Partnership for Quality Measurement
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2025 Measure Set Review (MSR) Recommendation Group Measure Review Meeting

Dr. Michelle Schreiber | Centers for Medicare & Medicaid Services (CMS)

Melissa Gross | CMS

Brenna Rabel | Battelle

Dr. Meridith Eastman | Battelle

Dr. Lydia Stewart-Artz | Battelle

Kate Buchanan | Battelle

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October 6-7, 2025

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.

Housekeeping Reminders

We are so pleased to have you join us and want to create a meaningful exchange.

To participate in the discourse, type in the chat or raise your hand. Battelle staff will serve as virtual moderators.

If you are experiencing technical issues, please contact the project team via chat on the virtual platform or at PQMsupport@battelle.org.

Community Guidance

- 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.

Acronyms

- AG: Advisory Group
- CBE: Consensus-Based Entity
- CMIT: CMS Measures Inventory Tool
- CMS: Centers for Medicare & Medicaid Services
- CoMM: Cascade of Meaningful Measures
- E&M: Endorsement and Maintenance
- EHR: Electronic Health Record
- MERIT: MUC Entry/Review Information Tool
- MIPS: Merit-based Incentive Payment System
- MSR: Measure Set Review
- MUC: Measures Under Consideration
- MUD: Measures Under Development
- NHDNG: Novel Hybrid Delphi and Nominal Groups
- PA: Preliminary Assessment
- PAC/LTC: Post-Acute Care/Long-Term Care
- PIE: Pre-Meeting Initial Evaluation
- PRMR: Pre-Rulemaking Measure Review
- PQM: Partnership for Quality Measurement
- RG: Recommendation Group
- STAR: Submission Tool and Repository

Welcome and Introductions

Brenna Rabel | Battelle

Introductions

Battelle Staff

- Brenna Rabel, MPH – Technical Director
- Meridith Eastman, PhD, MSPH – Pre-Rulemaking Measure Review (PRMR)/MSR Task Lead
- Jeff Geppert, JD, EdM – Scientific Methods Lead
- Kate Buchanan, MPH – Deputy Task Lead
- Lydia Stewart-Artz, PhD, MHS – Measure Evaluation Lead
- Isaac Sakyi, MSGH – Lead Analyst

Centers for Medicare & Medicaid Services (CMS) Staff

- Michelle Schreiber, MD, Deputy Director of Quality, Center for Clinical Standards and Quality (CCSQ)
- Helen Dollar-Maples, RN, Director, Division of Program and Measurement Support (DPMS), CCSQ
- Nidhi Singh Shah, MPH, Deputy Director, DPMS, CCSQ
- Melissa Gross, BSN, CMS MSR Lead
- Charlayne Van, JD, CMS Contracting Officer's Representative
- CMS Medical Officers
- CMS Leads

Meeting Agenda Day 1

10:00 AM	Welcome and Process Overview
11:10 AM	Measure Review
12:30 PM	Lunch
1:30 PM	Measure Review
4:30 PM	Adjourn

* All times listed in ET

Roll Call and Disclosures of Interest

Kate Buchanan | Battelle

Disclosures of Interest (DOIs)

- Prior to the meeting, committee members were asked to complete a “measure-specific DOI” form for each measure, or batch of measures, assigned to the committee.
- During the Recommendation Group (RG) meeting, committee members verbally disclose relevant interests.
- If there is a perceived or actual conflict of interest (COI), Battelle requires affected members to recuse themselves from voting regarding the applicable measure(s); however, the affected members may participate in discussion about the measure(s).

MSR Roll Call

Co-Chairs: Martin Hatlie and Sheila Roman

Maureen Albertson
Reginald Barnes
David Basel
Lyn Behnke
Zahid Butt
April Coxon
Missy Danforth
Tejal Gandhi
Caitlin Gillooley
Sunny Jhamnani
Vera Macon
Julie Marcinek
Erin O'Rourke
Lori Pearlmutter
Cheryl Phillips
Ed Pollak
Amir Qaseem
Koryn Rubin
Jill Shuemaker
Jeffrey Silberzweig
Janice Tufte
Melanie Wascom

Non-voting expert:
Michael Trangle

MSR Co-Chair Introductions

Martin Hatlie

Sheila Roman

MSR Process

Dr. Meridith Eastman | Battelle

MSR Committee Organization

MSR
(25-30 ppl)

PRMR
(~180 ppl)

- **Hospital Committee** (~60 ppl)
  - **Advisory Group** (30-35 ppl)
  - **Recommendation Group** (25-30 ppl)
- **Clinician Committee** (~60 ppl)
  - **Advisory Group** (30-35 ppl)
  - **Recommendation Group** (25-30 ppl)
- **PAC/LTC Committee** (~60 ppl)
  - **Advisory Group** (30-35 ppl)
  - **Recommendation Group** (25-30 ppl)

PRMR

- Advisory and Recommendation Groups provide written feedback
  - Recommendation Groups meet to review and recommend

PRMR and MSR Committees

A select group of **PRMR committee members,** identified based on representation criteria to ensure a range of voices, receive invitations to serve on the MSR Recommendation Group.

The **MSR Recommendation Group** has 25 to 30 members and is inclusive of representatives across the three different settings (Hospital, Clinician, and PAC/LTC) in the PRMR process.

MSR and the Cascade of Meaningful Measures

We aim to **strategically** consider all measures used in CMS quality programs for MSR over the course of a **5-year period**.

The portfolio has been divided into **three cycles** using the **Cascade of Meaningful Measures** as a guide.

The **Cascade of Meaningful Measures**, based on the eight health care priorities of Meaningful Measures 2.0, is a framework to help prioritize existing health care quality measures, align or reduce measures where there are too many, and identify gaps where new measures may need to be developed. More information about the Cascade is available at www.cms.gov/cascade-measures.

Anticipated MSR Review Schedule

Year	Cycle	Cycle Description	Cascade of Meaningful Measures Domains (Number of Measures)
Year 1 – Pilot Year (2023)	N/A	To pilot the MSR process, the year 1 cycle focused on measures in the End-Stage Renal Disease (ESRD) Quality Improvement Program (QIP).	• N/A (15)
Year 2 (2024)	**Cycle C:** Cost-Effectiveness and Efficiency in Health Care Utilization	This group of measures addresses the financial and operational aspects of health care delivery.	• Value, Affordability, and Efficiency (107)
Year 3 (2025)	**Cycle A:** Patient-Centered and Outcome-Focused Care	This group of measures focuses on the individualized needs of patients, emphasizing personalized care plans, preventive measures, and chronic disease management.	• Person-Centered Care (81) • Wellness and Prevention (43) • Chronic Conditions and Related Acute Events (74)
Year 4 (2026)	**Cycle A:** Patient-Centered and Outcome-Focused Care (Continued)	See above.	• Behavioral Health (32)
Year 5 (2027)	**Cycle B:** Safety, Quality, and Closing Gaps in Care in Health Care Delivery	This group of measures focuses on creating a safe and coordinated health care environment for all.	• Safety (144) • Seamless Care Coordination (28) • Closing Gaps of Care (22)

2025 MSR Cycle

Cycle: Cycle A: Patient-Centered and Outcome-Focused Care.

Cascade Priorities: Person-Centered Care; Wellness and Prevention; Chronic Conditions and Related Acute Events; and Safety (selected Merit-based Incentive Payment System [MIPS] measures only).

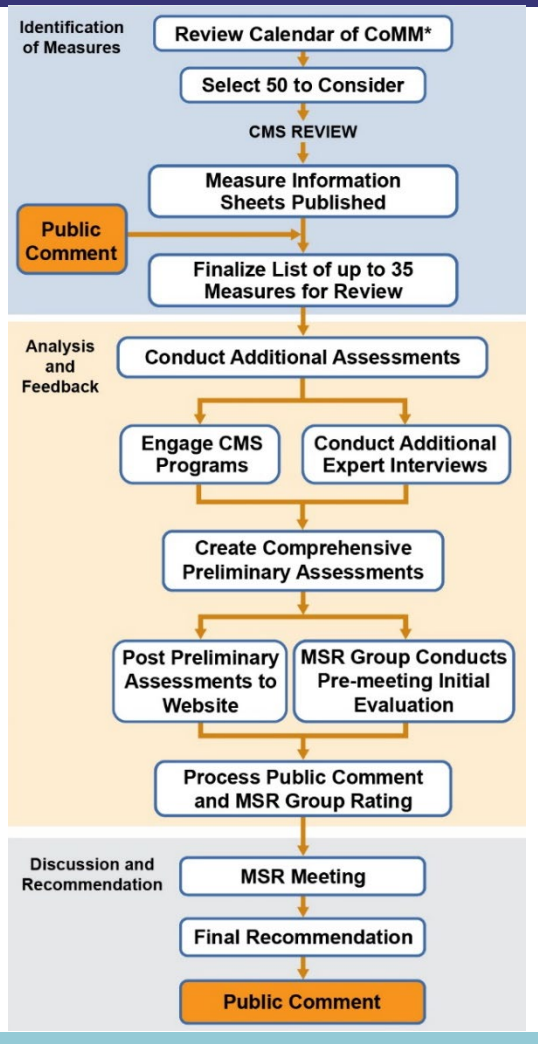
This group of measures focuses on the individualized needs of patients, emphasizing personalized care plans, preventive measures, and chronic disease management.

MSR Process Overview

The purpose of the MSR process is to optimize the CMS measure portfolio via review of measures for continued use of measures in programs.

Three major steps:

- Measure identification
- Analysis and feedback
- Discussion and recommendations



*Cascade: Cascade of Meaningful Measures.

MSR Evaluation

Dr. Lydia Stewart-Artz | Battelle

MSR Assertions

Meaningfulness in the Context of Use

- When evaluating meaningfulness in the context of use, committees should consider if the measure provides importance, conformance, feasibility, validity, reliability, and usability.

  - ✓ Do the available materials explain why using this measure in the quality program provides/will provide more benefits than costs? (Importance, Context of Use)
  - ✓ Do measure components and specifications align with the measure's intent and target population? (Conformance)
  - ✓ Do the available materials for the measure demonstrate that the tools, process, and people necessary to implement and report on the measure are reasonably available? (Feasibility)

MSR Assertions *(cont., 1)*

Meaningfulness in the Context of Use

- When evaluating meaningfulness in the context of use, committees should consider if the measure provides importance, conformance, feasibility, validity, reliability, and usability.
  - ✓ Do the available materials for the measure show with data or reasoning that there are effective methods for improving performance on the measure? (Validity)
  - ✓ Do the performance data show that most differences in performance are due to those effective methods? (Reliability)
  - ✓ Did the available materials identify and address any obstacles or supports that might affect how the measure can be used? (Usability)

MSR Assertions *(cont., 2)*

Measured Entity Data Stream Parsimony

When evaluating entity data stream parsimony, committee members should evaluate whether:

- The clinical data flow required for the measure promotes **non-burdensome** data collection and reporting.
- **Measure set redundancy** in data streams is identified and mitigated.

MSR Assertions *(cont., 3)*

Patient Health Care Journey

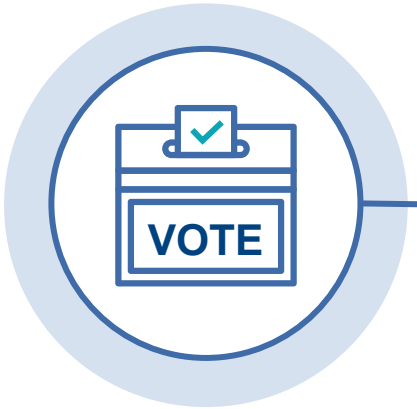
- When evaluating the patient journey, committee members should evaluate whether:
  - ✓ The measure addresses the appropriate aspects of care to align with the way patients experience health care.
  - ✓ The measure set is implemented across the patient health care journey in a manner consistent with the measure set impact model.

This graphic is intended to show the trajectory of a temporarily hospitalized patient to their former level of function. We recognize that many healthy individuals also use assistive devices in their daily lives.

MSR Voting Procedures

Dr. Meridith Eastman | Battelle

Voting Procedure – Consensus



Battelle staff will work with co-chairs to establish meeting ground rules and goals, keep discussion on track, prevent discussions from being dominated by a small number of participants, and ensure decisions are reached.

Battelle will utilize an online voting system to capture votes by committee members.

Consensus is a simple majority: greater than 50%.

Online Voting

Online voting via Poll Everywhere

Link provided via email to voting members

Vote at time indicated by facilitator for each measure

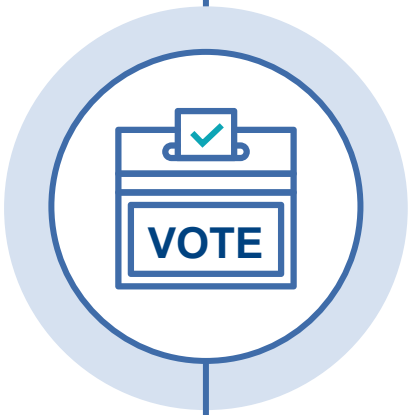
If you need voting assistance, please contact the project team via chat on the virtual platform or at PQMsupport@battelle.org.

MSR Recommendation

Committee votes on overall recommendation of the measure

- Recommend the measure **continue to be used** in the designated CMS quality program
- Recommend that the measure **not continue to be used** in the designated CMS quality program

Voting Procedure – Quorum



Discussion quorum: The discussion quorum requires the attendance of at least 60% of the Recommendation Group members at roll call at the beginning of the meeting.

Voting quorum: The voting quorum requires at least 80% of active Recommendation Group members who have not been recused.

Voting Procedure – Quorum *(cont. 1)*

Maintaining voting quorum is extremely important to the process, and we kindly request you stay for the entirety of discussion and voting.

- If the voting quorum is not met, we will collect the votes for those present and follow up with absent participants until a voting quorum is reached.

Quorum Requirements

24 MSR committee members

Discussion Quorum

- 15 needed to have discussion

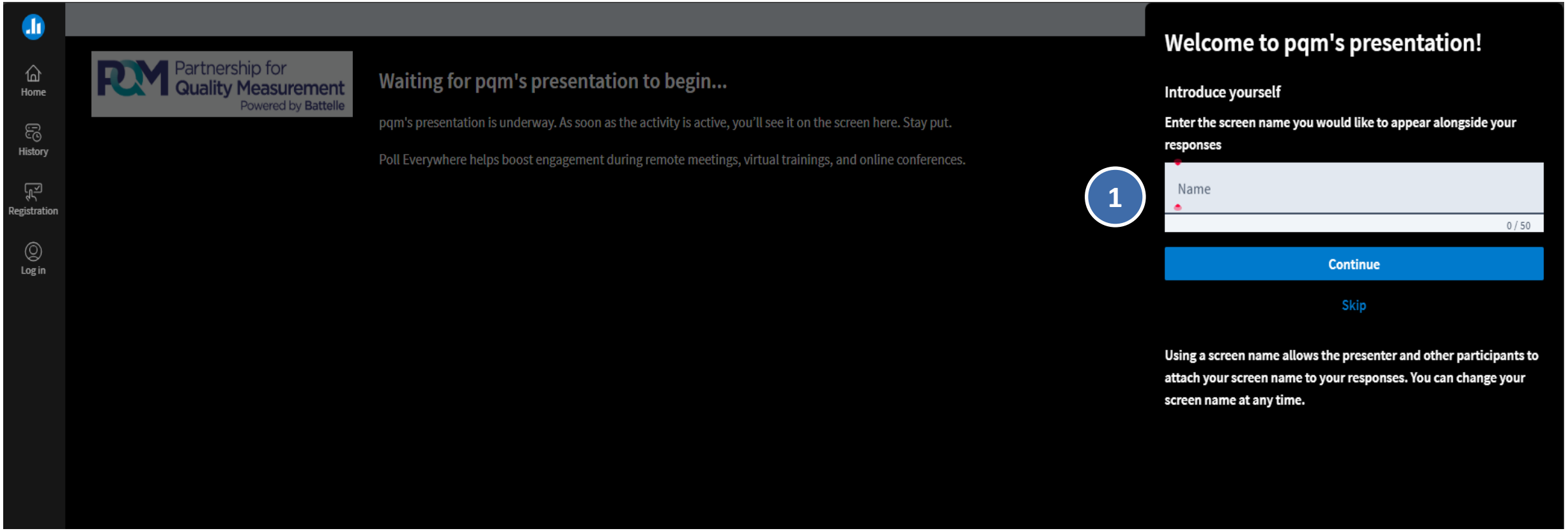
Voting Quorum

- 20 members need to vote

Voting Test

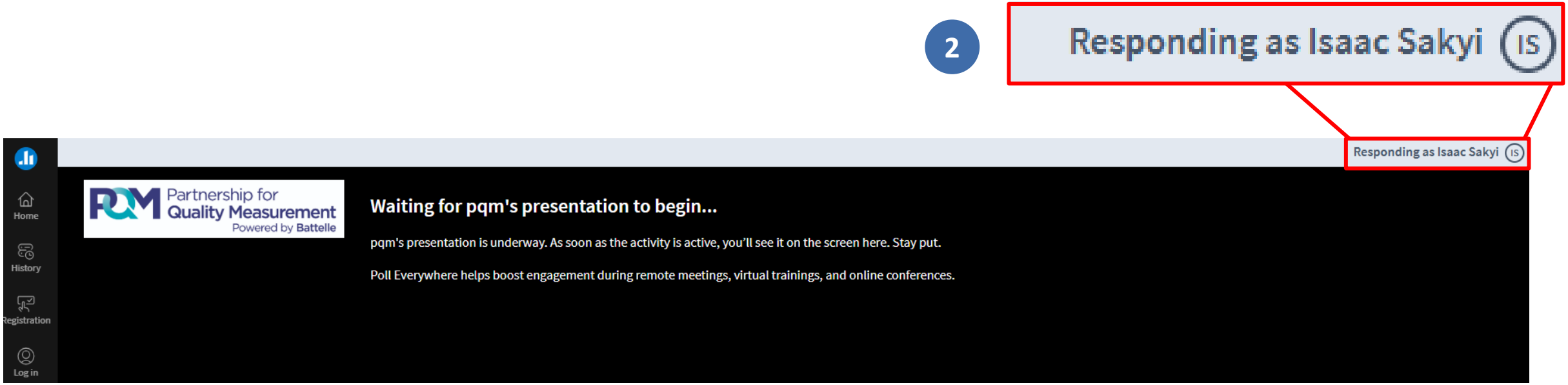
Isaac Sakyi | Battelle

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.

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MSR Recommendation Group Measure Review

Overview of Public Comments, PIE Results, and Closing Gaps of Care Considerations

Dr. Meridith Eastman | Battelle

Summary of First Public Comment Period

Battelle posted Measure Information Sheets on the initial

50

MEASURES for this cycle

Public comment period from **June 16** to **June 30**

21 **Measures selected for MSR**

3 **Comments received on selected MSR measures**

Closing Gaps of Care Considerations

- Battelle conducted a search of peer-reviewed literature and federal agency websites to identify how measure topics and conditions might differ by:
  - Age
  - Geography (urban vs. rural)
  - Insurance status
  - Dual Medicare and Medicaid eligibility
  - Language
- Closing gaps of care is not an MSR evaluation criterion.
- We provide these findings to committee members to consider as they reflect on how each measure, through use in a Medicare quality program, may contribute to closing or widening gaps of care for various population groups.

Pre-Meeting Initial Evaluation (PIE)

- Battelle assigned each committee member four or five measures for review.
- Committee members reviewed preliminary assessments and consulted peers during PIE Form completion.
- Online PIE Forms asked if each measure met or did not meet the criteria:
  - Meaningfulness, Data Stream Parsimony, and Patient Health Journey.
  - Committee members provided their rationale for the rating.
- We achieved an 87% completion rate this year.

Measure Review Steps

- For each measure:
  - Battelle will summarize measure information.
  - CMS medical officer will provide brief measure overview and/or contextual background.
  - Battelle will review PIE results, public comments, and closing gaps of care considerations.
  - Committee will discuss.
  - Committee will vote.

Anticoagulation Therapy for Atrial Fibrillation/Flutter

00062-04-E-HIQR

Anticoagulation Therapy for Atrial Fibrillation/Flutter
Measure Overview

Brief Description of Measure: Ischemic stroke patients with atrial fibrillation/flutter who are prescribed or continuing to take anticoagulation therapy at hospital discharge.

Measure Steward: The Joint Commission

CMS-Provided Rationale: Several recent studies have reported less-than-favorable trends in oral anticoagulant use among patients with atrial fibrillation. While ischemic stroke rates have decreased (i.e., 18% 2016-2021) due in part to increased use of newer direct oral anticoagulant medications (DOACs) relative to warfarin,[1] rates of oral anticoagulant use remain suboptimal, especially in older adults with new onset atrial fibrillation. According to Navar and colleagues, one in three patients with non-valvular atrial fibrillation and elevated stroke risk are not on a DOAC or warfarin, and use varies by health system.[2] These studies support a wider performance gap for STK-3 (Anticoagulation Therapy for Atrial Fibrillation/Flutter) compared to the antithrombotic therapy measures STK-2 (Discharged on Antithrombotic Therapy) and STK-5 (Antithrombotic Therapy by End of Hospital Day 2.

Program Use	Measure Type	Level of Analysis	CBE Endorsement Status and History
Hospital Inpatient Quality Reporting Program	Process	Facility/Hospital/ Agency	Not Currently Endorsed*

* The eCQM version is not currently endorsed. The non-digital version of this measure has the following endorsement history: Endorsed with Reserve Status Neurology Project 2015-2016; Initial Endorsement, 2008

[1] William, A., et al, J Stroke Cerebrovasc Dis, 2024 Dec;33(12)108081
[2] Navar, A.M., et al, J Am Heart Assoc, 2022 Nov 15;11(22):e026723

Anticoagulation Therapy for Atrial Fibrillation/Flutter
PIE Form Summary

Support Themes

Meaningfulness

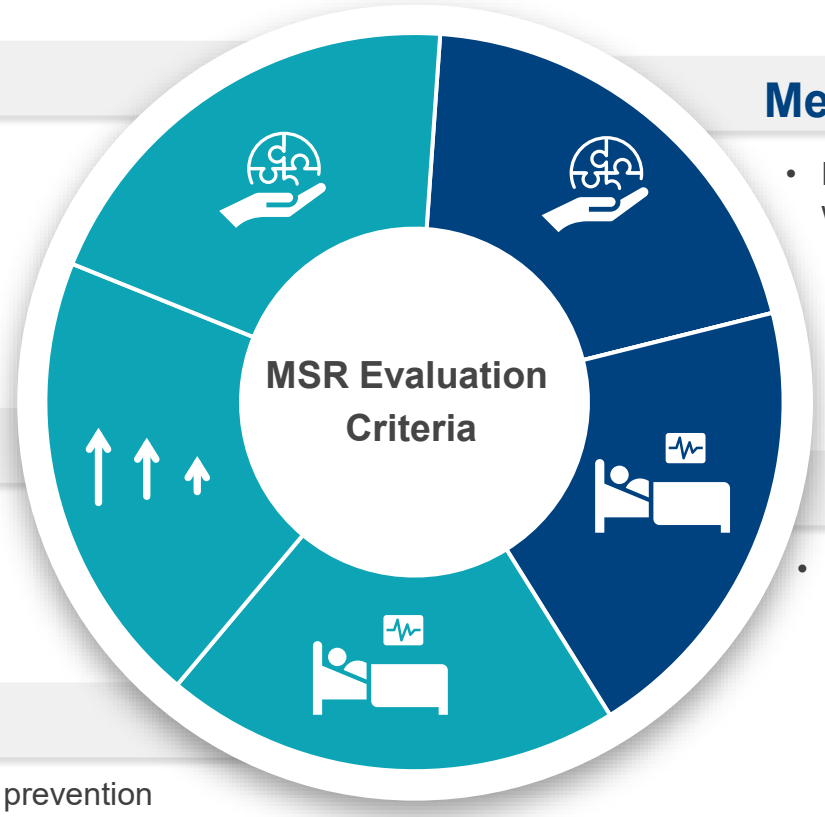
- Patient & clinician support for evidence base & measure importance.
- Performance gaps indicate room for improvement.
- Measure is actionable due to integration with existing hospital workflows.

Data Stream Parsimony

- Measure aligns with existing workflows and uses routinely collected data, making it easy to implement without adding administrative burden.

Patient Health Journey

- Strong patient support for secondary stroke prevention as relevant to the patient journey as well impactful to the broader care landscape.



Concern Themes

Meaningfulness

- Performance data sample size is too small; member would have liked to see more measured entities included.

Patient Health Journey

- Additional considerations include ensuring anticoagulant prescriptions are maintained for patients with comorbidities and exploring follow-up outpatient visits at discharge for lab monitoring and ongoing therapy management.

Anticoagulation Therapy for Atrial Fibrillation/Flutter
Closing Gaps of Care Considerations

- Rural patients are more likely to be prescribed warfarin (which requires monitoring) rather than direct oral anticoagulants (DOACs).[1]
- Patients who have Medicare or self-pay insurance are more likely to receive a warfarin prescription.[2]
- Older adults especially those with coexisting dementia, frailty, and anemia are less likely to be prescribed anticoagulation therapy.[3]

1. Lin, M. P., Zhang, Y., & Wadhera, R. K. (2025). Rural–urban disparities in atrial fibrillation care in the United States: A systematic review. *Journal of the American Heart Association, 14*(17), e036899. https://doi.org/10.1161/JAHA.124.036899
2. Khatib, R., Glowacki, N., Colavecchia, C., Mills, J. R., Glosner, S., Cato, M., & Brady, P. (2023). Associations between clinical and social factors and anticoagulant prescription among patients with atrial fibrillation: A retrospective cohort study from a large healthcare system. *PloS one*, *18*(8), e0289708. https://doi.org/10.1371/journal.pone.0289708
3. Ko D, Lin KJ, Bessette LG, et al. Trends in Use of Oral Anticoagulants in Older Adults With Newly Diagnosed Atrial Fibrillation, 2010-2020. JAMA Netw Open. 2022;5(11):e2242964. doi:10.1001/jamanetworkopen.2022.42964

Anticoagulation Therapy for Atrial Fibrillation/Flutter

00062-04-E-PI

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Program Use	Measure Type	Level of Analysis	CBE Endorsement Status and History
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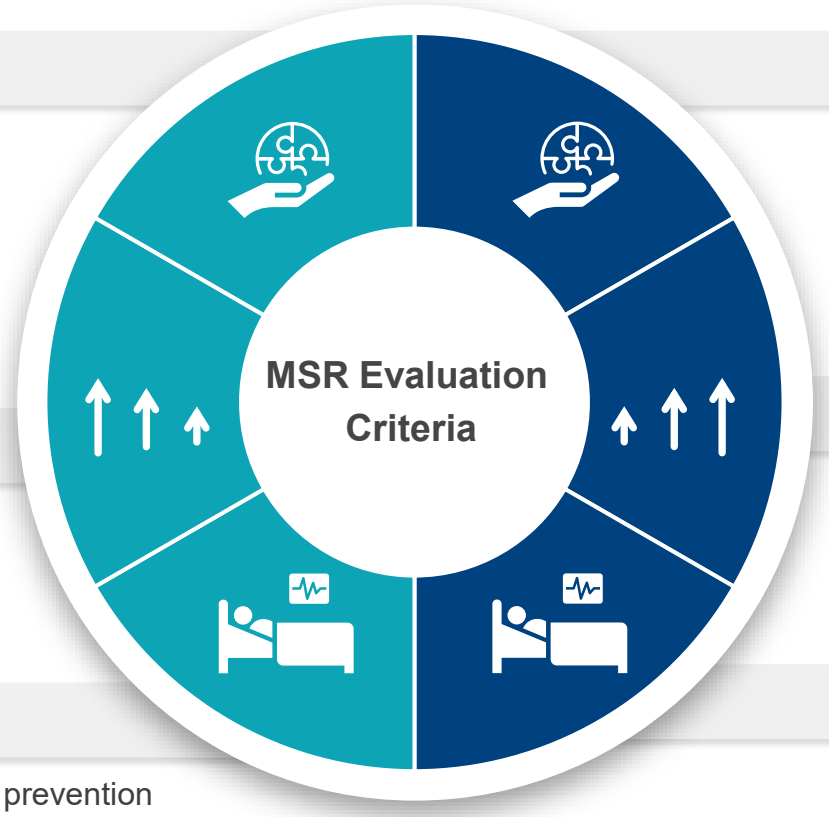

Concern Themes

Meaningfulness

- Performance data sample size is too small; member would have liked to see more measured entities included.
- Contraindications and patient declinations are often recorded in free-text notes, requiring updates to EHR templates, provider training, and IT coordination to support structured, reportable data.

Data Stream Parsimony

- Measure should include better integration with outpatient care and clearer reporting guidance to improve the measure's effectiveness over time.
- Potential for duplication of efforts since this measure is collected for multiple programs.

Patient Health Journey

- Measure should ensure anticoagulant prescriptions are maintained for patients with comorbidities and explore follow-up outpatient visits at discharge for lab monitoring and ongoing therapy management.

Anticoagulation Therapy for Atrial Fibrillation/Flutter
Closing Gaps of Care Considerations

- Rural patients are more likely to be prescribed warfarin (which requires monitoring) rather than direct oral anticoagulants (DOACs).[1]
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Antithrombotic Therapy by the End of Hospital Day Two

00064-03-E-HIQR

Antithrombotic Therapy by the End of Hospital Day Two
Measure Overview

Brief Description of Measure: Ischemic stroke patients administered antithrombotic therapy by the end of hospital day 2.

Measure Steward: The Joint Commission

CMS-Provided Rationale: Early antithrombotic therapy is recommended by the American Heart Association and other professional societies to increase the likelihood of favorable patient outcomes following an acute ischemic stroke event. The recommended timeframe for administration is within 24 to 48 hours of stroke onset.

Program Use	Measure Type	Level of Analysis	CBE Endorsement Status and History
Hospital Inpatient Quality Reporting Program	Process	Facility/Hospital/ Agency	Endorsed with Reserve Status*

*The eCQM version is not currently endorsed. The non-digital version of this measure has the following endorsement history: Endorsed with Reserve Status Neurology Project 2015-2016; Initial Endorsement, 2008

Antithrombotic Therapy by the End of Hospital Day Two
PIE Form Summary

Support Themes

Meaningfulness

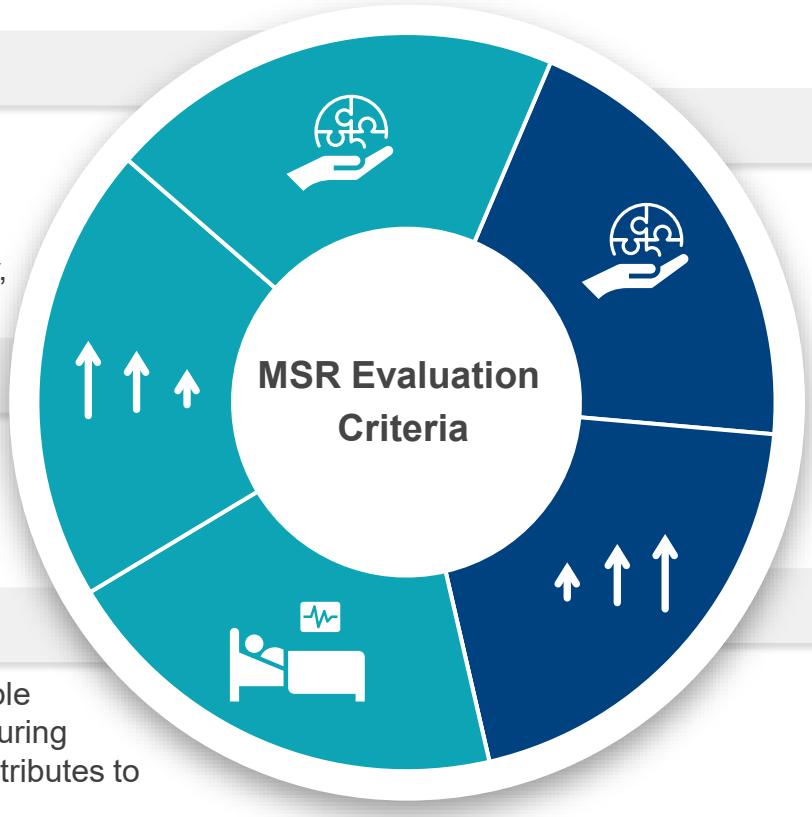
- Addresses a critical clinical condition of importance to patients.
- Supported by evidence showing improved outcomes with timely antithrombotic therapy, making it meaningful and actionable.

Data Stream Parsimony

- Measure uses routinely collected EHR data and does not impose significant additional burden.

Patient Health Journey

- Measure supports patients during a vulnerable transition point—hospital discharge—by ensuring appropriate therapy is prescribed, which contributes to better long-term outcomes.
- Discharge and transition of care is one of the highest-risk times for errors and miscommunication.



Concern Themes

Meaningfulness

- Contraindications and patient declinations are often recorded in free-text notes, requiring updates to EHR templates, provider training, and IT coordination to support structured, reportable data.
- Measure might be “topped out,” given the CBE endorsement status for the non-digital version of the measure.

Data Stream Parsimony

- Potential for duplication of efforts because multiple programs collect this measure.

Antithrombotic Therapy by the End of Hospital Day Two
Closing Gaps of Care Considerations

- Older adults are less likely to receive antithrombotic therapy, often due to concerns about bleeding risk, comorbidities, or perceived contraindications.[1]
- Uninsured patients are less likely to be started on antithrombotic therapy when admitted to the hospital.[2]
- Non-English-speaking patients are less likely to receive antithrombotic therapy by day 2. Language barriers can delay diagnosis, consent, and administration of therapy.[3]

1. Vleeshouwers, K., Bastings, J. J. C., Brüggemann, R., de Jong, M. J., van den Boogaart, M., Poeze, M., van Es, N., Hanssen, N. M. J., Brouns, S., Magdelijns, F., & Spaetgens, B. (2025). Antithrombotic Therapy and Mortality Risk in Older Adults with Hip Fractures. *Journal of the American Medical Directors Association*, *26*(8), 105690. https://doi.org/10.1016/j.jamda.2025.105690
2. Wang, T. F., et al. (2022). Insurance status and disparities in anticoagulation therapy among patients with venous thromboembolism. *Thrombosis Research, 213*, 1–7. https://doi.org/10.1016/j.thromres.2022.04.011
3. Rodriguez, F., et al. (2021). Language barriers and medication adherence: A systematic review. *Patient Education and Counseling, 104*(2), 292–298. https://doi.org/10.1016/j.pec.2020.08.022

Antithrombotic Therapy by the End of Hospital Day Two

00064-03-E-PI

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Program Use	Measure Type	Level of Analysis	CBE Endorsement Status and History
Medicare Promoting Interoperability Program	Process	Facility/Hospital/ Agency	Not Currently Endorsed*

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Antithrombotic Therapy by the End of Hospital Day Two
PIE Form Summary

Support Themes

Meaningfulness

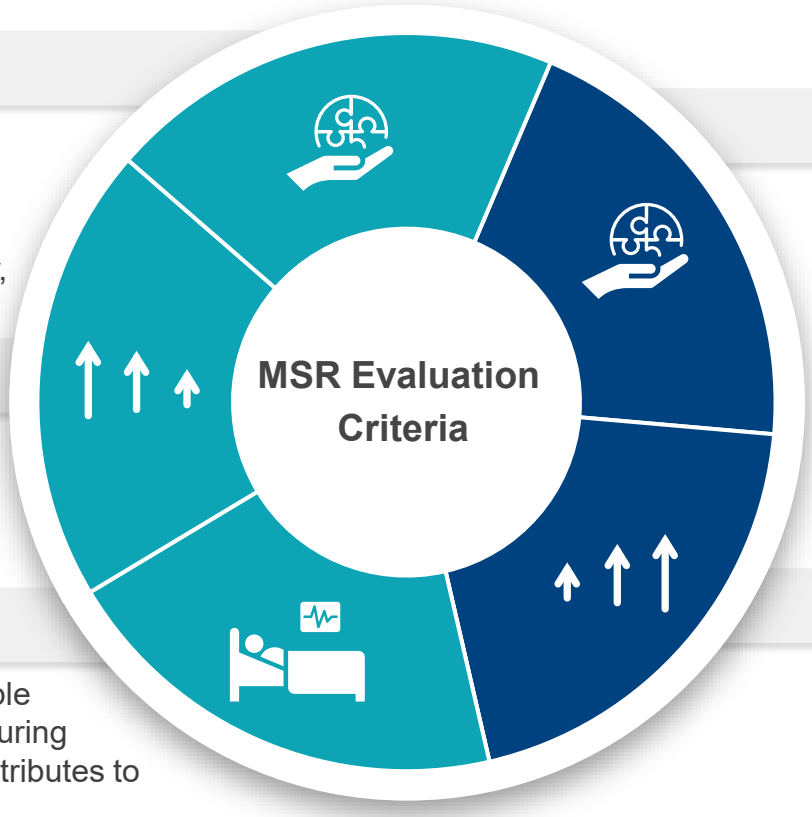
- Addresses a critical clinical condition of importance to patients.
- Supported by evidence showing improved outcomes with timely antithrombotic therapy, making it meaningful and actionable.

Data Stream Parsimony

- Measure uses routinely collected EHR data and does not impose significant additional burden.

Patient Health Journey

- Measure supports patients during a vulnerable transition point—hospital discharge—by ensuring appropriate therapy is prescribed, which contributes to better long-term outcomes.
- Discharge and transition of care is one of the highest-risk times for errors and miscommunication.



Concern Themes

Meaningfulness

- Contraindications and patient declinations are often recorded in free-text notes, requiring updates to EHR templates, provider training, and IT coordination to support structured, reportable data.
- Measure might be “topped out,” given the CBE endorsement status for the non-digital version of the measure.

Data Stream Parsimony

- Potential for duplication of efforts because multiple programs collect this measure.

Antithrombotic Therapy by the End of Hospital Day Two
Closing Gaps of Care Considerations

- Older adults are less likely to receive antithrombotic therapy, often due to concerns about bleeding risk, comorbidities, or perceived contraindications.[1]
- Uninsured patients are less likely to be started on antithrombotic therapy when admitted to the hospital.[2]
- Non-English-speaking patients are less likely to receive antithrombotic therapy by day 2. Language barriers can delay diagnosis, consent, and administration of therapy.[3]

1. Vleeshouwers, K., Bastings, J. J. C., Brüggemann, R., de Jong, M. J., van den Boogaart, M., Poeze, M., van Es, N., Hanssen, N. M. J., Brouns, S., Magdelijns, F., & Spaetgens, B. (2025). Antithrombotic Therapy and Mortality Risk in Older Adults with Hip Fractures. *Journal of the American Medical Directors Association*, *26*(8), 105690. https://doi.org/10.1016/j.jamda.2025.105690
2. Wang, T. F., et al. (2022). Insurance status and disparities in anticoagulation therapy among patients with venous thromboembolism. *Thrombosis Research, 213*, 1–7. https://doi.org/10.1016/j.thromres.2022.04.011
3. Rodriguez, F., et al. (2021). Language barriers and medication adherence: A systematic review. *Patient Education and Counseling, 104*(2), 292–298. https://doi.org/10.1016/j.pec.2020.08.022

Discharged on Antithrombotic Therapy

00211-02-E-HIQR

Discharged on Antithrombotic Therapy
Measure Overview

Brief Description of Measure: Ischemic stroke patients prescribed or continuing to take antithrombotic therapy at hospital discharge.

Measure Steward: The Joint Commission

CMS-Provided Rationale: Long-term antithrombotic usage is a key therapy recommended by the American Heart Association (AHA) and other professional societies to reduce the occurrence of another stroke following an acute ischemic stroke event. It should be prescribed prior to hospital discharge for secondary stroke prevention. According to Behavioral Risk Factor Surveillance System (BRFSS) 2022 data (unpublished National Heart, Lung, and Blood Institute [NHLBI] tabulation), stroke prevalence in adults was 3.4% (median) in the United States, with the lowest prevalence in Puerto Rico (1.8%) and South Dakota (2.1%) and the highest prevalence in Arkansas (4.8%) (American Heart Association [AHA], 2025 Heart Disease and Stroke Statistics).

Program Use	Measure Type	Level of Analysis	CBE Endorsement Status and History
Hospital Inpatient Quality Reporting Program	Process	Facility/Hospital/ Agency	Not Currently Endorsed*

*The eCQM version is not currently endorsed. The non-digital version of this measure has the following endorsement history: Endorsed with Reserve Status Neurology Project 2015-2016; Initial Endorsement, 2008

Discharged on Antithrombotic Therapy
PIE Form Summary

Support Themes

Meaningfulness

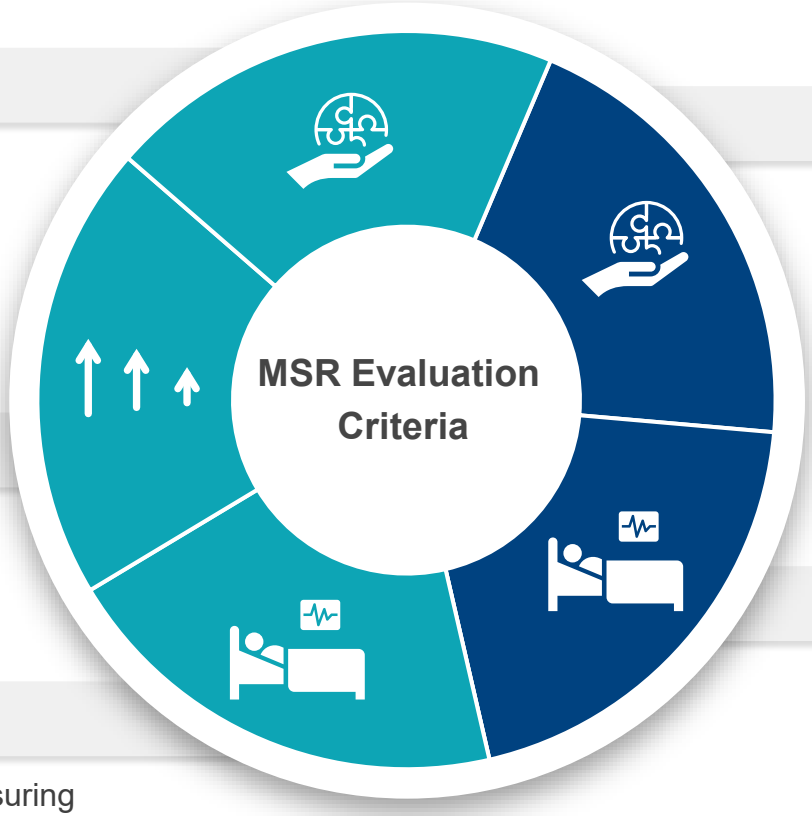
- Addresses a critical clinical condition of importance to patients.
- Aligns with evidence base and clinical guidelines.
- Cost-effective by reducing health care utilization.

Data Stream Parsimony

- Measure uses routinely collected EHR data and does not impose significant additional burden for collection or reporting.

Patient Health Journey

- Measure supports the patient journey by ensuring appropriate follow-up care and long-term use of antithrombotic therapy after hospital discharge.



Concern Themes

Meaningfulness

- Measure may be topped out with limited variation across hospitals, raising questions about its continued utility and reliability in low-volume settings.
- Treatment decisions are very complex, especially those regarding anticoagulation safety and appropriateness for different stroke etiologies (non-cardioembolic ischemic stroke).
- Suggestion to consider exclusion of patients already anticoagulated for atrial fibrillation.

Patient Health Journey

- Patients may be concerned about the side effects from the treatment.

Discharged on Antithrombotic Therapy
Closing Gaps of Care Considerations

- Uninsured patients are less likely to be discharged on antithrombotic therapy. Cost barriers, lack of access to outpatient follow-up, and inability to afford medications contribute to lower rates of therapy.[1]
- Dual-eligible patients may be less likely to be discharged on antithrombotic therapy, often due to complex medical and social needs, polypharmacy concerns, and administrative barriers.[2]
- Older adults are less likely to be discharged on antithrombotic therapy, often due to concerns about bleeding risk, comorbidities, or perceived contraindications.[3]

1. Baca, A., Hines, J., & McCormick, M. (2023). *Barriers to optimal antiplatelet therapy at discharge: A retrospective study at a safety-net hospital*. Journal of the American College of Clinical Pharmacy, 6(2), 123–130. https://doi.org/10.1002/jac5.1789
2. Baca, A., Hines, J., & McCormick, M. (2023). *Barriers to optimal antiplatelet therapy at discharge: A retrospective study at a safety-net hospital*. Journal of the American College of Clinical Pharmacy, 6(2), 123–130. https://doi.org/10.1002/jac5.1789
3. Valgimigli, M., Bueno, H., Byrne, R. A., Collet, J. P., Costa, F., Jeppsson, A., ... & Windecker, S. (2022). *2022 ESC Guidelines on cardiovascular disease prevention in clinical practice*. European Heart Journal, 43(34), 3727–3784. https://doi.org/10.1093/eurheartj/ehac282

Discharged on Antithrombotic Therapy

00211-02-E-PI

Discharged on Antithrombotic Therapy
Measure Overview

Brief Description of Measure: Ischemic stroke patients prescribed or continuing to take antithrombotic therapy at hospital discharge.

Measure Steward: The Joint Commission

CMS Provided Rationale: Long-term antithrombotic usage is a key therapy recommended by the American Heart Association (AHA) and other professional societies to reduce the occurrence of another stroke following an acute ischemic stroke event. It should be prescribed prior to hospital discharge for secondary stroke prevention. According to Behavioral Risk Factor Surveillance System (BRFSS) 2022 data (unpublished National Heart, Lung, and Blood Institute [NHLBI] tabulation), stroke prevalence in adults was 3.4% (median) in the United States with the lowest prevalence in Puerto Rico (1.8%) and South Dakota (2.1%) and the highest prevalence in Arkansas (4.8%) (AHA, 2025 Heart Disease and Stroke Statistics).

Program Use	Measure Type	Level of Analysis	CBE Endorsement Status and History
Medicare Promoting Interoperability Program	Process	Facility/Hospital/ Agency	Not Currently Endorsed*

*The eCQM version is not currently endorsed. The non-digital version of this measure has the following endorsement history: Endorsed with Reserve Status Neurology Project 2015-2016; Initial Endorsement, 2008

Discharged on Antithrombotic Therapy
PIE Form Summary

Support Themes

Meaningfulness

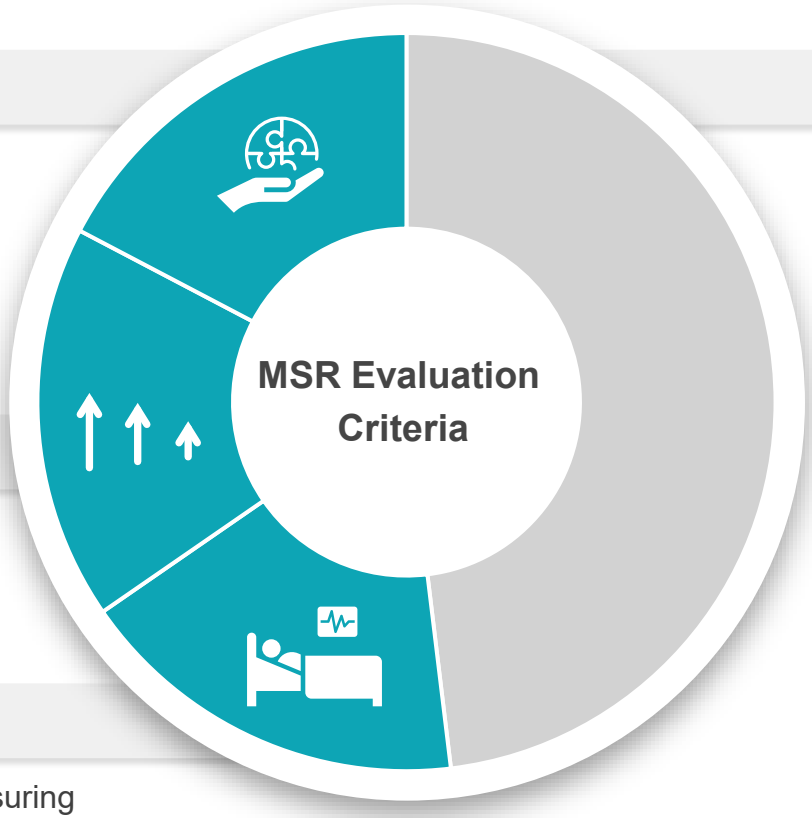
- Addresses a critical clinical condition of importance to patients.
- Aligns with evidence base and clinical guidelines.
- Cost-effective by reducing health care utilization.

Data Stream Parsimony

- Measure uses routinely collected EHR data and does not impose significant additional burden for collection or reporting.

Patient Health Journey

- Measure supports the patient journey by ensuring appropriate follow-up care and long-term use of antithrombotic therapy after hospital discharge.



Concern Themes

No concerns

Discharged on Antithrombotic Therapy
Closing Gaps of Care Considerations

- Uninsured patients are less likely to be discharged on antithrombotic therapy. Cost barriers, lack of access to outpatient follow-up, and inability to afford medications contribute to lower rates of therapy.[1]
- Dual-eligible patients may be less likely to be discharged on antithrombotic therapy, often due to complex medical and social needs, polypharmacy concerns, and administrative barriers.[2]
- Older adults are less likely to be discharged on antithrombotic therapy, often due to concerns about bleeding risk, comorbidities, or perceived contraindications.[3]

1. Baca, A., Hines, J., & McCormick, M. (2023). *Barriers to optimal antiplatelet therapy at discharge: A retrospective study at a safety-net hospital*. Journal of the American College of Clinical Pharmacy, 6(2), 123–130. https://doi.org/10.1002/jac5.1789
2. Baca, A., Hines, J., & McCormick, M. (2023). *Barriers to optimal antiplatelet therapy at discharge: A retrospective study at a safety-net hospital*. Journal of the American College of Clinical Pharmacy, 6(2), 123–130. https://doi.org/10.1002/jac5.1789
3. Valgimigli, M., Bueno, H., Byrne, R. A., Collet, J. P., Costa, F., Jeppsson, A., ... & Windecker, S. (2022). *2022 ESC Guidelines on cardiovascular disease prevention in clinical practice*. European Heart Journal, 43(34), 3727–3784. https://doi.org/10.1093/eurheartj/ehac282

Lunch Break

Please return by 1:30 PM

The PRMR and MSR Guidebook introduces processes and incorporates changes as suggested by interested parties through a public comment period.

The Measures Management System (MMS) Hub is a great plain-language general resource on quality measures.

Become a PQM member – it's free!

Screening for Metabolic Disorders

00673-01-C-IPFQR

Screening for Metabolic Disorders
Measure Overview

Brief Description of Measure: Percentage of patients discharged from an Inpatient Psychiatric Facility (IPF) with a prescription for one or more routinely scheduled antipsychotic medications for which a structured metabolic screening for four elements was completed in the 12 months prior to discharge, either prior to or during the index IPF stay.

Measure Steward: CMS

CMS-Provided Rationale: Studies show that both second-generation antipsychotics (SGAs) and antipsychotics increase the risk of metabolic syndrome. In 2004, the American Diabetes Association (ADA), the American Psychiatric Association (APA), the American Association of Clinical Endocrinologists, and the North American Association released a consensus statement that recommended providers obtain baseline screening for metabolic syndrome prior to or immediately after the initiation of antipsychotics to reduce the risk of preventable adverse events and improve the physical health status of the patient. The Screening for Metabolic Disorders measure was developed to assess the percentage of patients discharged with antipsychotics from an IPF for which a structured metabolic screening for four elements was completed in the past year.

Program Use	Measure Type	Level of Analysis	CBE Endorsement Status and History
Inpatient Psychiatric Facility Quality Reporting Program	Process	Facility/Hospital/ Agency	Not Currently Endorsed

Screening for Metabolic Disorders
PIE Form Summary

Support Themes

Meaningfulness

- Evidence supports screening for metabolic risks.
- Responses emphasized the importance of safety and quality for patients on antipsychotics.

Data Stream Parsimony

- The required data for the measure are not overly complex and presumably can be collected with minimal burden.

Patient Health Journey

- The measure addresses an important safety concern for patients on antipsychotics.
- Screening while a person is hospitalized would allow physical concerns to be address alongside psychiatric conditions.

Concern Themes

Meaningfulness

- The measure has not gone through the CBE endorsement process; its scientific acceptability has not been reviewed.
- The measure creates an additional feasibility burden on health care providers because required data elements are not routinely captured in EHR.

Screening for Metabolic Disorders
Closing Gaps of Care Considerations

- Rural IPFs are less likely to consistently screen for metabolic disorders compared to urban facilities due to limited access to laboratory services, fewer staff trained in medical comorbidities, and less integration of physical and mental health care.[1]
- Insured patients, especially those with comprehensive coverage, are more likely to receive recommended screening.[1]
- Older adults are more likely to be screened for metabolic disorders, as age is a strong predictor of screening and older patients are often prioritized for preventive care.[2]
- Language barriers can impede communication about the importance of screening, consent, and follow-up.[3]

1. Mangurian, C., Newcomer, J. W., Vittinghoff, E., et al. (2025). *Diabetes screening among underserved adults with severe mental illness who take antipsychotic medications*. *JAMA Internal Medicine*, *175*(12), 1977–1979. https://doi.org/10.1001/jamainternmed.2015.6098
2. Centers for Disease Control and Prevention. (2025). *Chronic disease among older adults: Behavioral Risk Factor Surveillance System findings*. U.S. Department of Health and Human Services. https://www.cdc.gov
3. Centers for Disease Control and Prevention. (2024). *Colorectal cancer screening disparities among Hispanic adults with limited English proficiency*. U.S. Department of Health and Human Services. https://www.cdc.gov

Influenza Immunization

00386-03-C-IPFQR

Influenza Immunization
Measure Overview

Brief Description of Measure: This prevention measure applies to acute care inpatients aged 6 months and older who are screened for seasonal influenza immunization and vaccinated prior to discharge if indicated. The numerator includes patients who were screened and, when appropriate, received the vaccine, as well as those with documented contraindications, those who declined the vaccine, and those already vaccinated during the current influenza season.

Measure Steward: The Joint Commission

CMS-Provided Rationale: This prevention measure aims to ensure that at-risk populations receive an immunization, which could prevent future illness and/or hospitalization. Those with serious mental illness are at an increased risk of death from infectious diseases, particularly from respiratory infections such as influenza. Increasing influenza (flu) vaccination can reduce unnecessary hospitalizations and secondary complications, particularly among high-risk populations. Vaccination is the most effective method for preventing influenza virus infection and its potentially severe complications, and vaccination is associated with reductions in influenza among all age groups. Many patients hospitalized in a psychiatric hospital or unit are diagnosed with serious mental illness and have multiple comorbidities, increasing their risk of hospitalization or death from influenza, which makes this measure important to remain in the IPFQR program.

Program Use	Measure Type	Level of Analysis	CBE Endorsement Status and History
Inpatient Psychiatric Facility Quality Reporting Program	Process	Facility/Hospital/ Agency	Endorsed with Reserve Status

Influenza Immunization
PIE Form Summary

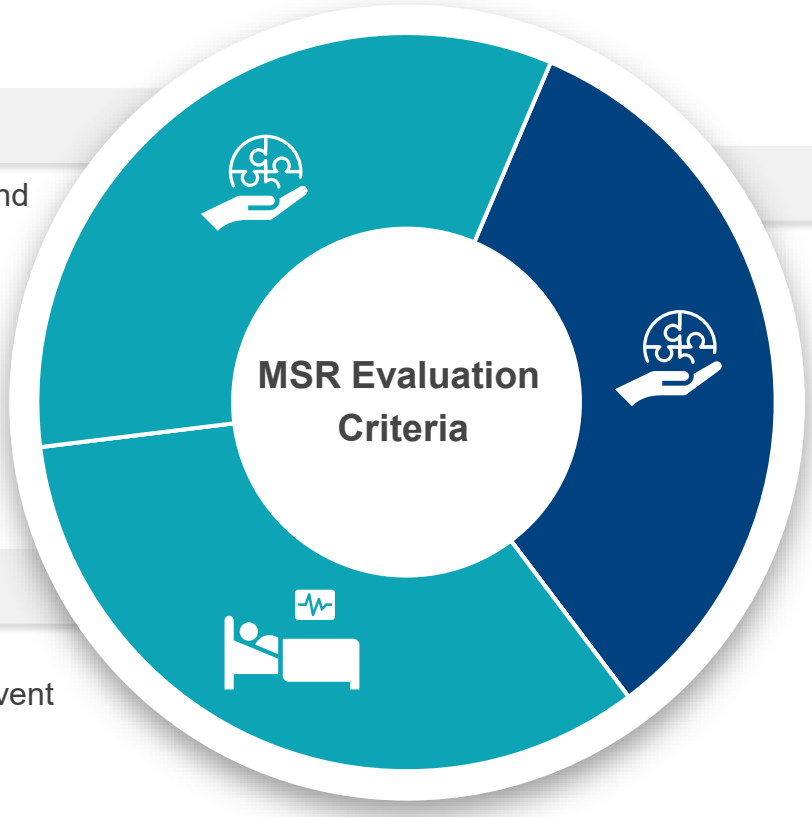
Support Themes

Meaningfulness

- Measure addresses an important concept and continues to demonstrate reliability and validity.
- Flu prevention is important to patients and seems appropriate for this program.

Patient Health Journey

- Flu vaccination at discharge could support a healthy transition out of the hospital and prevent avoidable readmissions.



Concern Themes

Meaningfulness

- Feasibility concerns related to relevant data availability in electronic sources and potential for manual abstraction.
- New testing on validity would be useful.

Influenza Immunization
Closing Gaps of Care Considerations

- Rural facilities may have less robust vaccination protocols and less staff training as compared to urban facilities.[1]
- Dual-eligible patients may have higher rates of influenza immunization due to more frequent health care interactions and coverage for preventive services. Fragmented care can still result in missed opportunities for vaccination.[2]
- Disparities in vaccination rates are linked to mistrust of health care, cultural beliefs, lower access to preventive care, and differences in provider recommendation.[3]
- Language barriers can impede communication about vaccine benefits, consent, and follow-up.[4]

1. Schaffer DeRoo, S., & Limaye, R. J. (2024). Culturally aware vaccine promotion: Evidence-based communication strategies for healthcare professionals. *American Journal of Public Health*, *114*(3), 234–240. https://doi.org/10.2105/AJPH.2023.307456
2. Roberts, E. T., Spanko, A., & Trivedi, A. N. (2024). Integrated care programs for dual-eligible beneficiaries: A systematic review. *Health Services Research*, *59*(2), 145–158. https://doi.org/10.1111/1475-6773.14123
3. Shen, A. K., & Orenstein, W. A. (2020). Fragmented Medicaid vaccine coverage and reimbursement: Challenges to adult immunization. *Health Affairs*, *39*(2), 297–304. https://doi.org/10.1377/hlthaff.2019.01061
4. Schaffer DeRoo, S., & Limaye, R. J. (2024). Culturally aware vaccine promotion: Evidence-based communication strategies for healthcare professionals. *American Journal of Public Health*, *114*(3), 234–240. https://doi.org/10.2105/AJPH.2023.307456

Influenza Immunization Received for Current Flu Season

00389-01-C-HHQR

Influenza Immunization Received for Current Flu Season
Measure Overview

Brief Description of Measure: Percentage of home health quality episodes of care during which patients received influenza immunization for the current flu season.

Measure Steward: CMS

CMS-Provided Rationale: This quality measure (QM) was added to the Home Health Quality Reporting Program (HHQRP) and remains in the HHQRP because addressing priority areas in the adult vaccination set is still important. Influenza disproportionately affects the patient population who make up the majority of those receiving the Medicare Home Health benefit. Continued inclusion of this QM, as well as other vaccine strategies, are vital in comprehensively addressing vaccination in home health care patients.

Program Use	Measure Type	Level of Analysis	CBE Endorsement Status and History
Home Health Quality Reporting Program	Process	Facility/Hospital/ Agency	Endorsement Removed in 2016; Initial Endorsement in 2009

Influenza Immunization Received for Current Flu Season
PIE Form Summary

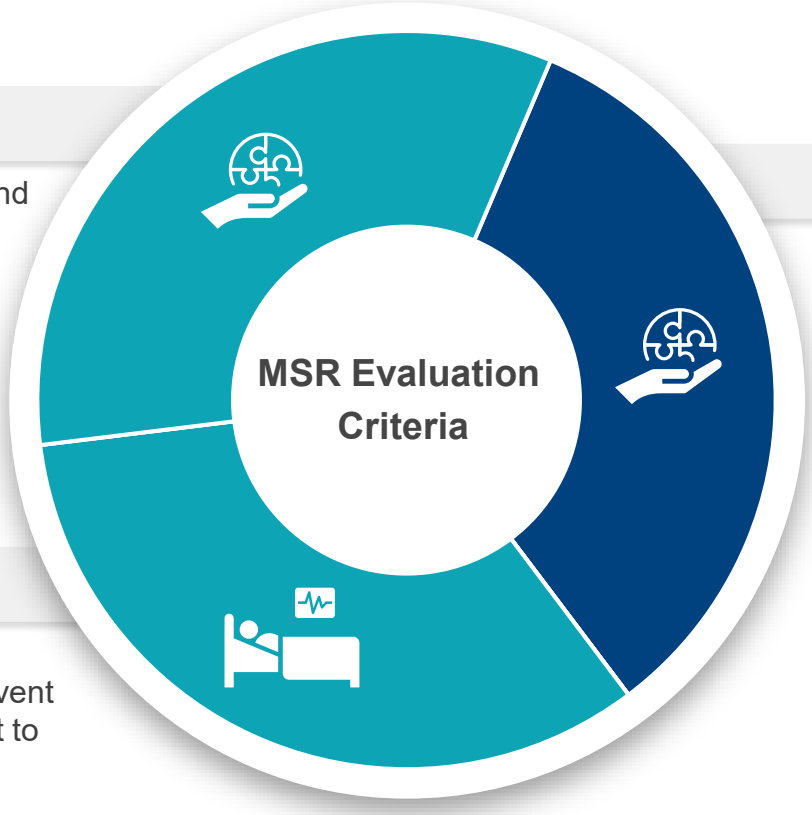
Support Themes

Meaningfulness

- Measure addresses an important concept and has clinical evidence to support use.
- Flu prevention is important to patients and seems appropriate for this program.

Patient Health Journey

- Flu vaccination at discharge could support a healthy transition out of the hospital and prevent avoidable readmissions, which are important to patients.



Concern Themes

Meaningfulness

- Measure needs the ability to add a tracking mechanism for vaccine refusals to distinguish between hesitancy and missing data.
- Measure needs updated validity testing data.

Influenza Immunization Received for Current Flu Season
Closing Gaps of Care Considerations

- Rural facilities may have less-robust vaccination protocols and less staff training as compared to urban facilities.[1]
- Dual-eligible patients may have higher rates of influenza immunization due to more frequent health care interactions and coverage for preventive services. Fragmented care can still result in missed opportunities for vaccination.[2]
- Disparities in vaccination rates are linked to mistrust of health care, cultural beliefs, lower access to preventive care, and differences in provider recommendation.[3]
- Language barriers can impede communication about vaccine benefits, consent, and follow-up.[4]

1. Schaffer DeRoo, S., & Limaye, R. J. (2024). Culturally aware vaccine promotion: Evidence-based communication strategies for healthcare professionals. *American Journal of Public Health*, *114*(3), 234–240. https://doi.org/10.2105/AJPH.2023.307456
2. Roberts, E. T., Spanko, A., & Trivedi, A. N. (2024). Integrated care programs for dual-eligible beneficiaries: A systematic review. *Health Services Research*, *59*(2), 145–158. https://doi.org/10.1111/1475-6773.14123
3. Shen, A. K., & Orenstein, W. A. (2020). Fragmented Medicaid vaccine coverage and reimbursement: Challenges to adult immunization. *Health Affairs*, *39*(2), 297–304. https://doi.org/10.1377/hlthaff.2019.01061
4. Schaffer DeRoo, S., & Limaye, R. J. (2024). Culturally aware vaccine promotion: Evidence-based communication strategies for healthcare professionals. *American Journal of Public Health*, *114*(3), 234–240. https://doi.org/10.2105/AJPH.2023.307456

Break

Please return by 3:15 PM

Left Without Being Seen

00410-01-C-HOQR

Left Without Being Seen
Measure Overview

Brief Description of Measure: Percent of patients who leave the emergency department (ED) without being evaluated by a physician/advanced practice nurse/physician's assistant (physician/APN/PA).

Measure Steward: Louisiana State University

CMS-Provided Rationale: We are proposing to remove this measure, and the Median Time for Discharged ED Patients measure, beginning with the CY 2028 reporting period/2030 payment determination, contingent upon finalization of adoption of the Emergency Care Access and Timeliness (ECAT) electronic clinical quality measure (eCQM).These changes are the result of growing concerns about the quality and timeliness of care in the ED as well as the burden associated with two chart-abstracted ED measures.

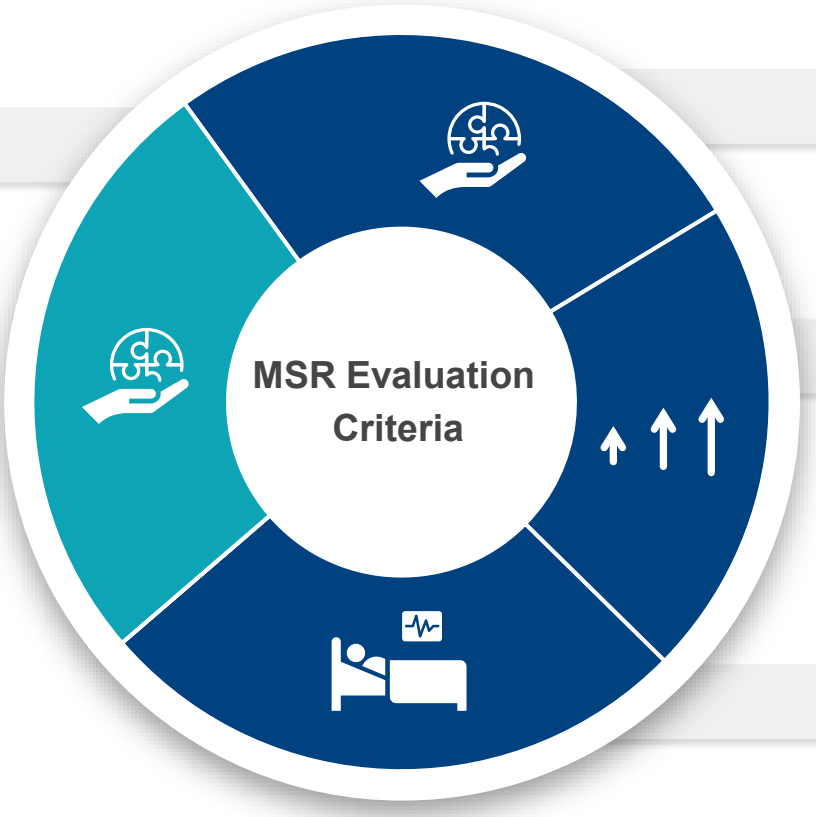
Program Use	Measure Type	Level of Analysis	CBE Endorsement Status and History
Hospital Outpatient Quality Reporting Program	Structure	Facility/Hospital/ Agency	Endorsement Removed in 2012; Initial Endorsement in 2008

Left Without Being Seen
PIE Form Summary

Support Themes

Meaningfulness

- Measure is important for capturing data on patients who leave the ED prematurely, especially among underserved populations.



Concern Themes

Meaningfulness

- Measure lacks current CBE endorsement.

Data Stream Parsimony

- This measure is duplicative, as CMS has proposed a more comprehensive replacement measure.
- While data collection is attainable, existing processes may need adaptation, and workload may increase with potential measure overlap.

Patient Health Journey

- Measure should be replaced with a more holistic version that better aligns with patient journey.

Left Without Being Seen
Closing Gaps of Care Considerations

- Urban EDs generally have higher LWBS rates than rural EDs, largely due to higher patient volumes, overcrowding, and longer wait times.[1]
- Dual-eligible patients often have complex health and social needs, which can contribute to longer wait times and increased frustration.[2]
- Younger adults are more likely to LWBS than older adults.[3]
- Non-English-speaking patients are more likely to LWBS, likely due to communication barriers, difficulty navigating the ED, and longer wait times for interpreter services.[4]

1. Greenwood-Ericksen, M. B., & Kocher, K. (2019). Trends in emergency department use by rural and urban populations in the United States. *JAMA Network Open*, *2*(4), e1920472. https://doi.org/10.1001/jamanetworkopen.2019.20472
2. Silvestri, D., Goutos, D., & Lloren, A. (2022). Factors associated with disparities in hospital readmission rates among US adults dually eligible for Medicare and Medicaid. *JAMA Health Forum*, *3*(1), e214611. https://doi.org/10.1001/jamahealthforum.2021.4611
3. Evans, C. S., Turer, R. W., Hanna, J. J., Pendley, E., & Medford, R. J. (2024). Emergency department return visits after having left without being seen. *JAMA*, *333*(9), 881–883. https://doi.org/10.1001/jama.2024.881
4. Taira, B. R. (2018). Improving communication with patients with limited English proficiency. *JAMA Internal Medicine*, *178*(5), 605–606. https://doi.org/10.1001/jamainternmed.2018.0373

Median Time from ED Arrival to ED Departure for Discharged ED Patients

00427-01-C-HOQR

Median Time from ED Arrival to ED Departure for Discharged ED Patients
Measure Overview

Brief Description of Measure: Median time from emergency department arrival to time of departure from the emergency room for patients discharged from the emergency department.

Measure Steward: CMS

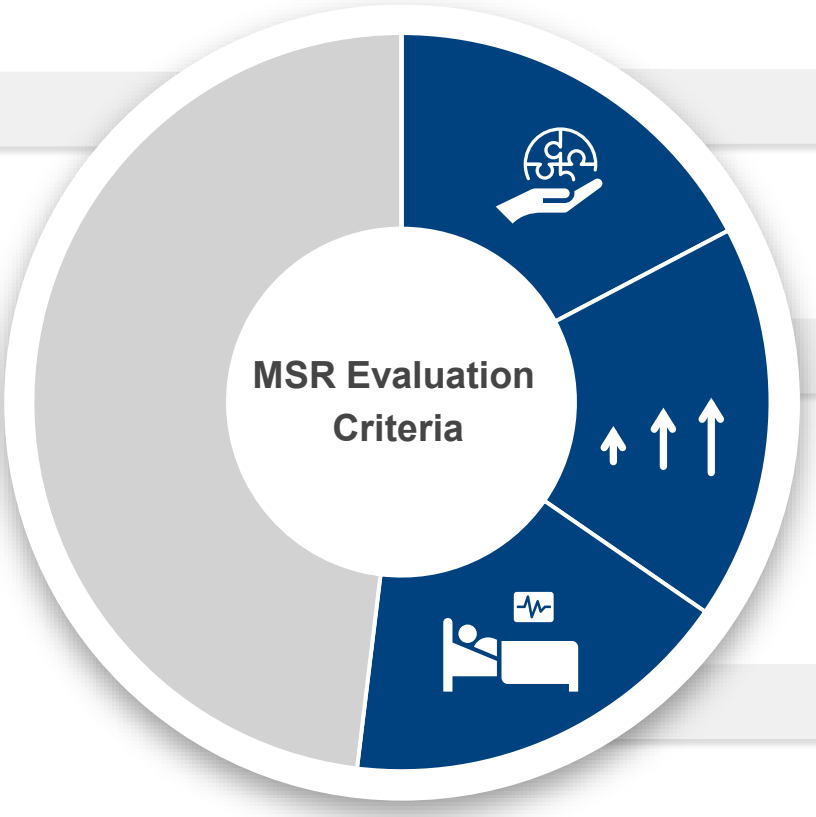
CMS-Provided Rationale: We are proposing to remove this measure, and the Median Time for Discharged ED Patients measure, beginning with the CY 2028 reporting period/2030 payment determination, contingent upon finalization of adoption of the Emergency Care Access and Timeliness (ECAT) electronic clinical quality measure (eCQM).These changes are the result of growing concerns about the quality and timeliness of care in the ED as well as the burden associated with two chart-abstracted ED measures.

Program Use	Measure Type	Level of Analysis	CBE Endorsement Status and History
Hospital Outpatient Quality Reporting Program	Process	Facility/Hospital/ Agency	Endorsement Removed in 2020; Initial Endorsement in 2008

Median Time from ED Arrival to ED Departure for Discharged ED Patients
PIE Form Summary

Support Themes

No support



Concern Themes

Meaningfulness

- Measure lacks current CBE endorsement.
- The measure overlaps with a newly proposed CMS measure and may no longer be necessary.

Data Stream Parsimony

- Duplicative of a new measure, Emergency Care Access and Timeliness electronic clinical quality measure (eCQM).

Patient Health Journey

- CMS has developed and proposed a new measure that better handles emergency room wait time and crowding, the Emergency Care Access and Timeliness eCQM.

Median Time from ED Arrival to ED Departure for Discharged ED Patients
Public Comment Summary

Support Themes

- The measure is one of only two measures on ED care in HOQR.
- Evidence that boarding harms patients and leads to worse outcomes, compromises patient privacy, increases medical errors and mortality, and results in delays in care.
- Financial burden – recent study found that daily ED boarding costs were ~2 times higher than daily inpatient costs for stroke patients.
    - Total daily cost for medical/surgical boarding was $1,856, compared to $993 for medical/surgical inpatient care.

Median Time from ED Arrival to ED Departure for Discharged ED Patients
Closing Gaps of Care Considerations

- Uninsured patients may experience longer ED stays, often due to delays in diagnostic testing, lower triage priority, or challenges in arranging follow-up care.[1]
- Older adults may experience longer ED stays due to more complex medical evaluations, polypharmacy, and need for social support or discharge planning.[2]
- Non-English-speaking patients may experience longer ED stays due to communication barriers, delays in obtaining interpreter services, and challenges in discharge instructions.[3]

1. Roberts, E. T., Duggan, C., & Stein, R. (2024). Quality, spending, utilization, and outcomes among dual-eligible Medicare-Medicaid beneficiaries in integrated care programs: A systematic review. *JAMA Health Forum*, *5*(7), e242187. https://doi.org/10.1001/jamahealthforum.2024.2187
2. Hunt, V. (2025). Older adults are spending too long in the ED—Here's why and what could help. *JAMA*, *334*(7), 560–561. https://doi.org/10.1001/jama.2025.10103
3. Cevallos, J., Lee, C., & Bongiovanni, T. (2024). Use of professional interpreters for patients with limited English proficiency undergoing surgery. *JAMA Network Open*, *7*(2), e2355014. https://doi.org/10.1001/jamanetworkopen.2023.55014

Next Steps

Dr. Meridith Eastman | Battelle

Partnership for
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Partnership for Quality Measurement
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Day 2

Meeting Agenda Day 2

10:00 AM	Welcome and Process Overview
10:15 AM	Measure Review
12:30 PM	Lunch
1:30 PM	Measure Review
3:45 PM	Adjourn

* All times listed in ET

Welcome

Dr. Meridith Eastman | Battelle

Roll Call and Disclosures of Interest

Kate Buchanan | Battelle

MSR Roll Call Day 2

Co-Chairs: Martin Hatlie and Sheila Roman

Maureen Albertson
Reginald Barnes
David Basel
Lyn Behnke
Zahid Butt
April Coxon
Missy Danforth
Tejal Gandhi
Caitlin Gillooley
Sunny Jhamnani
Vera Macon
Julie Marcinek
Erin O'Rourke
Lori Pearlmutter
Cheryl Phillips
Ed Pollak
Amir Qaseem
Koryn Rubin
Jill Shuemaker
Jeffrey Silberzweig
Janice Tufte
Melanie Wascom

Voting Test

Isaac Sakyi | Battelle

Oncology: Medical and Radiation - Pain Intensity Quantified

00474-01-C-MIPS and 00474-02-E-MIPS

Oncology: Medical and Radiation - Pain Intensity Quantified
Measure Overview

Brief Description of Measure: Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified.

Measure Steward: American Society of Clinical Oncology (ASCO)

CMS Provided Rationale: The measure is part of the Medical Oncology Core Quality Measures Collaborative (CQMC) and aligned with the Center for Medicare and Medicaid Innovation (CMMI) Enhancing Oncology Model, which is consistent with the CMS priority to align measures across programs. While both collection types are topped out, they are included in the Advancing Cancer Care MIPS Value Pathway (MVP) as one of four specialty-specific measures and in the Radiation Oncology specialty set. Additionally, they have the new topped-out benchmark applied to allow for more meaningful scoring of measure performance. CMS is encouraging the measure steward to consolidate the two Oncology: Medical and Radiation pain-related measures to offer a single, more robust measure.

Program Use	Measure Type	Level of Analysis	CBE Endorsement Status and History
Merit-based Incentive Payment System	Process	Clinician: Group/Practice	Endorsed with Conditions

Oncology: Medical and Radiation - Pain Intensity Quantified
PIE Form Summary

Support Themes

Meaningfulness

- Pain intensity is meaningful to patients undergoing cancer treatment and should be included in care planning.

Patient Health Journey

- Measure aligns with the cancer care timeline and supports ongoing assessment during treatment.
- Multiple timepoints for pain assessment are relevant to the patient journey.

Concern Themes

Meaningfulness

- The performance on the measure is high with little room for improvement.
- Manual chart abstraction may be required for some data elements, causing burden on the reporting entity.
- The measure has issues with the reliability.

Data Stream Parsimony

- Potential duplication of effort with Plan of Care for Pain measure.

Oncology: Medical and Radiation - Pain Intensity Quantified
Public Comment Summary

Support Themes

- This measure is not duplicative of the Plan of Care for Pain measure (CMIT Measure ID #473)
  - Measures are intended to be paired and implemented sequentially to achieve a comprehensive clinical outcome: this measure confirms the patient's pain was evaluated while CMIT Measure ID #473 validates that a patient care plan for pain was developed based on assessment and the pain quantification.
- The Pain Intensity Quantified Measure was Recently re-endorsed in 2023.
- This measure is high priority in the Advancing Cancer Care MVP.
- Maintain this measure in MIPS to support assessment of cancer-related pain care until a new measure is available.

Oncology: Medical and Radiation - Pain Intensity Quantified
Closing Gaps of Care Considerations

- Rural patients are less likely to have their pain intensity quantified compared to urban patients.[1]
- Uninsured patients are less likely to have their pain intensity quantified.[2]
- Dual-eligible patients may have more complex pain management needs and are at risk for underassessment and undertreatment of pain.[3]

1. Shen, M. J., Stokes, T., Yarborough, S., et al. (2024). Improving pain self-management among rural older adults with cancer. *JAMA Network Open*, *7*(7), e2421298. https://doi.org/10.1001/jamanetworkopen.2024.21298
2. Virk, S. K., Tham, S., Hatef, C., et al. (2025). Acceptability and barriers to chronic pain treatment in refugee torture survivors. *JAMA Network Open*, *8*(8), e2529775. https://doi.org/10.1001/jamanetworkopen.2025.29775
3. Roberts, E. T., Duggan, C., & Stein, R. (2024). Quality, spending, utilization, and outcomes among dual-eligible Medicare-Medicaid beneficiaries in integrated care programs: A systematic review. *JAMA Health Forum*, *5*(7), e242187. https://doi.org/10.1001/jamahealthforum.2024.2187

Oncology: Medical and Radiation - Plan of Care for Pain

00473-01-C-MIPS

Oncology: Medical and Radiation - Plan of Care for Pain
Measure Overview

Brief Description of Measure: Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain.

Measure Steward: American Society of Clinical Oncology (ASCO)

CMS Provided Rationale: MIPS Measure 473 specifically addresses the documented plan of care to address that pain. Quantifying pain is a crucial first step, but without a subsequent, documented plan, the information gathered may not translate into effective patient care. Retaining MIPS Measure 473 emphasizes the necessity of developing and implementing strategies to manage pain, rather than just assessing it.

Program Use	Measure Type	Level of Analysis	CBE Endorsement Status and History
Merit-based Incentive Payment System	Process	Clinician: Group/Practice	Endorsed

Oncology: Medical and Radiation - Plan of Care for Pain
PIE Form Summary

Support Themes

Meaningfulness

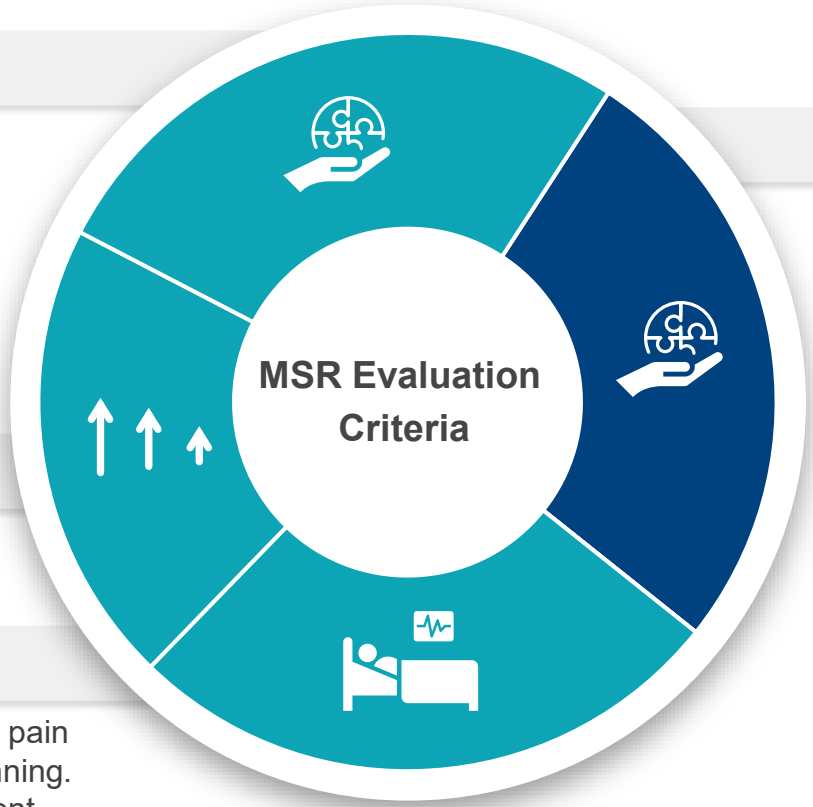
- Assessing and documenting pain for cancer patients is essential for quality care.
- Feasibility seen as high, with minimal burden.
- The measure has strong reliability, validity, and feasibility.

Data Stream Parsimony

- No burden for data collection or reporting.

Patient Health Journey

- Incorporates patient goals, preferences, and pain priorities, elevating patient voice in care planning.
- Broadens pain measures and improves patient experience.
- Fills prior gap in measurement on this topic.



Concern Themes

Meaningfulness

- The measure is meaningful, but it is not optimal in isolation as it does not address the appropriateness of that plan of care for pain nor whether pain has been reduced or relieved.
- Measure may be topped out.

Oncology: Medical and Radiation - Plan of Care for Pain
Public Comment Summary

Support Themes

- This measure is not duplicative of the Pain Intensity Quantified measure (CMIT Measure ID #474)
  - Measures are intended to be paired and implemented sequentially to achieve a comprehensive clinical outcome: CMIT Measure ID #474 confirms the patient's pain was evaluated while this measure validates that a patient care plan for pain was developed based on assessment and the pain quantification.
- The Plan of Care for Pain measure was recently re-endorsed in 2023.
  - Patient/caregivers noted that this was an important measure during the endorsement meeting.
- Plan of Care for Pain is included as a high-priority measure in the Advancing Cancer Care MVP.

Oncology: Medical and Radiation - Plan of Care for Pain
Closing Gaps of Care Considerations

- Rural patients with cancer are less likely to have comprehensive pain assessments.[1]
- Uninsured patients are less likely to have a documented pain management plan due to cost of medications and limited access to pain specialists.[2]
- Dual-eligible patients may have more complex pain management needs and are at risk for underassessment and undertreatment of pain.[3]
- Language barriers can impede pain assessment, shared decision-making, and understanding of pain management options.[4]

1. Shen, M. J., Stokes, T., Yarborough, S., et al. (2024). Improving pain self-management among rural older adults with cancer. *JAMA Network Open*, *7*(7), e2421298. https://doi.org/10.1001/jamanetworkopen.2024.21298
2. Smith, T. J., & Hillner, B. E. (2019). The cost of pain. *JAMA Network Open*, *2*(4), e191532. https://doi.org/10.1001/jamanetworkopen.2019.1532
3. Roberts, E. T., Duggan, C., & Stein, R. (2024). Quality, spending, utilization, and outcomes among dual-eligible Medicare-Medicaid beneficiaries in integrated care programs: A systematic review. *JAMA Health Forum*, *5*(7), e242187. https://doi.org/10.1001/jamahealthforum.2024.2187
4. Joo, H., Fernández, A., Wick, E. C., et al. (2023). Association of language barriers with perioperative and surgical outcomes: A systematic review. *JAMA Network Open*, *6*(7), e2312345. https://doi.org/10.1001/jamanetworkopen.2023.12345

Sentinel Lymph Node Biopsy for Invasive Breast Cancer

00676-01-C-MIPS

Sentinel Lymph Node Biopsy for Invasive Breast Cancer
Measure Overview

Brief Description of Measure: The percentage of clinically node negative (clinical stage T1N0M0 or T2N0M0) breast cancer patients before or after neoadjuvant systemic therapy, who undergo a sentinel lymph node (SLN) procedure.

Measure Steward: American Society of Breast Surgeons

CMS Provided Rationale: CMS proposed this measure for removal from MIPS during PY2026 rulemaking at the measure steward's request as the measure no longer aligns with current clinical guidelines.

Program Use	Measure Type	Level of Analysis	CBE Endorsement Status and History
Merit-based Incentive Payment System	Process	Clinician: Group/Practice	Not Currently Endorsed

Sentinel Lymph Node Biopsy for Invasive Breast Cancer
PIE Form Summary

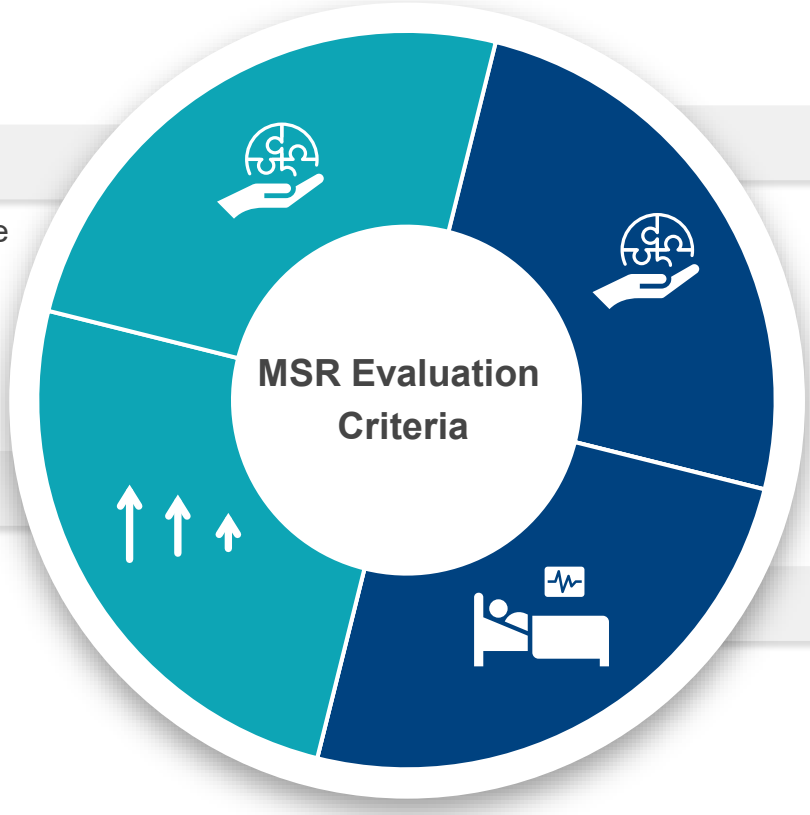
Support Themes

Meaningfulness

- Measure has high feasibility as elements are routinely captured electronically, minimizing burden.

Data Stream Parsimony

- Data are readily available and not duplicative.



Concern Themes

Meaningfulness

- The measure is based on outdated clinical guidelines and no longer aligns with current practice.
- General support for measure removal.

Patient Health Journey

- Not useful for coordination across aspects of the patient care journey or aligned with health journey.

Sentinel Lymph Node Biopsy for Invasive Breast Cancer
Closing Gaps of Care Considerations

- Uninsured patients may present at later stages, have less access to high-quality surgical care, and face financial barriers.[1]
- Some studies have found sentinel lymph node biopsy can be omitted in older patients to reduce complications and improve quality of life.[2]
- Non-English-speaking patients are more likely to have significant delays in definitive surgical management of breast cancer.[3]

1. Martinez, K. A., et al. (2023). Association of insurance status with racial disparities in stage at diagnosis and guideline-concordant treatment of breast cancer. JAMA Oncology, 9(3), 365–373. https://doi.org/10.1001/jamaoncol.2022.7221
2. Di Leone, A., et al. (2025). Omission of sentinel lymph node biopsy in women aged ≥70 years with luminal-type breast cancer and negative axillary imaging: A multicenter prospective study. Cancers, 17(3), 765. https://doi.org/10.3390/cancers17030765
3. Lee, J. Y., et al. (2025). Association of non–English language preference with delays in surgical management of breast cancer. JAMA Network Open, 8(1), e245678. https://doi.org/10.1001/jamanetworkopen.2025.5678

Coronary Artery Disease (CAD): Antiplatelet Therapy

00178-01-C-MIPS

Coronary Artery Disease (CAD): Antiplatelet Therapy
Measure Overview

Brief Description of Measure: Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease (CAD) seen within a 12-month period who were prescribed aspirin or clopidogrel.

Measure Steward: American Heart Association

CMS Provided Rationale: Coronary Artery Disease (CAD): Antiplatelet Therapy is part of the Core Quality Measures Collaborative (CQMC) Cardiology measure set consistent with the CMS priority of alignment across programs. While the measure is in the second year of the topped-out lifecycle, it is included in the Advancing Care for Heart Disease Merit-based Incentive Payment System (MIPS) Value Pathway (MVP) and addresses a CMS priority for management of chronic conditions. CMS analyzes measure annually to ensure meaningful reporting within MIPS.

Program Use	Measure Type	Level of Analysis	CBE Endorsement Status and History
Merit-based Incentive Payment System	Process	Clinician: Individual	Endorsed

Coronary Artery Disease (CAD): Antiplatelet Therapy
PIE Form Summary

Support Themes

Meaningfulness

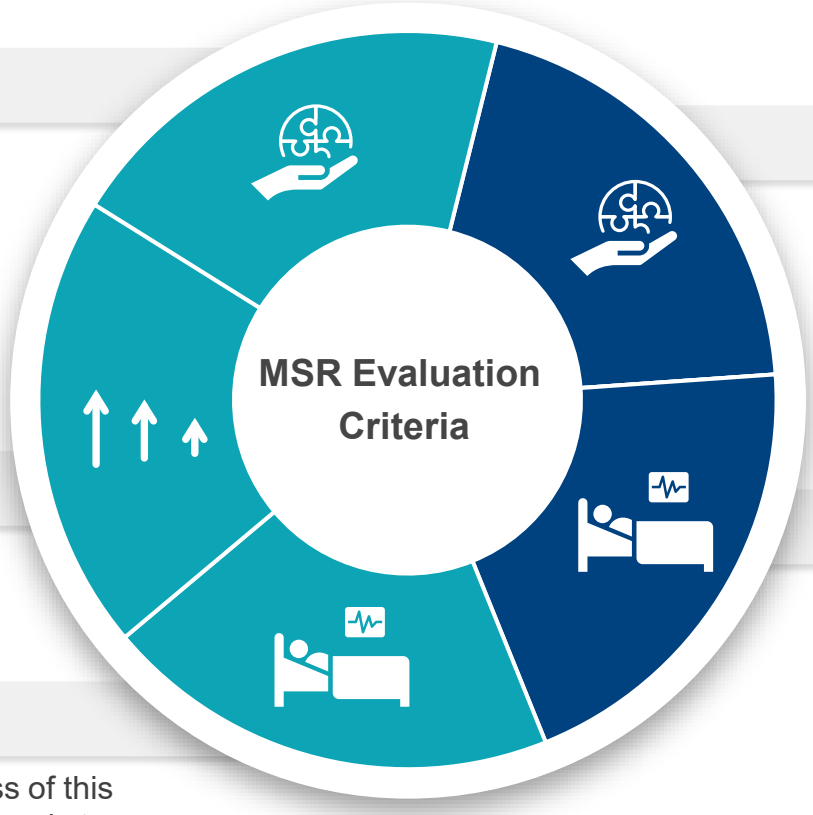
- Measure is clinically important and aligns with established guidelines for coronary artery disease treatment, reinforcing its continued relevance.
- The measure uses readily available EHR data and does not add reporting burden, supporting its feasibility.

Data Stream Parsimony

- Measure uses existing data collection and reporting, demonstrating data stream parsimony.

Patient Health Journey

- “As a patient, I have witnessed the effectiveness of this measure firsthand, and I can confidently say it leads to positive outcomes.”



Concern Themes

Meaningfulness

- The measure may be topped out, with limited variation in performance, reducing its utility for quality improvement.

Patient Health Journey

- Measure should be refined to exclude patients with contraindications or those on anticoagulation to better align with patient journey.

Coronary Artery Disease (CAD): Antiplatelet Therapy
Closing Gaps of Care Considerations

- Rural patients often face reduced access to cardiovascular medications, including antiplatelet therapy.[1]
- Dual-eligible patients may be less likely to receive antiplatelet therapy, often due to complex medical and social needs, polypharmacy concerns, and administrative barriers.[2]
- Older adults are less likely to be prescribed antiplatelet therapy, often due to concerns about bleeding risk, comorbidities, or perceived contraindications.[3]

1. Rao, S. V., O'Donoghue, M. L., Ruel, M., Rab, T., Tamis-Holland, J. E., Alexander, J. H., ... Williams, M. S. (2025). 2025 ACC/AHA/ACEP/NAEMSP/SCAI guideline for the management of patients with acute coronary syndromes: A report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. *Circulation, 151*(e771–e862). https://doi.org/10.1161/CIR.0000000000001309
2. Trifan, G., Gorelick, P. B., & Testai, F. D. (2021). Efficacy and safety of using dual versus monotherapy antiplatelet agents in secondary stroke prevention: Systematic review and meta-analysis of randomized controlled clinical trials. *Circulation, 143*(24), 2441–2453. https://doi.org/10.1161/CIRCULATIONAHA.121.053782
3. Kovacevic, M., Pompei, G., & Kunadian, V. (2023). Tailoring antiplatelet therapy in older patients with coronary artery disease. *Platelets*, *34*(1), 2285446. https://doi.org/10.1080/09537104.2023.2285446

Functional Status Assessments for Heart Failure

00282-05-E-MIPS

Functional Status Assessments for Heart Failure
Measure Overview

Brief Description of Measure: Percentage of patients 18 years of age and older with heart failure who completed initial and follow-up patient-reported functional status assessments.

Measure Steward: CMS

CMS-Provided Rationale: Functional Status Assessments for Heart Failure is a high-priority patient-centered process measure within Merit-based Incentive Payment System (MIPS) and is included in the Core Quality Measures Collaborative (CQMC) measure set. While the measure has low adoption, it has been included in the Advancing Care for Heart Disease MIPS Value Pathway (MVP), which we believe will increase adoption and allow for meaningful reporting of the measure.

Program Use	Measure Type	Level of Analysis	CBE Endorsement Status and History
Merit-based Incentive Payment System	Process	Clinician: Group/Practice	Not Currently Endorsed

Functional Status Assessments for Heart Failure
PIE Form Summary

Support Themes

Meaningfulness

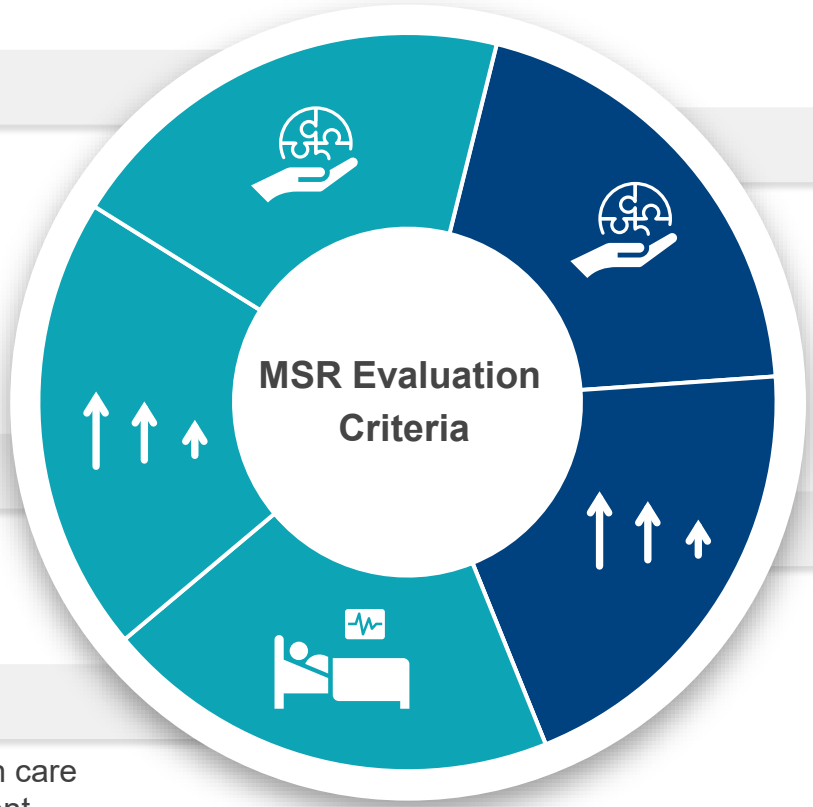
- Measure focuses on clinically meaningful aspect of care, encouraging the use of standardized functional status assessments to guide heart failure management.
- Helps significantly with the emotional component of being diagnosed with heart failure.

Data Stream Parsimony

- Measure would not be burdensome for systems already equipped to capture patient-reported outcome measures (PROMs).

Patient Health Journey

- Measure addresses a previously unmet need in care management and contributes to improved patient outcomes. If removed, there would be a gap in medical care management.



Concern Themes

Meaningfulness

- Low number of entities reporting this measure and lack of performance data available made evaluation difficult.

Data Stream Parsimony

- Adoption challenges could exist for practices that have not yet operationalized PROM workflows.

Functional Status Assessments for Heart Failure
Closing Gaps of Care Considerations

- Rural patients with heart failure are less likely to have documented functional status assessments compared to urban patients.[1]
- Uninsured patients are less likely to receive functional status assessments.[2]
- Older adults are less likely to have formal functional status assessments, often due to cognitive impairment, frailty, or perceived limited benefit.[3]

1. Loccoh, E. C., Maddox, K. E. J., Wang, Y., Kazi, D. S., Yeh, R. W., & Wadhera, R. K. (2022). Rural-urban disparities in outcomes of myocardial infarction, heart failure, and stroke in the United States. *Journal of the American College of Cardiology, 79*(3), 267–279. https://www.acc.org/Latest-in-Cardiology/Journal-Scans/2022/01/19/16/09/Rural-Urban-Disparities-in-Outcomes
2. Seo, V., Baggett, T. P., Thorndike, A. N., Hull, P., Hsu, J., Newhouse, J. P., & Fung, V. (2019). Access to care among Medicaid and uninsured patients in community health centers after the Affordable Care Act. *BMC Health Services Research, 19*, 291. https://doi.org/10.1186/s12913-019-4124-z
3. Tang, K. F., Teh, P. L., & Lee, S. W. H. (2023). Cognitive frailty and functional disability among community-dwelling older adults: A systematic review. *Innovation in Aging, 7*(2), igad005. https://doi.org/10.1093/geroni/igad005

Lunch Break

Please return by 1:30 PM

The PRMR and MSR Guidebook introduces processes and incorporates changes as suggested by interested parties through a public comment period.

The Measures Management System (MMS) Hub is a great plain-language general resource on quality measures.

Become a PQM member – it's free!

Perioperative Temperature Management

00555-03-C-MIPS

Perioperative Temperature Management
Measure Overview

Brief Description of Measure: Percentage of patients, regardless of age, who undergo surgical or therapeutic procedures under general or neuraxial anesthesia of 60 minutes duration or longer for whom at least one body temperature greater than or equal to 35.5 degrees Celsius (or 95.9 degrees Fahrenheit) was achieved within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time.

Measure Steward: American Society of Anesthesiologists

CMS Provided Rationale: CMS proposed removal of the MIPS measure Perioperative Temperature Management during PY2026 rulemaking. The rationale for proposed removal is due to extremely high performance with limited opportunity for continued improvement, indicating the quality action has become a standard of care. The average performance rate is 98.55% per the PY2025 historical benchmark, and the measure has been topped out and capped at 7 points since PY2023. As indicated in the CY2025 Physician Fee Schedule Final Rule, scoring requirements were met for the Topped-Out removal policy and applied for this measure.

Program Use	Measure Type	Level of Analysis	CBE Endorsement Status and History
Merit-based Incentive Payment System	Outcome	Clinician: Group/Practice	Endorsement Removed in 2020; Initial Endorsement in 2015

Perioperative Temperature Management
PIE Form Summary

Support Themes

Meaningfulness

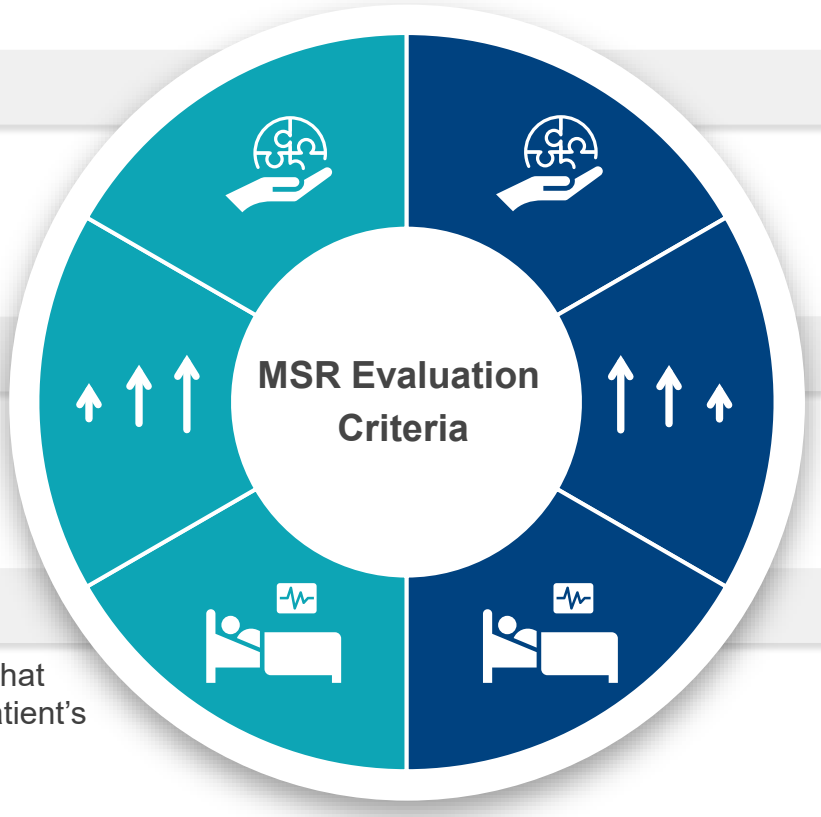
- Measure addresses relevant aspect of care for patients and has an evidence base.

Data Stream Parsimony

- Non-burdensome as data elements are readily available.

Patient Health Journey

- Measure addresses a specific clinical process that could prevent long-term complications in the patient's health care journey.



Concern Themes

Meaningfulness

- Issues with consistent high performance and limited potential for improvement.

Data Stream Parsimony

- May be duplicative if same data elements are used for other measures in reporting.

Patient Health Journey

- The measure is not meaningful to patients "in and of itself" and has value only through relationship to other outcomes.

Perioperative Temperature Management
Closing Gaps of Care Considerations

- Urban hospitals have higher adherence to perioperative temperature management protocols than rural hospitals.[1]
- Dual-eligible patients may be at risk for suboptimal temperature management due to complex health needs and care fragmentation.[2]
- Older adults are at higher risk for perioperative hypothermia due to physiological changes and comorbidities.[3]
- Non-English-speaking patients may be at risk for suboptimal temperature management due to communication barriers affecting preoperative and postoperative instructions.[4]

1. Greenwood-Ericksen, M. B., Kamdar, N., Lin, P., et al. (2021). Association of rural and critical access hospital status with patient outcomes after emergency department visits among Medicare beneficiaries. *JAMA Network Open*, *4*(11), e2134980. https://doi.org/10.1001/jamanetworkopen.2021.34980
2. Kim, H., Senders, A., Cheekati, M., et al. (2025). Medicare and Medicaid plan integration among dual-eligible individuals. *JAMA Network Open*, *8*(7), e2522774. https://doi.org/10.1001/jamanetworkopen.2025.22774
3. Peiris, A. N., Jaroudi, S., & Gavin, M. (2018). Hypothermia. *JAMA*, *319*(12), 1290. https://doi.org/10.1001/jama.2018.0749
4. Joo, H., Fernández, A., Wick, E. C., et al. (2023). Association of language barriers with perioperative and surgical outcomes: A systematic review. *JAMA Network Open*, *6*(7), e2312345. https://doi.org/10.1001/jamanetworkopen.2023.12345

Amyotrophic Lateral Sclerosis (ALS) Patient Care Preferences

00053-01-C-MIPS

Amyotrophic Lateral Sclerosis (ALS) Patient Care Preferences
Measure Overview

Brief Description of Measure: Percentage of patients diagnosed with Amyotrophic Lateral Sclerosis (ALS) who were offered assistance in planning for end-of-life issues (e.g., advance directives, invasive ventilation, lawful physician-hastened death, or hospice) or whose existing end of life plan was reviewed or updated at least once annually or more frequency as clinically indicated (i.e., rapid progression).

Measure Steward: American Academy of Neurology

CMS Provided Rationale: Amyotrophic Lateral Sclerosis (ALS) Patient Care Preferences is a high-priority patient experience of care measure and the only ALS-focused measure within MIPS. While the measure has low adoption, it is included in the Quality Care for Patients with Neurological Conditions MIPS Value Pathway (MVP), which we believe will increase adoption and allow for meaningful reporting of the measure.

Program Use	Measure Type	Level of Analysis	CBE Endorsement Status and History
Merit-based Incentive Payment System	Process	Clinician: Group/Practice	Not Currently Endorsed

Amyotrophic Lateral Sclerosis (ALS) Patient Care Preferences
PIE Form Summary

Support Themes

Meaningfulness

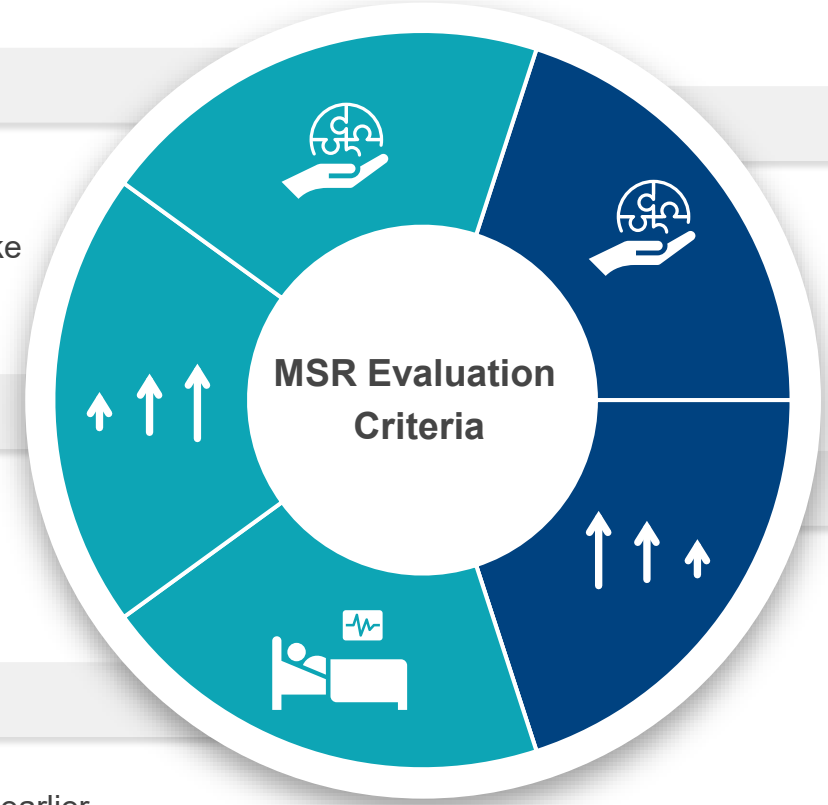
- Valuable from a patient perspective for improving ALS care.
- Measure may reduce costs as people will make medical decisions before they become emergencies and potentially more costly.

Data Stream Parsimony

- Non-burdensome.
- Alignment with other advance care planning metrics will help streamline data collection for this metric.

Patient Health Journey

- Supports patient voice in care planning.
- Promotes active patient/family involvement at earlier times in the journey.



Concern Themes

Meaningfulness

- EHRs may lack structured data fields for documentation of advance care planning.
- Smaller hospitals without interoperability to outpatient facilities may lack documentation needed for this measure.
- Measure has low uptake.

Data Stream Parsimony

- Data collection and reporting may be burdensome in instances of EHRs that lack the appropriate fields for the data required for this measure.

Amyotrophic Lateral Sclerosis (ALS) Patient Care Preferences
Closing Gaps of Care Considerations

- Patients in urban areas with ALS are diagnosed at younger age compared to patients in rural areas.[1]
- Older patients are more likely to have documented care preferences, possibly due to increased awareness of end-of-life issues and more frequent health care interactions.[2]
- Language barriers impede communication about complex care decisions.[3]

1. Hart, A. A., Swenson, A., Narayanan, N. S., & Simmering, J. E. (2024). Rurality modifies the association between symptoms and the diagnosis of amyotrophic lateral sclerosis. *Amyotrophic Lateral Sclerosis and Frontotemporal Degeneration*, *25*(5-6), 517-527.
2. Glass, A. P., et al. (2021). Advance care planning documentation and treatment preferences among older adults in a large integrated health system. *JAMA Network Open, 4*(3), e211317. https://doi.org/10.1001/jamanetworkopen.2021.1317
3. Nguyen, N. V., Guillen Lozoya, A. H., Caruso, M. A., Capetillo Porraz, M. G. D., Pacheco-Spann, L. M., Allyse, M. A., & Barwise, A. K. (2024). Through the eyes of Spanish-speaking patients, caregivers, and community leaders: a qualitative study on the in-patient hospital experience. *International journal for equity in health*, *23*(1), 164. https://doi.org/10.1186/s12939-024-02246-9

Urinary Symptoms Score Change 6-12 Months After Diagnosis of Benign Prostatic Hyperplasia

00741-01-E-MIPS

Urinary Symptoms Score Change 6-12 Months After Diagnosis of Benign Prostatic Hyperplasia
Measure Overview

Brief Description of Measure: Percentage of patients with an office visit within the measurement period and with a new diagnosis of clinically significant Benign Prostatic Hyperplasia who have International Prostate Symptoms Score (IPSS) or American Urological Association (AUA) Symptom Index (SI) documented at time of diagnosis and again 6-12 months later with an improvement of 3 points.

Measure Steward: Large Urology Group Practice Association

CMS Provided Rationale: Urinary Symptom Score Change 6-12 Months After Diagnosis of Benign Prostatic Hyperplasia is an outcome measure that represents a CMS priority of patient-reported outcomes, as this measure evaluates the patient's response regarding their urinary symptoms associated with the diagnosis of benign prostatic hyperplasia (BPH). Clinicians can use results in evaluating whether the patient's symptoms have improved during the 6 to 12 months after diagnosis and treatment of this condition. While this measure has had low adoption in MIPS, it was finalized for PY2025 in the Optimal Care for Patients with Urologic Conditions MVP, which could increase adoption as a specialty-specific measure.

Program Use	Measure Type	Level of Analysis	CBE Endorsement Status and History
Merit-based Incentive Payment System	Patient-Reported Outcome-Based Performance Measure (PRO-PM)	Clinician: Group/Practice	Not Currently Endorsed

Urinary Symptoms Score Change 6-12 Months After Diagnosis of Benign Prostatic Hyperplasia
PIE Form Summary

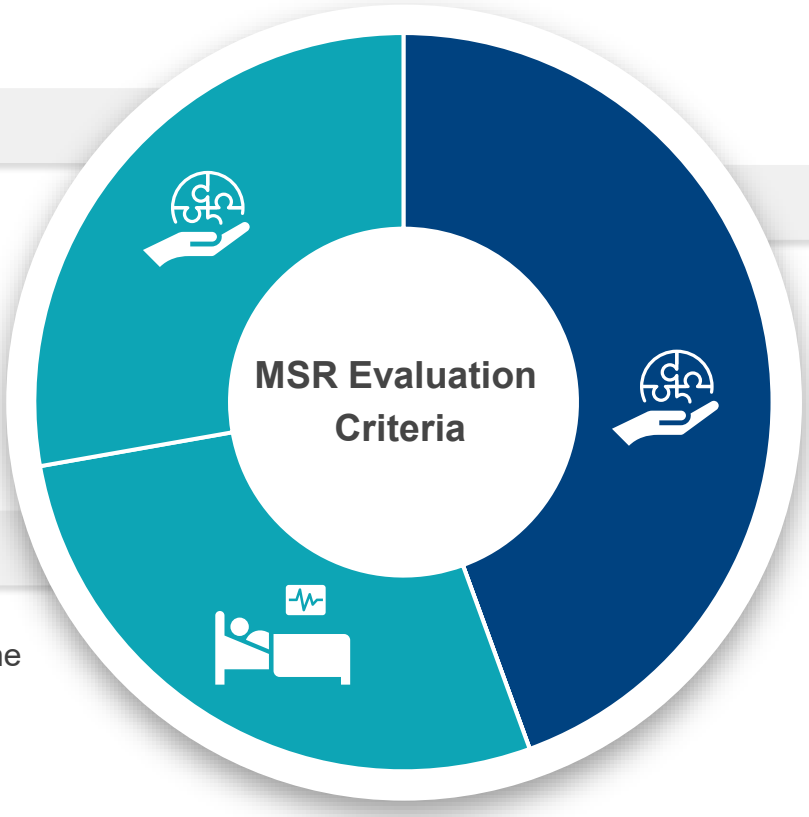
Support Themes

Meaningfulness

- Measure target is important to patients and clinicians.
- Addresses a gap in care for this topic area.
- This measure is a patient-reported outcome performance measure, which is "rare and needed in MIPS."

Patient Health Journey

- Measure can improve outcomes for patients suffering from benign prostatic hyperplasia at the appropriate timepoint for evaluating treatment effectiveness.



Concern Themes

Meaningfulness

- Low number of measured entities reporting on this measure and lack of performance data for evaluation.
- Issues with feasibility, specifically data collection burden and potential EHR workflow modifications.

Urinary Symptoms Score Change 6-12 Months After Diagnosis of Benign Prostatic Hyperplasia
Closing Gaps of Care Considerations

- Benign prostatic hyperplasia increases as men age, increasing the risk of lower urinary tract symptoms.[1]
- Although some assessment tools have been translated into other languages, challenges with translation may arise because of cultural differences.[2]

1. Ng, M., Leslie, S. W., & Baradhi, K. M. (2024, October 20). Benign prostatic hyperplasia. In StatPearls [Internet]. StatPearls Publishing. Retrieved January 2025, from https://www.ncbi.nlm.nih.gov/books/NBK558920/International Continence Society. (2022). Assessment tools for urinary incontinence and quality of life. https://www.ics.org
2. Yao, M. W., & Green, J. S. A. (2022). How international is the International Prostate Symptom Score? A literature review of validated translations of the IPSS, the most widely used self-administered patient questionnaire for male lower urinary tract symptoms. Lower urinary tract symptoms, 14(2), 92–101. https://doi.org/10.1111/luts.12415

Children Who Have Dental Decay or Cavities

00126-02-E-MIPS

Children Who Have Dental Decay or Cavities
Measure Overview

Brief Description of Measure: Percentage of children, 1-20 years of age at the start of the measurement period, who have had dental decay or cavities during the measurement period as determined by a dentist.

Measure Steward: CMS

CMS-Provided Rationale: MIPS CQM #378: Children Who Have Dental Decay or Cavities is a high-priority outcome measure and one of two measures in the Dentistry Specialty Set. While not included within a MIPS Value Pathway (MVP), this inverse measure's performance indicates a continued gap in care with a 2025 Historical Benchmark of 19.97%. Due to the low number of statutorily required dentistry measures available for MIPS reporting, the National Quality Forum (NQF) Measure Applications Partnership conditionally supported removal of this measure once a suitable replacement is found.

Program Use	Measure Type	Level of Analysis	CBE Endorsement Status and History
Merit-based Incentive Payment System	Outcome	Clinician: Group/Practice	Not Currently Endorsed

Children Who Have Dental Decay or Cavities
PIE Form Summary

Support Themes

Meaningfulness

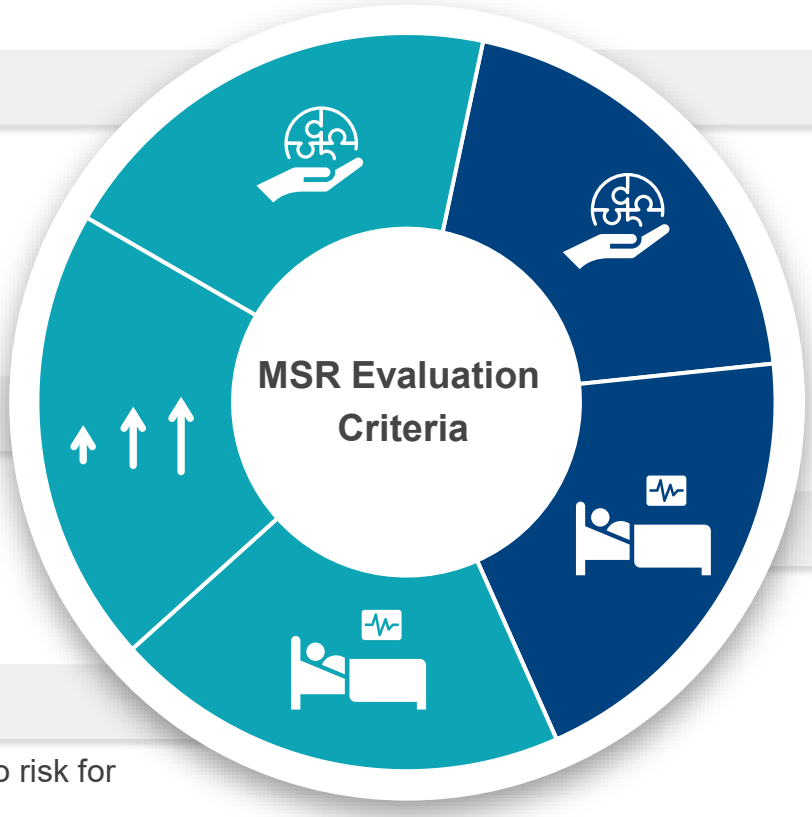
- Data availability and use of existing infrastructure to improve feasibility were seen as beneficial.
- Measure is supported by epidemiologic data and fills a measurement gap on this topic.

Data Stream Parsimony

- Measure is designed to avoid overlapping with other data requests, helping reduce reporting burden and make use of existing hospital workflows efficiently.

Patient Health Journey

- Dental hygiene has been shown to be related to risk for major morbidities, so assessment at this age is appropriate.



Concern Themes

Meaningfulness

- Measure will not include children at risk for dental decay or cavities but who lack regular dental care.
- Dentists may artificially increase their score by “by diagnosing fewer cavities or caring for populations with naturally lower cavity prevalence.”
- Potential confounding; the measure may only be an indicator of wellness in the community rather than a reflection of performance by a particular physician.

Patient Health Journey

- Measure does not measure whether children are receiving timely dental screenings, treatment, or referrals once cavities are found.
- Completion of referrals for dentistry may be challenged by lack of access to services.

Children Who Have Dental Decay or Cavities
Closing Gaps of Care Considerations

- Residents of rural areas often face challenges accessing dental care. The number of dentists per capita is much lower in rural areas compared to urban areas.[1]
- Insurance (especially Medicaid/CHIP) increases access to preventive and restorative dental care, but gaps remain in utilization and provider acceptance.[2]
- About three in five children (60%) aged 6 to 9 years from lower-income households have had cavities in their primary (baby) or permanent teeth, compared with two in five children (40%) from higher-income households.[3]
- Children from non-English-speaking households are more likely to have dental decay.[4]

1. Hedges, I., Flynn, B., Vujicic, M., Smith, A., Ward, L., & Tampio, C. (2024, July). *Improving dental care access for vulnerable populations*. American Dental Association Health Policy Institute & Association of Dental Support Organizations. https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/dental_care_access_vulnerable_populations.pdf
2. Hedges, I., Flynn, B., Vujicic, M., Smith, A., Ward, L., & Tampio, C. (2024, July). *Survey of dentists and Medicaid beneficiaries in eight states*. American Dental Association Health Policy Institute. https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/Survey_Dentists_Medicaid_Beneficiaries_Eight_States.pdf
3. Centers for Disease Control and Prevention. *Oral Health Surveillance Report: Dental Caries, Tooth Retention, and Edentulism, United States, 2017–March 2020*. U.S. Dept of Health and Human Services; 2024. Accessed October 17, 2024. https://www.cdc.gov/oral-health/php/2024-oral-health-surveillance-report/index.html
4. Rajbhandari, P., Hall, M., & Berry, J. G. (2025). Disparities in Preventive Care for Children From English- and Non-English-Speaking Households. *Pediatrics*, *155*(6), e2024069651. https://doi.org/10.1542/peds.2024-069651

Feedback on MSR Process

Dr. Meridith Eastman | Battelle

Committee Reflections

Open discussion considering topics like:

- Announcements and communications
- PAs and PIE Forms
- Committee Member Education Meeting
- MSR Recommendation Group Meeting measure discussion and voting process

What went well this cycle?

What could have gone better?

Next Steps

Kate Buchanan | Battelle

Recommendation Report

Following the MSR Recommendation Group review, Battelle synthesizes the results into a report for CMS.

The report includes:

- Committee recommendations and rationale
- Committee and interested parties' concerns or areas of dissent

The report is submitted to CMS and posted on the PQM website.

2025 MSR Timeline

Event	Dates
MSR Recommendation Group Post-Meeting Survey distributed via Forms	10/8/2025
MSR Recommendation Group Meeting Summary published on PQM website	11/5/2025
Final MSR Recommendation Spreadsheet and Report published on PQM website	11/26/2025
MSR Recommendation Spreadsheet open for public comment on PQM website	11/26/2025-12/10/2025

Questions or Comments?

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

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