with schizophrenia are more likely to miss psychiatric and behavioral health appointments and after several absences will be discharged from specialty care. • The developer said they are also concerned about how these patients are often shifted from the most appropriate setting of care; however, performance rates were similar across psychiatrists and primary care clinicians, suggesting no significant difference in adherence by provider type. • One of the co-chairs noted that keeping the measure at a broader spectrum of care is important because of the example scenario above.

Discussion Topic/Theme	Recommendation Group Discussion
Risk Adjustment	• A Recommendation Group member said they believed the risk adjustment for this measure is reasonable because while some patient factors may present barriers, providers still have factors they can control. • The developer confirmed that the primary factors they have found are related to system of care and choices made by physicians. They highlighted that while certain patients may have more difficulty with adherence, systems can be put into place to optimize adherence (e.g., staff calling the patient, providing reminders).

Next Steps

Battelle staff shared that they would publish a meeting summary by September 4, 2025. The appeals period will run from August 27-September 16, 2025. If an eligible appeal is received, the Appeals Committee will meet on September 30, 2025, to evaluate the appeal and determine whether to maintain or overturn an endorsement decision.

Appendix A: Acronyms

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

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

Acronym	Definition
CPG	Clinical Practice Guidelines
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

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Acronym	Definition
HOPD	Hospital Outpatient Department
HOPE	Hospice Outcomes and Patient Evaluation
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

Acronym	Definition
MAT	Measure Authoring Tool
MCCS	Medicaid: Child Core Set
MCO	Managed Care Organization
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

Acronym	Definition
PL	Project Leader
PM	Project Manager
PMP	Project Management Plan
POC	Point of Contact
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

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Acronym	Definition
SUD	Substance Use Disorder
TBD	To Be Determined
TEP	Technical Expert Panel
TL	Task Lead
UMLS	Unified Medical Language System
USCDI	United States Core Data for Interoperability
VSAC	Value Set Authority Center
Yale CORE	Yale Center for Outcomes Research and Evaluation

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