Partnership for Quality Measurement
Powered by Battelle

National Consensus Development and Strategic Planning for Health Care Quality Measurement

2025-2026 Pre-Rulemaking Measure Review (PRMR) Hospital Listening Session Meeting Summary

January 2026

Prepared by:
Battelle
505 King Avenue, Columbus, Ohio 43201

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.

National Consensus Development and Strategic Planning for Health Care Quality Measurement

Deliverable 2-11: 2025-2026 PRMR Hospital Listening Session Meeting Summary

Prepared by:
Battelle Memorial Institute
505 King Avenue
Columbus, Ohio 43201-2696

Technical POC:
Dr. Nicole Brennan
Project Leader
brennan@battelle.org

Contract POC:
Ms. Shadie Teymourian
Sr. Contracts Manager
teymourian@battelle.org

Submitted to:
Department of Health and Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Technical POC:
Ms. Charlayne Van, JD
Contracting Officer's Representative (COR)
charlayne.van2@cms.hhs.gov

Government Authorized Signatory:
Mr. Scott Filipovits
Contracting Officer (CO)
scott.filipovits@cms.hhs.gov

Shadie Teymourian

Authorized Signatory

Submitted Date: January 15, 2026

Version 1.0 | January 2026 | *The analyses upon which this publication (or document) 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.

Table of Contents

Page

Pre-Rulemaking Measure Review (PRMR) — 2025-2026 Hospital Committee Listening Session Meeting Summary

Battelle virtually convened 164 attendees for the Hospital Committee Listening Session on **January 6, 2026, from 1:00-2:00 PM ET**. During this session, attendees provided spoken public comment and asked questions on measures considered for inclusion in the following programs:

- Ambulatory Surgical Center Quality Reporting Program
- End-Stage Renal Disease Quality Incentive Program
- Hospital-Acquired Condition Reduction Program
- Hospital Inpatient Quality Reporting Program
- Hospital Outpatient Quality Reporting Program
- Hospital Readmissions Reduction Program
- Hospital Value-Based Purchasing Program
- Inpatient Psychiatric Facility Quality Reporting Program
- Medicare Promoting Interoperability Program
- Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program
- Rural Emergency Hospital Quality Reporting Program

Attendees of the listening session included members of the public, developers and stewards of measures being discussed, Centers for Medicare & Medicaid Services (CMS) staff, and interested PRMR committee members. The measures are from the 2025 Measures Under Consideration (MUC) List, a list of quality and efficiency measures under consideration for future rulemaking.

Welcome and Introductions

Kate Buchanan, PRMR deputy task lead, welcomed participants to the listening session and encouraged them to provide spoken comments during the listening session and written comments on the Partnership for Quality Measurement (PQM) website by January 6, 2026, at 11:59 PM ET. Ms. Buchanan explained that the purpose of the session was to provide feedback on measures proposed for various CMS quality reporting and value-based programs. Ms. Buchanan shared the guidelines for the session, provided instructions on the Zoom interface, and defined common acronyms that might be used throughout the meeting. A list of acronyms can be found on the PQM glossary page.

Opening Remarks from the Centers for Medicare & Medicaid Services

Dr. Ronald Kline, Chief Medical Officer of the Quality Measurement and Value-based Incentives Group (QMVIG) at the Center for Clinical Standards and Quality (CCSQ) at CMS, expressed gratitude to attendees for taking the time to share their thoughts and experiences. Dr. Kline framed the listening session as a collaborative, stakeholder-driven part of a year-round

 The analyses upon which this publication (or document) 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.

measurement process, with the CMS MUC Entry/Review Information Tool (MERIT) process occurring in May, and CMS carefully considering which measures to move forward. Dr. Kline reiterated CMS's appreciation of the public's judgment, experience, and knowledge in ensuring that the measures are as good as they can be. Dr. Kline emphasized that quality measurement is a participatory activity and highlighted the importance of diverse perspectives in refining measures.

Dr. Michelle Schreiber, deputy director for quality and value at the CCSQ and the director of the QMVIG at CMS, emphasized the centrality of the patient voice and CMS's deep appreciation of patient input.

PRMR Process Overview

Ms. Buchanan provided a brief overview of the PRMR process to inform attendees how the feedback obtained during the session culminates in recommendations to CMS on the use measures in Medicare quality programs. She noted that the goal of PRMR is to build consensus recommendations on MUC List measures for inclusion in CMS quality reporting and value-based programs. Committees of interested parties including clinicians, patients, professional associations, researchers, and others meet to evaluate measures on the MUC List based on whether they are:

- Meaningful
- Tailored to a unique program and population need
- Balanced and scaled to meet program-specific goals
- Demonstrate a clear vision of near- and long-term program impacts.

Ms. Buchanan indicated that the PRMR process is divided into three major steps, with public comment falling into the second step, Analysis and Feedback. During this step, Battelle collects written and spoken public comments and shares them with CMS and PRMR committee members to consider when they decide on recommendations for measure use. Attendees can review the PRMR and Measure Set Review (MSR) Guidebook for additional detail on the PRMR process.

Roundtable: Administration Priorities for Quality Measurement

Ms. Buchanan introduced the Roundtable Administration Priorities for Quality Measurement. CMS included a set of measures and measure concepts in the MUC List overview on which they are also accepting comments. These highlighted measures align with Make America Healthy Again (MAHA) priorities, and CMS is interested in hearing whether these measures and measure concepts should be specified and expanded for use in additional programs. Attendees were able to provide comments on this set as well.

PRMR Hospital Committee Measures

MUC2025-036 Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction (AMI) Hospitalization

This measure did not receive public comments during this session.

 The analyses upon which this publication (or document) 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.

MUC2025-037 Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Heart Failure (HF) Hospitalization

This measure did not receive public comments during this session.

MUC2025-040 Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization

This measure did not receive public comments during this session.

MUC2025-044 Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Pneumonia (PN) Hospitalization

This measure did not receive public comments during this session.

MUC2025-046 Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) Surgery

This measure did not receive public comments during this session.

MUC2025-053 Excess Days in Acute Care (EDAC) After Hospitalization for Diabetes

This measure did not receive public comments during this session.

MUC2025-030 Excess Days in Acute Care (EDAC) after Hospitalization for Acute Myocardial Infarction (AMI)

One commenter asked for clarification on the substantive change and expressed support for adding Medicare Advantage (MA) data while acknowledging that there are health plan dynamics outside the hospital's control.

Another commenter agreed that MA data are important and noted that MA data need to be separated from traditional Medicare data to truly know the outcomes of each population.

CMS confirmed the addition of MA data as a substantive change and clarified that the measure would report one score.

The measure developer described risk-adjustment updates, including an MA indicator and ICD-10 specificity. The developer also confirmed ICD-10-based risk modeling and CMS's migration to open-source tooling with public methodology reports and software availability.

MUC2025-031 Excess Days in Acute Care (EDAC) after Hospitalization for Heart Failure (HF)

This measure did not receive public comments during this session.

MUC2025-039 Excess Days in Acute Care (EDAC) after Hospitalization for Pneumonia

This measure did not receive public comments during this session.

MUC2025-072 Emergency Care Access & Timeliness (ECAT)

One commenter expressed approval of this measure, stating that the measure focuses on a significant, nationwide issue that impacts patients with existing rare or chronic conditions. They shared their perspective that without a measure addressing this issue, proper improvements cannot be implemented.

Another commenter raised feasibility concerns during seasonal surges such as the current flu epidemic, noting that the measure targets might be unachievable. They stated that hospitals can try as much as they can to expedite discharges but there are many circumstances outside of their control, for example, a lack of inpatient beds.

One commenter shared their concern with this measure possibly being used for value-based purchasing programs. They stated that backlog and boarding are issues resulting from a shortage of mental health care beds, skilled nursing facilities, and hospice centers, which makes rapid discharge challenging. They emphasized that the issue extends beyond emergency room inefficiency and affects the broader community and other facilities.

A commenter expressed support for efforts to improve timely, private care in the emergency department (ED); however, they indicated that this measure would add significant pressure to an already strained workforce and further contribute to burnout and turnover. They stated that delays in room placement are rarely driven by ED workflow alone and are primarily the result of inpatient capacity constraints, psychiatric boarding, and hospital-wide throughput failures, all of which are outside of the ED's control. They recommended that this measure be framed as a system-wide or inpatient metric, not an ED performance measure. The commenter cautioned that without this distinction, the measure risks penalizing ED teams for structural barriers they cannot resolve and may incentivize unsafe workarounds that compromise both patient safety and staff well-being.

CMS emphasized that boarding is a fundamental safety concern and expressed their hope that bringing this measure forward will drive organization to pay more attention to the issue.

Another commenter asked whether the substantive change to the measure was the addition of MA data. CMS confirmed that this was correct, highlighting the importance of capturing as much data as possible, particularly with increasing shift from Medicare fee-for-service to MA.

MUC2025-067 Hospital Harm - Postoperative Venous Thromboembolism

This measure did not receive public comments during this session.

MUC2025-016 Excess Antibiotic Duration for Adult Hospitalized Patients with Uncomplicated Community-Acquired Pneumonia

This measure did not receive public comments during this session.

MUC2025-019 Inappropriately Broad Empiric Antibiotic Selection for Adult Hospitalized Patients with Uncomplicated Community-Acquired Pneumonia

This measure did not receive public comments during this session.

MUC2025-055 Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Sepsis Hospitalization

This measure did not receive public comments during this session.

MUC2025-047 Hospital Sepsis Program Core Elements Score

This measure did not receive public comments during this session.

MUC2025-045 Adult Community-Onset (CO) Sepsis Standardized Mortality Ratio (SMR)

One commenter commended CMS and the measurement community for the structural measure strategy that has been unfolding from year to year. They indicated that this type of measure fills a gap, stating that while outcomes and processes are important, structural measures get to the responsibility of the leadership of an organization to empower its frontline staff, management, and the organization as a whole. They stated that overall, this is a good measure and thanked CMS for relentlessly moving this strategy forward.

Another commenter echoed their support for the measure and noted their agreement with the previous commenter's perspective.

MUC2025-011 Dialysis Facility Discussion of Patient Life Goals

This measure did not receive public comments during this session.

MUC2025-064 Facility Level Percentage of Chronic Hyperphosphatemia in Dialysis Patients

This measure did not receive public comments during this session.

MUC2025-023 CollaboRATE Shared Decision-Making Tool for Ambulatory or Outpatient Surgery Patients (Surgical CollaboRATE OAS-PM)

One commenter indicated that this measure should hold the physicians who bring the patient for surgery accountable for reporting the measure, not the hospital, describing it as a logistic nightmare.

Another commenter responded to this concern, stating that they are impressed by the flexibility of this measure and that it can be implemented in a variety of ways. They expressed confusion as to why it might be challenging to implement, stating that the measure is short and available in multiple languages.

Several commenters agreed with the concern about hospitals being held accountable for this measure.

Another commenter expressed their support for shared decision-making as it relates to preference-sensitive medicine, stating that shared decision-making has been shown to reduce decisional conflict for patients. However, they shared their concern with this specific measure, arguing that responsibility should rest with the surgeon's office because, once a patient arrives at the hospital for ambulatory surgery, the decision has already been made. At that point, the

patient is undergoing the surgical process; therefore, assigning responsibility for this measure to the surgical team preoperatively risks rote compliance that is not meaningful. The commenter stated that while the measure deserves merit and reconsideration, its implementation belongs in the surgeon's office. They also noted that the measure is not connected to outcomes.

A commenter stated that small rural hospitals do not employ their surgeons and reiterated that the measure should be provider based rather than hospital based.

Another commenter suggested moving the measure to a more appropriate program, stating that while the rationale is sound, it should not be used in a hospital program.

A commenter agreed with the concerns expressed by others, stating that the measure is important but would likely be more valuable if implemented earlier in the patient journey.

One commenter shared their perspective that if the measure is going to be in the hospital setting, it should focus on emergency surgeries. They indicated that outpatient procedures should be measured in the surgeon's office.

One commenter asked about potential survey volume burden while another commenter sought clarity on who would administer the tool.

The measure developer reported that reliability was similar under surgeon and facility attribution with facilities more likely to meet volume thresholds.

Another commenter indicated that they were pleased to see a shared decision-making measure but agreed with the comments about the appropriateness of the measure as a hospital measure. They also questioned the inclusion in the numerator of offering the three-question tool, stating that the measure could be easily manipulated and might result in a superficial offering to patients simply to obtain a positive survey response.

MUC2025-065 Malnutrition Care Score

One commenter supported the measure's focus on a vulnerable population and the importance of assessing nutrition in the hospital setting, even if screening is not traditionally seen as a primary responsibility of the hospital. They stated that hospitals often serve as places where people seek help for their problems. The commenter reiterated the importance of evaluating nutrition and expressed satisfaction with the introduction of this measure. Several attendees agreed with the points the commenter raised.

Another commenter indicated that this measure is very important but noted that hospitals in rural and medically underserved communities often lack community resources for referrals and often cannot find registered dieticians for evaluations. Another commenter acknowledged the concern about limited resources and shared their perspective that collecting this data will strengthen the evidence for advocacy to policymakers on closing this gap.

Another commenter thanked a previous commenter for articulating the importance of structural measures and expressed the support of their patient advocacy organization for this work. They welcomed patients to participate in advancing patient safety.

A commenter stated that, as a nurse for many years, they have seen patients discharged home with significant weight loss and no follow-up plan because providers do not always recognize this issue.

One commenter inquired about the numerator and denominator for the measure. CMS indicated that this information would be shared in more detail during the Recommendation Group meetings.

Another commenter expressed concern with possible issues implementing this measure in large electronic health records (EHRs). The measure developer clarified the scope and feasibility, stating that the measure focuses on inpatient care and does not include post-discharge elements.

CMS noted typical electronic clinical quality measure (eCQM) implementation phasing to accommodate workflow and data flow challenges, stating that eCQMs are introduced as voluntary and usually have 2 to 3 years before they become mandatory.

MUC2025-020 Advance Care Planning (ACP)

This measure did not receive public comments during this session.

Roundtable: Administration Priorities for Quality Measurement

Discharge Function Score

This measure did not receive public comments during this session.

Malnutrition Care Score (MCS)

See above for comments on MUC2025-065.

Percent of Residents Who Received an Antipsychotic Medication (Long-Stay)

This measure did not receive public comments during this session.

Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

A commenter thanked CMS for including this measure and the Well-Being Signs measure for discussion, as they focus on prevention and holistic care for everyone.

Well-Being Signs

A commenter thanked CMS for including this measure and Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan for discussion as they focus on prevention and holistic care for everyone.

Cross-Measure Comment

With regard to all eCQMs under consideration, one commenter noted that small, rural hospitals need sufficient time (approximately 1 year) to obtain funding and implement electronic medical record changes required for new measures. Many rural hospitals use multiple interoperable electronic health systems. Because of these challenges, rural hospitals are often not yet ready to participate in voluntary reporting periods. The commenter urged CMS to consider this timeline when considering and implementing new eCQMs.

Next Steps

Dr. Meridith Eastman, PRMR task lead, encouraged participants to provide written public comments on the proposed measures by January 6, 2026. She then shared the timeline for the next steps in the process. On January 12-13, 2026, the Hospital Recommendation Group will meet virtually, and the public are welcome to listen. The MAHA-aligned roundtable discussion will take place on January 14, 2026. Following the Recommendation Group meeting, a second public comment period will take place in February. While this public comment period will not change the Recommendation Group votes, it allows for further feedback and data points for CMS to consider in their rulemaking process.

Dr. Eastman encouraged participants to become PQM members and utilize available resources on the PQM website.

Closing Remarks

Dr. Eastman expressed gratitude for the valuable comments, feedback, and dialogue from participants, CMS, and measure developers.

Dr. Schreiber thanked participants for their thoughtful feedback and reaffirmed the importance of patient and stakeholder voices in shaping program decisions.

Version 1.0 | January 2026 | *The analyses upon which this publication (or document) 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.