Partnership for Quality Measurement
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Pre-Rulemaking Measure Review (PRMR) 2025-2026 Hospital Recommendation Group Meeting

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

Brenna Rabel | Battelle

Dr. Meridith Eastman | Battelle

Kate Buchanan | Battelle

Dr. Lydia Stewart-Artz | Battelle

January 12-13, 2026

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Meeting Agenda Day 1

10:00 AM	Welcome and Process Overview
11:15 AM	Measure Review
12:30 PM	Lunch
1:15 PM	Measure Review
5:00 PM	Adjourn

* All times listed in ET

Welcome and Introductions

Brenna Rabel | 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

- CBE: Consensus-Based Entity
- CMIT: CMS Measures Inventory Tool
- CMS: Centers for Medicare & Medicaid Services
- E&M: Endorsement and Maintenance
- EHR: Electronic Health Record
- MERIT: MUC Entry/Review Information Tool
- MSR: Measure Set Review
- MUC: Measures Under Consideration
- PA: Preliminary Assessment
- PIE: Pre-Meeting Initial Evaluation
- PRMR: Pre-Rulemaking Measure Review
- PQM: Partnership for Quality Measurement
- RG: Recommendation Group
- STAR: Submission Tool and Repository

Introductions

Battelle Staff

- Brenna Rabel, MPH, Partnership for Quality Measurement (PQM) Technical Director
- Jeff Geppert, JD, EdM, Measure Science Team Lead
- Dr. Meridith Eastman, PhD, MSPH, PRMR/MSR Task Lead
- Kate Buchanan, MPH, PRMR/MSR Deputy Task Lead
- Dr. Lydia Stewart-Artz, PhD, MHS, PRMR/MSR Evaluation Lead
- Isaac Sakyi, MSGH, PRMR/MSR Lead Analyst
- Dr. Ruth Gatiba, DrPH, PMP, PRMR/MSR Program Manager

Centers for Medicare & Medicaid Services (CMS) Staff

- Dr. Michelle Schreiber, MD, Deputy Director of the Center for Clinical Standards and Quality for the Centers (CCSQ) and the Director of the Quality Measurement and Value-Based Incentives Group (QMVIG)
- Helen Dollar-Maples, RN, Acting Deputy, QMVIG
- Nidhi Singh Shah, MPH, Acting Director, DPMS, CCSQ
- Charlayne Van, JD, CMS Contracting Officer's Representative
- Melissa Gross, BSN, CMS PRMR/MSR Lead
- CMS Medical Officers
- CMS Leads

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).

Hospital Recommendation Group Roll Call

Co-Chairs: Darlene Shelton and Julie Marcinek

Terry Adirim
Rosie Bartel
Marissa Carvalho
Thomas Ciesielski
Caitlin Gillooley
Michelle Doll
Geoff Dougherty
Nick Fitterman
Thomas Frederickson
Martin Hatlie
Sandi Hyde
Abigail Khan
Michael Lane
Stefanie Ledbetter
Merranda Logan
Tilithia McBride
Ann Marie McDonald
Ben McGaugh
Devika Nair
Hien Nguyen
Glorimar Ortiz
Mark Parker
Kathleen Rauch
Jessica Schumacher
Jeffrey Silberzweig
Christopher Wilson

PRMR Hospital Co-Chair Introductions

Darlene Shelton

Dr. Julie Marcinek

CMS Opening Remarks

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

PRMR Process Overview

Dr. Meridith Eastman | Battelle

PRMR Overview

The **PRMR process** builds consensus to recommend measures under consideration (MUCs) for inclusion in CMS quality reporting and value-based programs.

Committees of interested parties evaluate measures on whether they are:

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

PRMR Cycle

The Department of Health & Human Services (HHS) annually publishes a list of measures under consideration (i.e., the MUC List) for future federal rulemaking by December 1.*

The PRMR process results in consensus-based recommendations about MUC List measures for CMS programs.

The PRMR process assesses if a measure is appropriate for use in the intended CMS program(s) and target population(s).

*The MUC List was published on December 15, 2025.

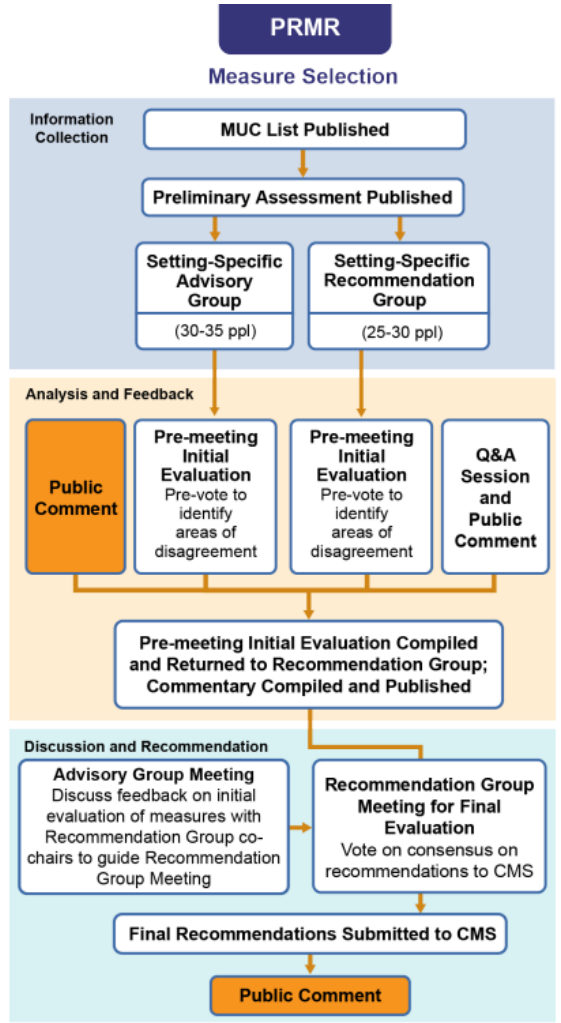
PRMR Process

The PRMR process builds consensus regarding MUC List measures as to whether they are appropriate for consideration for CMS quality reporting programs and value-based programs.

Three major phases:

1. Information collection
2. Analysis and feedback
3. Discussion and recommendation

Complete details on the PRMR process are in the Guidebook of Policies and Procedures for Pre-Rulemaking Measure Review (PRMR) and Measure Set Review (MSR).



PRMR Measure Evaluation

Dr. Lydia Stewart-Artz | Battelle

PRMR Assertions

Meaningfulness: Concept of Interest

- When evaluating meaningfulness of the concept of interest, committees should evaluate whether the measure provides:
  - ✓Evidence that the measure focus is associated with a material outcome for persons and entities (Importance)
  - ✓Measure components and specifications that are designed to align with the intent of the measure focus and target population (Conformance)
  - ✓Demonstration that the tools, process, and people necessary to implement and report on the measure are reasonably available (Feasibility)

PRMR Assertions
(cont., 1)

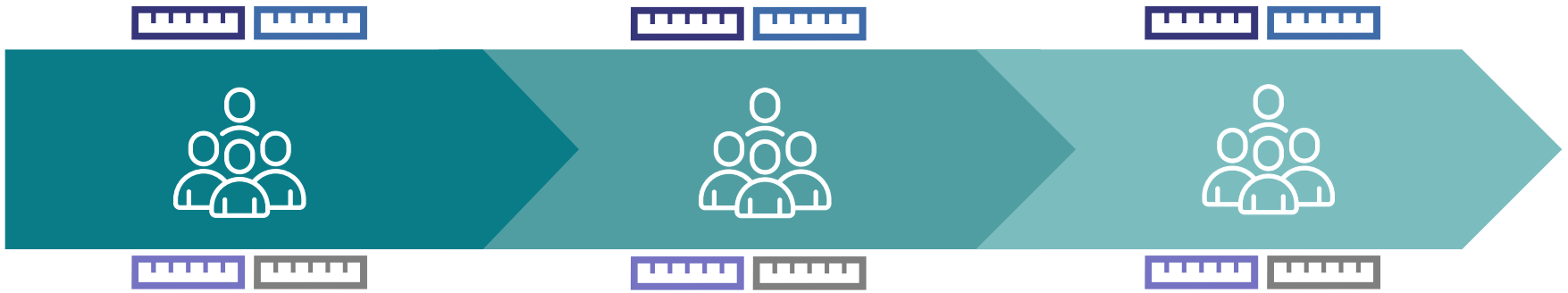
Meaningfulness: Context of Use

- When considering meaningfulness in the context of use, committees should evaluate whether the measure provides:
  - ✓A rationale for why the measure's use in the selected quality program will generate benefits that exceed the costs (Importance)
  - ✓Demonstration through data or logic that there are known and effective ways that the person or entity should use to improve the measure focus (Validity)
  - ✓Demonstration through data that changes in measure performance are due to improvements in quality of care (Reliability)
  - ✓Demonstration that any barriers or facilitators to whether the person or entity could use those ways are known and addressed (Usability)

PRMR Assertions
(cont., 2)

Appropriateness of Scale:

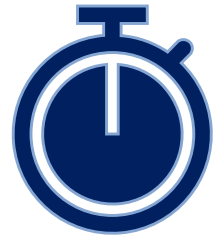
- Is the measure balanced and scaled to meet program-target population-specific goals?
  - ✓Evaluation of the appropriateness of scale assertion considers the evidence about the distribution of benefits and of risks/harms of the measure distributed across subpopulations and how risks/harms of the measure may be mitigated.



PRMR Assertions
(cont., 3)

Time-to-Value Realization:

- Does the measure have a plan for near- and long-term positive impacts on the targeted program and population as measure matures?
  - ✓The time-to-value realization addresses changes in the benefits or harms that may come from measuring something over time.
  - ✓Committees can evaluate the time-to-value realization by considering how the harms and benefits change over time, ways the benefits of the measure might be prolonged, and how potential harms could be prevented.



Preliminary Assessments

- Battelle provided committee members with measure-specific preliminary assessments (PAs).
- PAs include:
  - Descriptive information about measure specification, endorsement, and use
  - CMS-provided rationale for measure inclusion in the CMS program
  - Considerations for statutorily required measure areas and upcoming rulemaking
  - Analysis of most recent past 3-year performance data in CMS program

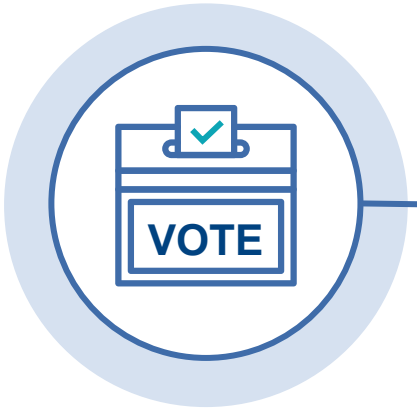
Preliminary Assessment Inputs

- Content submitted through CMS MERIT
- Information in the PQM Submission Tool and Repository (STAR) database
- Results from additional reliability analyses conducted by Battelle, when possible
- Findings from the scientific literature
- Learnings from conversations with measure developers/measure stewards and CMS

PRMR Voting Procedures

Kate Buchanan | Battelle

Voting Procedures

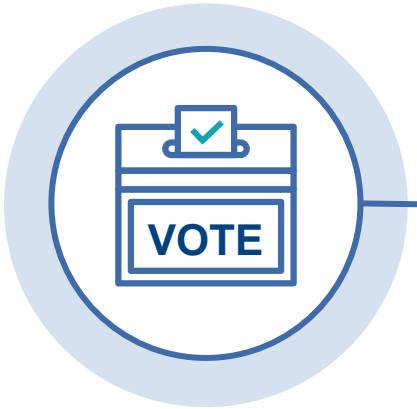


The Battelle moderator will open voting for the measure, and the discussion pauses for 1 minute to begin collection of votes.

RG members may continue voting while the meeting moves to the next measure.

Battelle will track all votes and follow up with any outstanding voters until quorum is reached. The Battelle voting staff will note in the chat when voting closes.

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 minimum of 75% agreement among members.

Online Voting

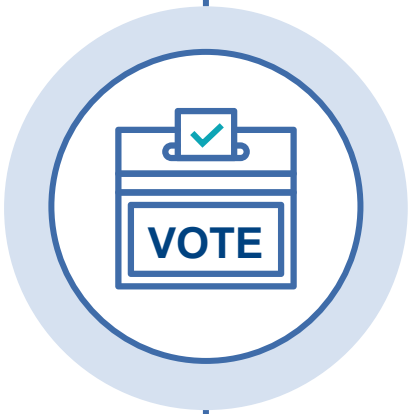
Online voting via Poll Everywhere

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.

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

28 Hospital RG members

Discussion Quorum

- 17 needed to have discussion

Voting Quorum

- 23 members needed to hold vote

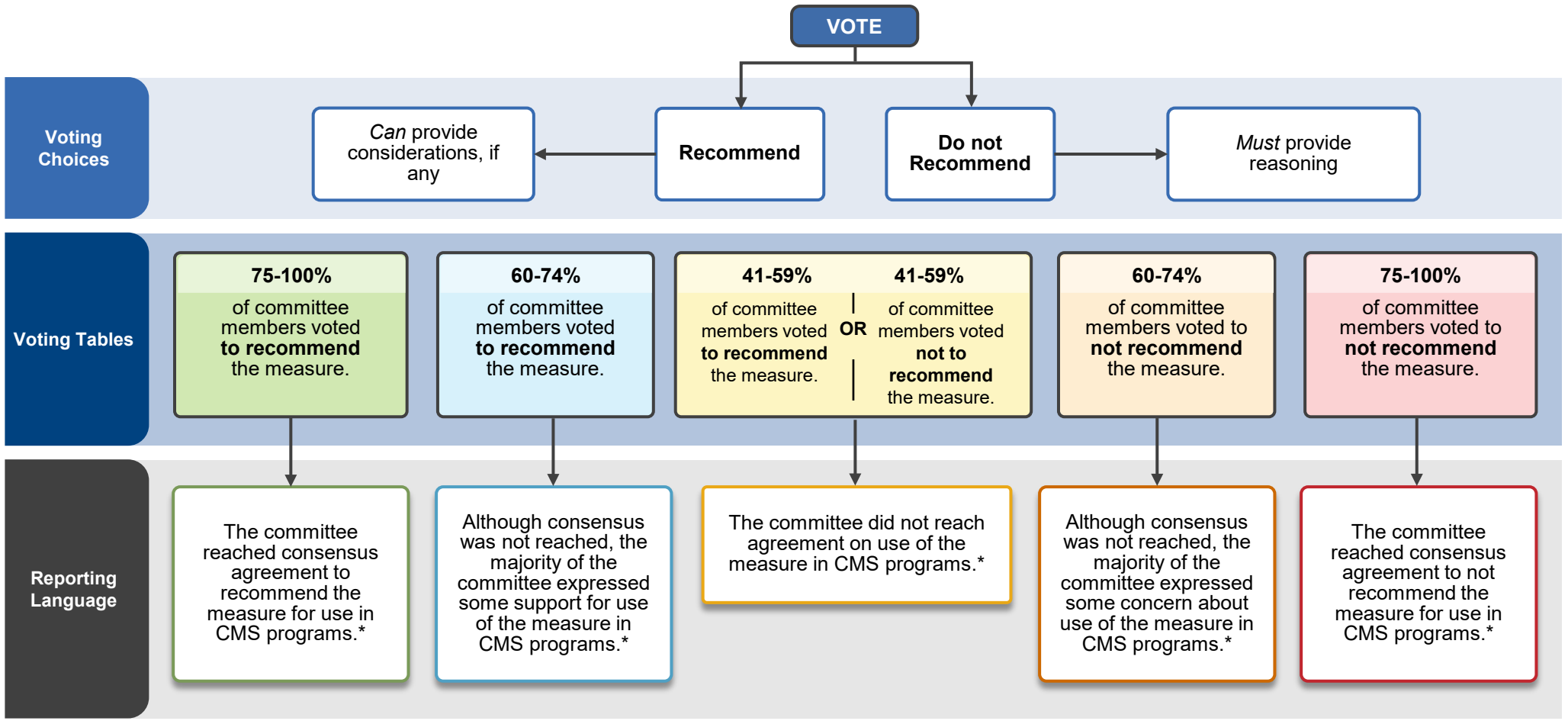
PRMR Recommendation Voting

Committee votes on overall recommendation of the measure

Recommend that the measure be added to the intended CMS program(s)
Committee members can provide considerations for CMS to review prior to implementation.

Do not recommend that the measure be added to the intended CMS program(s)
Committee members must provide reasoning to describe a vote to not recommend.

PRMR Voting

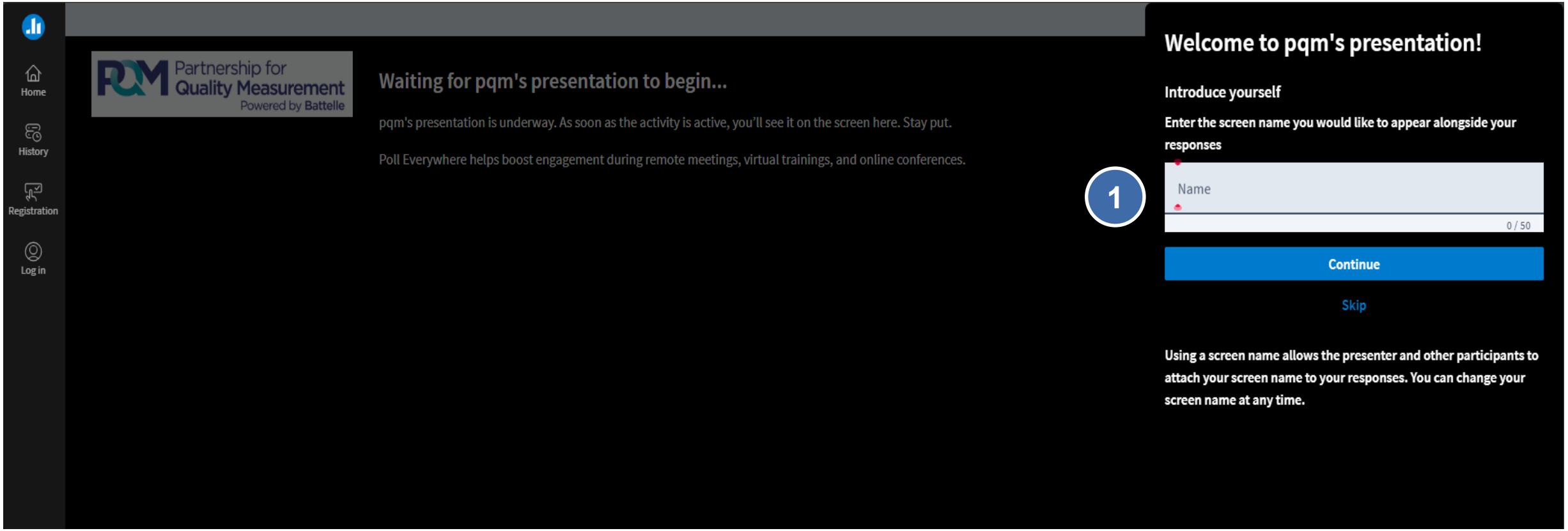


*Battelle will report all considerations for positive votes and all reasons for negative votes.

Voting Test

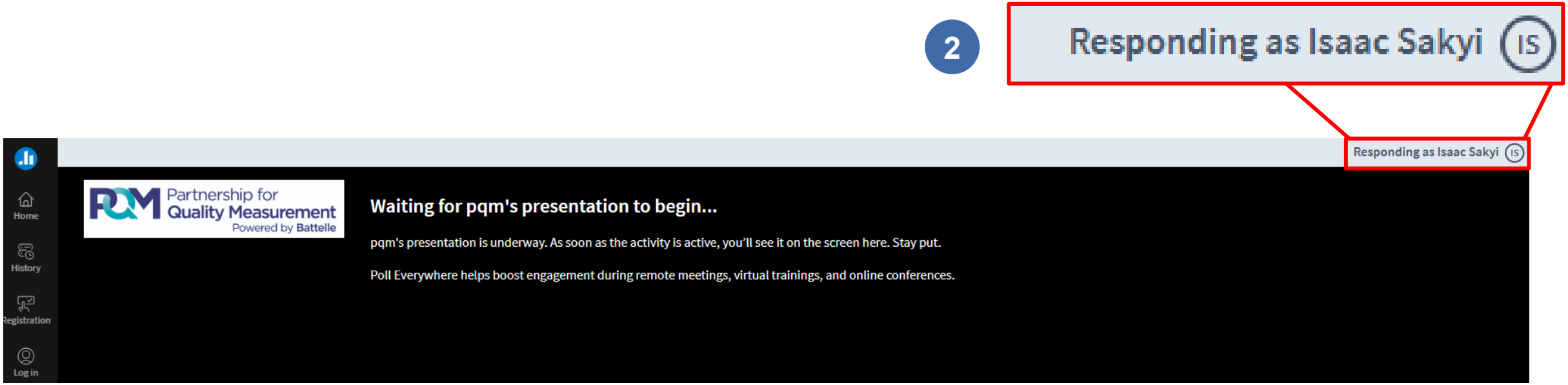
Isaac Sakyi | Battelle

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)*



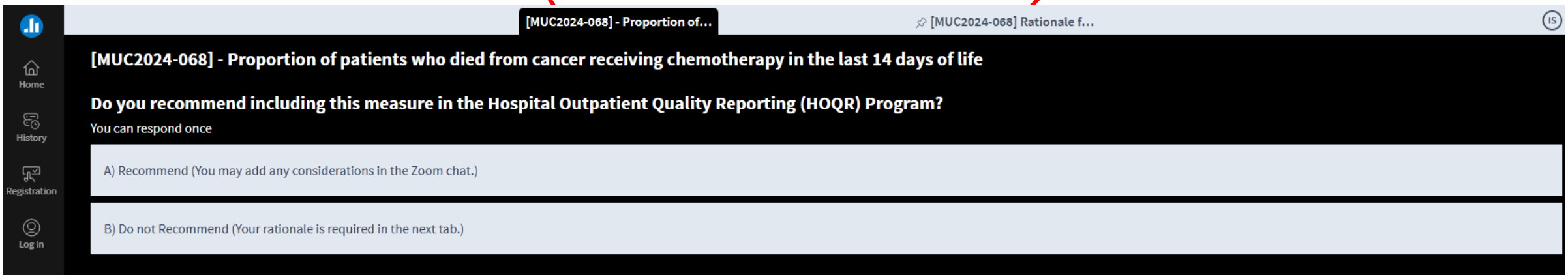
2 Once you enter your name you will see “Responding as First name Last name” followed by your initials.

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

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

3 Select your vote

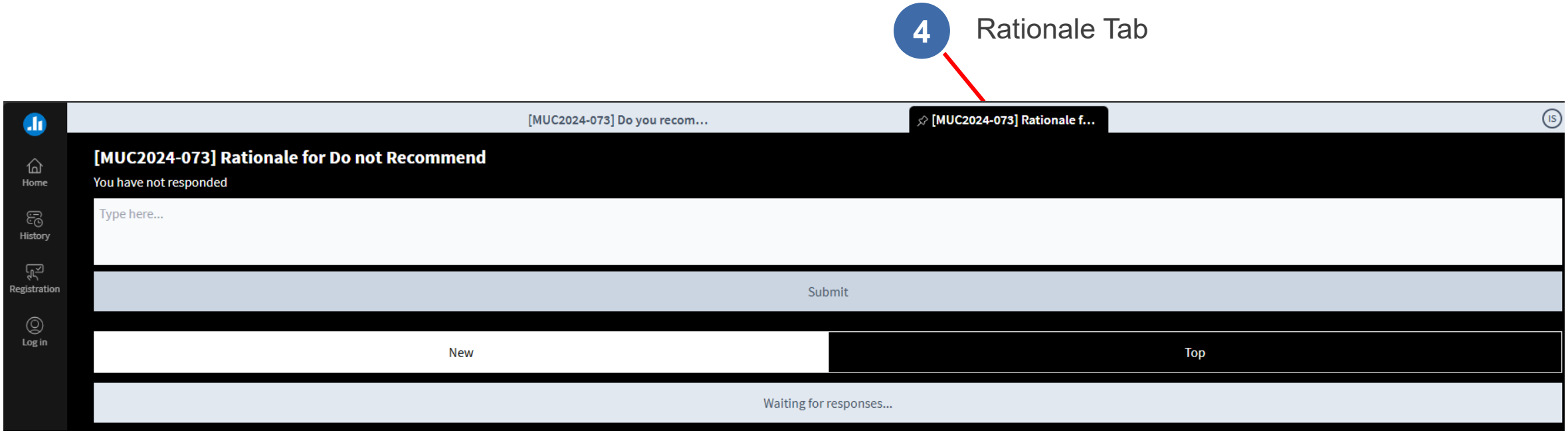
4 Rationale Tab



3 If voting to recommend a measure, you may provide any considerations in the Zoom chat.

4 When voting not to recommend a measure, you are required to document your rationale in the rationale tab.

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



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

Break

Please return by 11:15 AM.

Partnership for Quality Measurement
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PRMR Hospital Recommendation Group Measure Review Day 1

Overview of Public Comments and Closing Gaps of Care Considerations

Dr. Meridith Eastman | Battelle

Summary of Public Comment Period

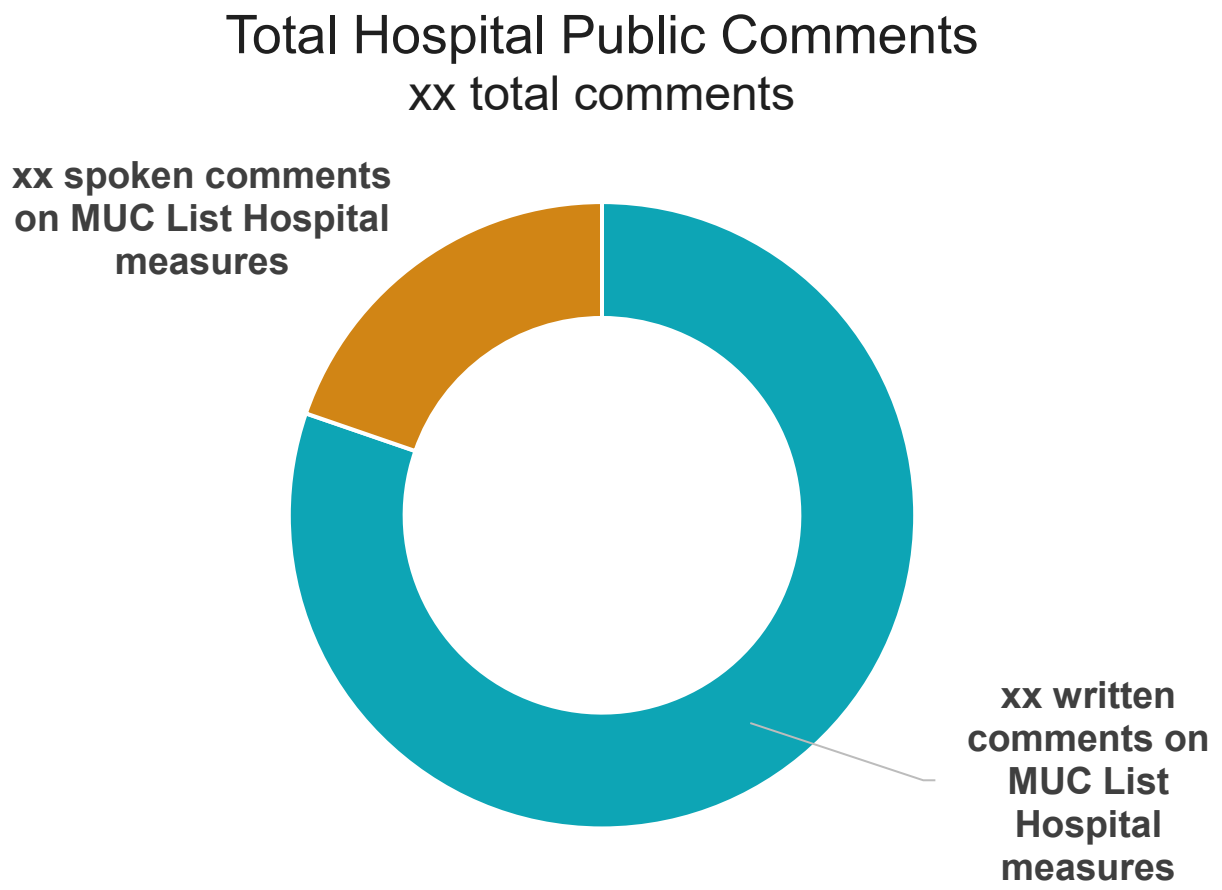
The MUC List contains **24** MEASURES for this cycle

Public comment period from **December 16** to **January 6**

x **Comments received**

* The MUC List was published on December 15, 2025.

Hospital Public Comments



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)
- Dual Medicare and Medicaid eligibility
- Insurance status
- Language/ Literacy

Closing gaps of care is not a PRMR 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.

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

MUC2025-036

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

Item	Description
Measure Description	The measure estimates a hospital-level 30-day risk-standardized mortality rate (RSMR) for Medicare patients (Fee-For-Service [FFS] and Medicare Advantage [MA]) aged 65 and older discharged from the hospital with a principal diagnosis of AMI. The outcome is all-cause 30 day mortality, defined as death from any cause within 30 days of the index admission date, including in-hospital death.
Measure Steward	CMS
CMS-Provided Rationale	Measurement of patient outcomes related to acute myocardial infarction (AMI) risk-standardized mortality rates permits an overall view of care provided by individual hospitals as compared to like facilities with similar patient populations. This process can assist patients and caregivers in evaluating outcomes for specific providers in relation to care and services for AMI. This opportunity provides patients with the opportunity to choose a provider based on their needs and provides hospitals with quality improvement opportunities.
Considered For	Hospital Inpatient Quality Reporting Program Hospital Value-Based Purchasing Program

Measure Type
Outcome
Level of Analysis
Facility
CBE Endorsement Status & History
Initial endorsement 2007; Endorsed during maintenance review in 2020.

Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction, Heart Failure, Chronic Obstructive Pulmonary Disease, Pneumonia, and Coronary Artery Bypass Graft Surgery

Closing Gaps of Care Considerations

	Age	• These measures are risk adjusted by age. • Older patients are more likely to have multiple comorbidities, frailty, and functional limitations, increasing their risk of complications and mortality after AMI.[1] • Elderly heart failure patients who are frail and have multiple comorbidities face a significantly higher risk of hospitalization, rehospitalization, disability, institutionalization, and death.[2] • Frailty increased the incidence of acute exacerbation and hospitalization, as well as increased mortality in older patients with stable COPD.[3] • Elderly patients with pneumonia have a high prevalence of comorbidities and a high in-hospital mortality rate.[4] • Patients over the age of 65 have a significantly higher odds of in-hospital death, symptomatic stroke, and postoperative atrial fibrillation.[5]
	Geography (urban vs. rural)	• Patients presenting to rural hospitals are significantly less likely to receive key procedures for AMI (cardiac catheterization, percutaneous coronary intervention, coronary artery bypass surgery) compared to those at urban hospitals.[6] • Rural facilities employ general cardiologists but are more likely to refer patients elsewhere for heart failure expertise.[7] • Rural COPD patients have decreased access to pulmonary specialists and pulmonary rehabilitation.[8] • The mortality rate for pneumonia is higher in rural areas compared to urban areas.[6]

Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction, Heart Failure, Chronic Obstructive Pulmonary Disease, Pneumonia, and Coronary Artery Bypass Graft Surgery

Closing Gaps of Care Considerations (cont. 1)

	Dual Medicare and Medicaid eligibility	• Those with dual Medicare-Medicaid eligibility have a higher risks of mortality from acute myocardial infarction.[10] • Hospitals with a higher proportion of dual-eligible beneficiaries provide lower rates of key heart failure care processes and have higher 30-day readmission rates.[11]
	Insurance status	• Uninsured individuals have an increased chance of in-hospital mortality and are less likely to use guideline-directed therapies for AMI compared to privately insured individuals.[12] • Patients enrolled in Medicare Advantage (MA) are more likely to be discharged home and less likely to be discharged to skilled nursing facilities or inpatient rehabilitation facilities compared with patients enrolled in fee-for-service (FFS) Medicare.[13] • Medicare-insured individuals have consistently higher all-cause mortality than those insured by Medicaid.[14] • Patients on Medicaid and uninsured patients are at increased risk for postsurgical inpatient mortality following a CABG surgery compared to patients with private insurance.[15]

Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction, Heart Failure, Chronic Obstructive Pulmonary Disease, Pneumonia, and Coronary Artery Bypass Graft Surgery

Closing Gaps of Care Considerations (cont. 2)

	Language/ Literacy	• Low health literacy is common among HF patients and is linked to worse outcomes, including higher hospitalization and mortality rates.[16] • Language differences hinder communication between health care providers and people with COPD from minority ethnic communities.[17] • Patients with Limited English Proficiency (LEP) reported significantly more post-discharge problems than patients proficient in English across all measured domains including difficulty understanding discharge instructions, trouble obtaining prescriptions, and questions about follow-up care.[18] • Patients with language barriers may experience less favorable outcomes after coronary revascularization (percutaneous intervention (PCI) or coronary artery bypass graft).[19]

Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction, Heart Failure, Chronic Obstructive Pulmonary Disease, Pneumonia, and Coronary Artery Bypass Graft Surgery

Closing Gaps of Care Considerations (cont. 3)

References

[1] Zong, M., Guan, X., Huang, W., Chang, J., & Zhang, J. (2023). Effect of Frailty on the Long-Term Prognosis of Elderly Patients with Acute Myocardial Infarction. Clinical interventions in aging, 18, 2021–2029. https://doi.org/10.2147/CIA.S433221

[2] Murad, K., & Kitzman, D. W. (2012). Frailty and multiple comorbidities in the elderly patient with heart failure: implications for management. Heart failure reviews, 17(4-5), 581–588. https://doi.org/10.1007/s10741-011-9258-y

[3]Luo, J., Zhang, D., Tang, W., Dou, L. Y., & Sun, Y. (2021). Impact of Frailty on the Risk of Exacerbations and All-Cause Mortality in Elderly Patients with Stable Chronic Obstructive Pulmonary Disease. *Clinical interventions in aging*, *16*, 593–601. https://doi.org/10.2147/CIA.S303852

[4] Li, S., Li, L., Wang, S., & Wu, H. (2025). Clinical characteristics and risk factors of hospital mortality in elderly patients with community-acquired pneumonia. *Frontiers in medicine*, *12*, 1512288. https://doi.org/10.3389/fmed.2025.1512288

[5]Peric, V., Jovanovic-Markovic, S., Peric, D., Rasic, D., Novakovic, T., Dejanovic, B., & Borzanovic, M. (2015). Quality of Life in Patients of Different Age Groups before and after Coronary Artery By-Pass Surgery. *Annals of thoracic and cardiovascular surgery : official journal of the Association of Thoracic and Cardiovascular Surgeons of Asia*, *21*(5), 474–480. https://doi.org/10.5761/atcs.oa.15-00041

[6]Loccoh, E. C., Joynt Maddox, K. E., 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://doi.org/10.1016/j.jacc.2021.10.045

[7] Rajagopalan, N., Leung, S. W., Craft, R. S., & Bailey, A. L. (2024). Improving Cardiovascular Health in Rural United States: Role of Academic Medical Centers. JACC. Advances, 3(7), 100950. https://doi.org/10.1016/j.jacadv.2024.100950

[8] Diaz Del Valle, F., Koff, P. B., Min, S. J., Zakrajsek, J. K., Zittleman, L., Fernald, D. H., Nederveld, A., Nease, D. E., Hunter, A. R., Moody, E. J., Miller Temple, K., Niblock, J. L., Grund, C., Oser, T. K., Greiner, K. A., & Vandivier, R. W. (2021). Challenges Faced by Rural Primary Care Providers When Caring for COPD Patients in the Western United States. *Chronic obstructive pulmonary diseases (Miami, Fla.)*, *8*(3), 336–349. https://doi.org/10.15326/jcopdf.2021.0215

[9]Barua, O., Karnan, N., Panayanthatta, S., Mansour, M. K., & Milano, C. (2025). Evaluating Disparities in Urban Versus Rural Mortality for Influenza and Pneumonia in the United States Using the CDC-WONDER Database Over a 22-Year Period. *Cureus*, *17*(1), e77475. https://doi.org/10.7759/cureus.77475

[10] Wang, Y., Leifheit, E. C., & Krumholz, H. M. (2022). Trends in 10-Year Outcomes Among Medicare Beneficiaries Who Survived an Acute Myocardial Infarction. JAMA cardiology, 7(6), 613–622. https://doi.org/10.1001/jamacardio.2022.0662

[11] Bahiru, E., Ziaeian, B., Moucheraud, C., Agarwal, A., Xu, H., Matsouaka, R. A., DeVore, A. D., Heidenreich, P. A., Allen, L. A., Yancy, C. W., & Fonarow, G. C. (2021). Association of Dual Eligibility for Medicare and Medicaid With Heart Failure Quality and Outcomes Among Get With The Guidelines-Heart Failure Hospitals. JAMA cardiology, 6(7), 791–800. https://doi.org/10.1001/jamacardio.2021.0611

[12] Vallabhajosyula, S., Kumar, V., Sundaragiri, P. R., Cheungpasitporn, W., Miller, P. E., Harsha Patlolla, S., Gersh, B. J., Lerman, A., Jaffe, A. S., Shah, N. D., Holmes, D. R., Jr, Bell, M. R., & Barsness, G. W. (2022). Management and Outcomes of Acute Myocardial Infarction-Cardiogenic Shock in Uninsured Compared With Privately Insured Individuals. Circulation. Heart failure, 15(5), e008991. https://doi.org/10.1161/CIRCHEARTFAILURE.121.008991

[13]Figueroa JF, Wadhera RK, Frakt AB, et al. Quality of Care and Outcomes Among Medicare Advantage vs Fee-for-Service Medicare Patients Hospitalized With Heart Failure. JAMA Cardiol. 2020;5(12):1349–1357. doi:10.1001/jamacardio.2020.3638

[14]Bazell, C., Alston, M., Feigler, N., Germack, H. D., Leary, S., Fopalan, W., & Mannino, D. (2025). Variation in Prevalence and Burden of Chronic Obstructive Pulmonary Disease by State and Insurance Type in the United States. *Chronic obstructive pulmonary diseases (Miami, Fla.)*, *12*(2), 158–174. https://doi.org/10.15326/jcopdf.2024.0560

[15] Connolly, T. M., White, R. S., Sastow, D. L., Gaber-Baylis, L. K., Turnbull, Z. A., & Rong, L. Q. (2018). The Disparities of Coronary Artery Bypass Grafting Surgery Outcomes by Insurance Status: A Retrospective Cohort Study, 2007-2014. *World journal of surgery*, *42*(10), 3240–3249. https://doi.org/10.1007/s00268-018-4631-9

[16]Ionescu, R., Allen, L. A., Breathett, K., Fowler, B. K., Jackson, E. A., Kundrick, J., Ogunniyi, M. O., & Magnani, J. W. (2025). Health Literacy in Heart Failure: A Review of the Gaps and Challenges. JACC. Advances, 4(3), 101608. https://doi.org/10.1016/j.jacadv.2025.101608

[17]Alamer, S., Robinson-Barellla, A., Cooper, M., Nazar, H., & Husband, A. (2025). Barriers and facilitators of adherence to treatment interventions for COPD amongst individuals from minority ethnic communities: Meta-ethnography. *Plos one*, *20*(2), e0318709.

[18] Malevanchik, L., Wheeler, M., Gagliardi, K., Karliner, L., & Shah, S. J. (2021). Disparities After Discharge: The Association of Limited English Proficiency and Postdischarge Patient-Reported Issues. *Joint Commission journal on quality and patient safety*, *47*(12), 775–782. https://doi.org/10.1016/j.jcjq.2021.08.013

[19]Gupta, A. K., Kleinig, O., Tan, S., Nagarathinam, B., Kovoor, J. G., Bacchi, S., Zaka, A., He, C., Stroebel, A., Beltrame, J. F., Vallely, M. P., Bennetts, J. S., & Maddern, G. J. (2023). Lost in Translation: The Impact of Language Barriers on the Outcomes of Patients Receiving Coronary Artery Revascularization. *Cardiovascular revascularization medicine : including molecular interventions*, *52*, 94–98. https://doi.org/10.1016/j.carrev.2023.03.016

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

Do you recommend including this measure in the Hospital Inpatient Quality Reporting Program?

A. Recommend (You may add considerations in the Zoom chat.)

B. Do not Recommend (Your rationale is required in the next tab.)

Voting on MUC2025-036 Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction (AMI) Hospitalization *(cont. 1)*

Do you recommend including this measure in the Hospital Value-Based Purchasing Program?

A. Recommend (You may add considerations in the Zoom chat.)

B. Do not Recommend (Your rationale is required in the next tab.)

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

MUC2025-037

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

Item	Description
Measure Description	The measure estimates a hospital-level 30-day risk-standardized mortality rate (RSMR) for Medicare patients (Fee-For-Service [FFS] and Medicare Advantage [MA]) aged 65 and older discharged from the hospital with a principal diagnosis of HF. The outcome is all-cause 30 day mortality, defined as death from any cause within 30 days of the index admission date, including in-hospital death.
Measure Steward	CMS
CMS-Provided Rationale	Measurement of patient outcomes related to risk-standardized mortality rates of heart failure permits an overall view of care provided by individual hospitals as compared to like facilities with similar patient populations. This process can assist patients and caregivers in evaluating outcomes for specific providers as relating to care and services for heart failure. This opportunity provides patients with the opportunity to choose a provider based on their needs and provides hospitals quality improvement opportunities.
Considered For	Hospital Inpatient Quality Reporting Program Hospital Value-Based Purchasing Program

Measure Type

Outcome

Level of Analysis

Facility

CBE Endorsement Status & History

Initial endorsement 2007; Endorsed during maintenance review in 2020.

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

Do you recommend including this measure in the Hospital Inpatient Quality Reporting Program?

A. Recommend (You may add considerations in the Zoom chat.)

B. Do not Recommend (Your rationale is required in the next tab.)

Voting on MUC2025-037 Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Heart Failure (HF) Hospitalization *(cont. 1)*

Do you recommend including this measure in the Hospital Value-Based Purchasing Program?

A. Recommend (You may add considerations in the Zoom chat.)

B. Do not Recommend (Your rationale is required in the next tab.)

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

MUC2025-040

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

Item	Description
Measure Description	The measure estimates a hospital-level 30-day risk-standardized mortality rate (RSMR) for Medicare patients (Fee-For-Service [FFS] and Medicare Advantage [MA]) aged 65 and older discharged from the hospital with a principal diagnosis of COPD. The outcome is all-cause 30 day mortality, defined as death from any cause within 30 days of the index admission date, including in-hospital death.
Measure Steward	CMS
CMS-Provided Rationale	Measurement of patient outcomes related to risk-standardized mortality rates for chronic obstructive pulmonary disease (COPD) hospitalization permits an overall view of care provided by individual hospitals as compared to like facilities with similar patient populations. This process can assist patients and caregivers in evaluating outcomes for specific providers in relation to care and services for chronic COPD. This opportunity provides patients with the opportunity to choose a provider based on their needs and provides hospitals with identifying quality improvement opportunities.
Considered For	Hospital Inpatient Quality Reporting Program Hospital Value-Based Purchasing Program

Measure Type

Outcome

Level of Analysis

Facility

CBE Endorsement Status & History

Received initial endorsement 2013;
Endorsed during maintenance review in 2020.

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

Do you recommend including this measure in the Hospital Inpatient Quality Reporting Program?

A. Recommend (You may add considerations in the Zoom chat.)

B. Do not Recommend (Your rationale is required in the next tab.)

Voting on MUC2025-040 Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization *(cont. 1)*

Do you recommend including this measure in the Hospital Value-Based Purchasing Program?

A. Recommend (You may add considerations in the Zoom chat.)

B. Do not Recommend (Your rationale is required in the next tab.)

Lunch Break

Please return by 1:15 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.

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

MUC2025-044

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

Item	Description
Measure Description	The measure estimates a hospital-level 30-day risk-standardized mortality rate (RSMR) for Medicare patients (Fee-For-Service [FFS] and Medicare Advantage [MA]) aged 65 and older discharged from the hospital with a principal diagnosis of Pneumonia. The outcome is all-cause 30 day mortality, defined as death from any cause within 30 days of the index admission date, including in-hospital death.
Measure Steward	CMS
CMS-Provided Rationale	Measurement of patient outcomes related to risk-standardized mortality rates after inpatient hospitalization for pneumonia permits an overall view of care provided by individual hospitals as compared to like facilities with similar patient populations. This process can assist patients and caregivers in evaluating outcomes for specific providers in relation to care and services for treatment of pneumonia. This opportunity provides patients with the opportunity to choose an in-patient facility based on their needs and hospital performance and hospitals in identifying quality improvement opportunities.
Considered For	Hospital Inpatient Quality Reporting Program Hospital Value-Based Purchasing Program

Measure Type
Outcome
Level of Analysis
Facility
CBE Endorsement Status & History
Initial endorsement 2007; Endorsed during maintenance review in 2020

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

Do you recommend including this measure in the Hospital Inpatient Quality Reporting Program?

A. Recommend (You may add considerations in the Zoom chat.)

B. Do not Recommend (Your rationale is required in the next tab.)

Voting on MUC2025-044 Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Pneumonia (PN) Hospitalization *(cont. 1)*

Do you recommend including this measure in the Hospital Value-Based Purchasing Program?

A. Recommend (You may add considerations in the Zoom chat.)

B. Do not Recommend (Your rationale is required in the next tab.)

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

MUC2025-046

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

Item	Description
Measure Description	The measure estimates a hospital-level 30-day risk-standardized mortality rate (RSMR) for Medicare patients (Fee-For-Service [FFS] and Medicare Advantage [MA]) aged 65 and older discharged from the hospital with a principal diagnosis of CABG. The outcome is all-cause 30 day mortality, defined as death from any cause within 30 days of the index admission date, including in-hospital death.
Measure Steward	CMS
CMS-Provided Rationale	Measurement of patient outcomes related to risk-standardized mortality rates after inpatient hospitalization related to coronary artery bypass graph (CABG) procedures permits an overall view of care provided by individual hospitals as compared to like facilities with similar patient populations. This process can assist patients and caregivers in evaluating outcomes for specific hospitals in relation to care and services for treatment of patients undergoing CABG procedures. This process provides patients with the opportunity to choose an in-patient facility based on their needs and hospital performance and provides hospitals with the chance to identify quality improvement opportunities.

Measure Type

Outcome

Level of Analysis

Facility

CBE Endorsement Status & History

Initial endorsement 2014; Endorsed during maintenance review in 2022

Considered For

Hospital Inpatient Quality Reporting Program; Hospital Value-Based Purchasing Program

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

Do you recommend including this measure in the Hospital Inpatient Quality Reporting Program?

A. Recommend (You may add considerations in the Zoom chat.)

B. Do not Recommend (Your rationale is required in the next tab.)

Voting on MUC2025-046 Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) Surgery *(cont. 1)*

Do you recommend including this measure in the Hospital Value-Based Purchasing Program?

A. Recommend (You may add considerations in the Zoom chat.)

B. Do not Recommend (Your rationale is required in the next tab.)

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

MUC2025-016

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

Item	Description
Measure Description	Percentage of adult non-ICU hospitalized patients with uncomplicated pneumonia that qualify for 5-day duration according to national guidelines who received excess antibiotic duration, defined as >/= 7 days of total antibiotic therapy including inpatient and discharge antibiotics. Measure is reported annually at the hospital level.
Measure Steward	University of Utah
CMS-Provided Rationale	Antibiotic overuse is a national and international public health emergency, with antibiotic resistant infections estimated to directly cause 1.27 million deaths globally and indirectly contribute to 4.95 million deaths. Monitoring the data incentivizes hospitals to track this health care patient safety concern.
Considered For	Hospital Inpatient Quality Reporting Program Medicare Promoting Interoperability Program

Measure Type
Process
Level of Analysis
Facility
CBE Endorsement Status & History
Endorsed with Conditions* in 2025

*See conditions for endorsement in MUC2025-016 PA

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

Closing Gaps of Care Considerations

	Age	• Older adult patients with community-acquired pneumonia have a longer treatment duration and more comorbidities than adult patients.[1]
	Geography (urban vs. rural)	• Physicians are more likely to prescribe a longer antibiotic duration for patients residing in rural settings.[2]
	Insurance status	• Reducing excessive antibiotic durations in adults with uncomplicated community-acquired pneumonia would lower unnecessary healthcare costs.[3]

[1] Fachri, M., Hatta, M., Zakia, D., Akaputra, R., Wahab, A., Azhar, A., & Junita, A. R. (2025). Comparison of Length of Treatment and Comorbidities in Older and Adult Hospitalized Patients with Bacterial Community-Acquired Pneumonia. The Eurasian journal of medicine, 57(3), 1–5. https://doi.org/10.5152/eurasianjmed.2025.25910

[2] Dunn, G. E., White, A. T., Giesler, D. L., Mashrah, D., Brancaccio, A., Szymczak, J. E., Horowitz, J. K., Neetz, R. A., & Vaughn, V. M. (2025). Influence of Access to Care on Decision-making About Antibiotic Duration at Discharge. *Open forum infectious diseases*, *12*(7), ofaf346. https://doi.org/10.1093/ofid/ofaf346

[3] Elaine Chua, Daniel Hearsey, P24 Auditing antibiotic course lengths for the management of community-acquired pneumonia and hospital-acquired pneumonia against current NICE guidance, *JAC-Antimicrobial Resistance*, Volume 5, Issue Supplement_2, June 2023, dlad066.028, https://doi.org/10.1093/jacamr/dlad066.028

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

Do you recommend including this measure in the Hospital Inpatient Quality Reporting Program?

A. Recommend (You may add considerations in the Zoom chat.)

B. Do not Recommend (Your rationale is required in the next tab.)

Voting on MUC2025-016 Excess Antibiotic Duration for Adult Hospitalized Patients with Uncomplicated Community-Acquired Pneumonia *(cont. 1)*

Do you recommend including this measure in the Medicare Promoting Interoperability Program?

A. Recommend (You may add considerations in the Zoom chat.)

B. Do not Recommend (Your rationale is required in the next tab.)

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

MUC2025-019

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

Item	Description
Measure Description	Percentage of adult non-ICU hospitalized patients with uncomplicated pneumonia who: a) did not have risk factors for methicillin-resistant Staphylococcus aureus (MRSA) or Pseudomonas aeruginosa, and b) received empiric (within first 48 hours of emergency department arrival) antibiotics targeting MRSA or Pseudomonas aeruginosa. Percentage reported annually at the hospital level.
Measure Steward	University of Utah
CMS-Provided Rationale	Determining the appropriate antibiotics to treat uncomplicated community-acquired pneumonia (CAP) is important to ensure patient safety and avoid overuse of broad empiric antibiotics best utilized to target CAP-specific organisms. A standard process to evaluate overprescription of broad empiric antibiotics for CAP can mitigate inappropriate or overuse of these antibiotics, which is vital because such inappropriate/overuse can lead to potential negative patient outcomes, including kidney injury or secondary infections.
Considered For	Hospital Inpatient Quality Reporting Program Medicare Promoting Interoperability Program

Measure Type
Process
Level of Analysis
Facility
CBE Endorsement Status & History
Endorsed with Conditions* in 2025

*See conditions for endorsement in MUC2025-019 PA

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

Closing Gaps of Care Considerations

	Age	• Patients aged 65 and older have the highest rates of inappropriate broad-spectrum antibiotic prescriptions.[1]
	Geography (urban vs. rural)	• Broad-spectrum antibiotic use for treatment of outpatient community-acquired pneumonia did not differ by rurality but varied by geographic region, with the highest proportion of broad-spectrum antibiotic use in the South.[2]
	Language/ Literacy	• Patients with limited English proficiency may not understand the unintended consequences of taking a broad-spectrum antibiotic inappropriately.[3]

[1] Young, E. H., Strey, K. A., Lee, G. C., Carlson, T. J., Koeller, J. M., Mendoza, V. M., & Reveles, K. R. (2022). National Disparities in Antibiotic Prescribing by Race, Ethnicity, Age Group, and Sex in United States Ambulatory Care Visits, 2009 to 2016. *Antibiotics (Basel, Switzerland)*, *12*(1), 51. https://doi.org/10.3390/antibiotics12010051

[2] Nickel, K. B., Durkin, M. J., Olsen, M. A., Sahrmann, J. M., Neuner, E., O'Neil, C. A., Butler, A. M., & CDC Prevention Epicenters Program (2024). Utilization of broad- versus narrow-spectrum antibiotics for the treatment of outpatient community-acquired pneumonia among adults in the United States. Pharmacoepidemiology and drug safety, 33(4), e5779. https://doi.org/10.1002/pds.5779

[3] Sliwinski, K., Kutney-Lee, A., McHugh, M. D., & Lasater, K. B. (2024). A Review of Disparities in Outcomes of Hospitalized Patients with Limited English Proficiency: The Importance of Nursing Resources. *Journal of health care for the poor and underserved*, *35*(1), 359–374.

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

Do you recommend including this measure in the Hospital Inpatient Quality Reporting Program?

A. Recommend (You may add considerations in the Zoom chat.)

B. Do not Recommend (Your rationale is required in the next tab.)

Voting on MUC2025-019 Inappropriately Broad Empiric Antibiotic Selection for Adult Hospitalized Patients with Uncomplicated Community-Acquired Pneumonia *(cont. 1)*

Do you recommend including this measure in the Medicare Promoting Interoperability Program?

A. Recommend (You may add considerations in the Zoom chat.)

B. Do not Recommend (Your rationale is required in the next tab.)

Break

Please return by 3:30 PM.

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

MUC2025-053

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

Item	Description
Measure Description	Excess Days in Acute Care (EDAC) After Hospitalization for Diabetes (“Diabetes EDAC measure”) measure assesses days spent in acute care within 30 days of discharge from an inpatient hospitalization for diabetes. This measure is intended to improve the quality of care (with a focus on care transitions) provided to discharged patients who had a diabetes hospitalization by collectively measuring a set of adverse acute care outcomes that can occur post-discharge: emergency department (ED) visits, observation stays, and unplanned readmissions at any time during the 30 days post-discharge. In order to aggregate all three events, we measure each in terms of days. The outcome is adjusted to account for age and patient comorbidities and incorporates exposure time to account for survival times shorter than 30 days (for patients who die within 30 days of discharge). The measure is calculated for admissions for patients who are 65 years or older, are enrolled in Medicare Fee-For-Service (FFS) or Medicare Advantage (MA) and are hospitalized in non-federal short-term acute care hospitals. The final risk-adjusted measure score is calculated as the difference (“excess”) between a hospital’s “predicted days” and “expected days,” per 100 discharges.

Measure Type
Outcome
Level of Analysis
Facility
CBE Endorsement Status & History
Not Endorsed; Never submitted

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

Item	Description
Measure Steward	CMS
CMS-Provided Rationale	Excess days in acute care after a hospitalization is an issue that affects patient outcomes and impacts the quality of care provided to patients. Measuring and reporting excess days in acute care provides transparency for consumers and informs health care providers about opportunities to improve care, strengthen incentives for quality improvement, and ultimately improve the quality of care (including better inpatient management of diabetes, as well as better peri-discharge care quality) received by Medicare patients
Considered For	Hospital Inpatient Quality Reporting Program

Measure Type
Outcome
Level of Analysis
Facility
CBE Endorsement Status & History
Not Endorsed; Never submitted

MUC2025-053 Excess Days in Acute Care (EDAC) After Hospitalization for Diabetes
Closing Gaps of Care Considerations

	Age	• This measure is risk adjusted by age. • Most hospitalized patients with diabetes are over the age of 65, frail, and have multiple comorbidities.[1]
	Geography (urban vs. rural)	• Rural patients are at increased risk for experiencing worse quality outcomes than their urban counterparts, even after adjustment for other contributing factors and despite being part of the same integrated health system.[2]
	Insurance status	• Insured adults with diabetes are more likely to have a usual source of care, a regular clinician, recent A1c testing, dilated eye exams, and daily glucose checks than uninsured peers.[3]
	Language/ Literacy	• Compared with English-speaking patients, those who speak neither English nor Spanish are less likely to meet targets for diabetes and cardiovascular risk factor control.[4]

[1] Davis, G. M., DeCarlo, K., Wallia, A., Umpierrez, G. E., & Pasquel, F. J. (2020). Management of Inpatient Hyperglycemia and Diabetes in Older Adults. *Clinics in geriatric medicine*, *36*(3), 491–511. https://doi.org/10.1016/j.cger.2020.04.008
[2] Foss, R., Fischer, K., Lampman, M. A., Laabs, S., Halasy, M., Allen, S. V., Garrison, G. M., Sobolik, G., Bernard, M., Sosso, J., & Thacher, T. D. (2023). Disparities in Diabetes Care: Differences Between Rural and Urban Patients Within a Large Health System. Annals of family medicine, 21(3), 234–239. https://doi.org/10.1370/afm.2962
[3] Casagrande SS, Park J, Herman WH, et al. Health Insurance and Diabetes. 2023 Dec 20. In: Lawrence JM, Casagrande SS, Herman WH, et al., editors. Diabetes in America [Internet]. Bethesda (MD): National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK); 2023-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK597725/
[4] Holman, H., Müller, F., Bhangu, N., Kottutt, J., & Alshaarawy, O. (2023). Impact of limited English proficiency on the control of diabetes and associated cardiovascular risk factors. The National Health and Nutrition Examination Survey, 2003-2018. *Preventive medicine*, *167*, 107394. https://doi.org/10.1016/j.ypmed.2022.107394

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

Do you recommend including this measure in the Hospital Inpatient Quality Reporting Program?

A. Recommend (You may add considerations in the Zoom chat.)

B. Do not Recommend (Your rationale is required in the next tab.)

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

MUC2025-030

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

Item	Description
Measure Description	This measure estimates days spent in acute care within 30 days post discharge from an inpatient hospitalization for acute myocardial infarction (AMI). The acute care outcomes include 1) Emergency Department (ED) visits, 2) observation stays (OBSs), and 3) unplanned readmissions. Unplanned readmissions are defined using the planned readmission algorithm (PRA). ED visits are counted as 1 day and OBSs are counted by hours and rounded up to 1 day. CMS annually reports the measure for patients who are 65 years or older and enrolled in fee-for-service (FFS) Medicare or Medicare Advantage (MA) and hospitalized in non-federal hospitals or Veterans Health Administration (VA) facilities.
Measure Steward	CMS

Measure Type
Outcome
Level of Analysis
Facility
CBE Endorsement Status & History
Initially Endorsed in 2016; Endorsed with Conditions* in Spring 2025 during maintenance review

*See conditions for endorsement in MUC2025-030 PA

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

Item	Description
CMS-Provided Rationale	Excess days in acute care after a hospitalization is an issue that affects patient outcomes and impacts the quality of care provided to patients. Measuring and reporting excess days in acute care provides transparency for consumers and informs health care providers about opportunities to improve care, strengthen incentives for quality improvement, and ultimately improve the quality of care (including better inpatient management of diabetes as well as better peri-discharge care quality) received by Medicare patients.
Considered For	Hospital Inpatient Quality Reporting Program

Measure Type

Outcome

Level of Analysis

Facility

CBE Endorsement Status & History

Initially Endorsed in 2016; Endorsed with Conditions* in Spring 2025 during maintenance review

*See conditions for endorsement in MUC2025-030 PA

Excess Days in Acute Care (EDAC) after Hospitalization for Acute Myocardial Infarction, Heart Failure, and Pneumonia
Closing Gaps of Care Considerations

	Age	• These measures are risk adjusted by age. • Older patients are more likely to have multiple comorbidities, frailty, and functional limitations, increasing their risk of complications and mortality after AMI.[1] • Elderly heart failure patients who are frail and have multiple comorbidities face a significantly higher risk of hospitalization, rehospitalization, disability, institutionalization, and death.[2] • Elderly patients with pneumonia have a high prevalence of comorbidities and a high in-hospital mortality rate.[3]
	Geography (urban vs. rural)	• Patients presenting to rural hospitals are significantly less likely to receive key procedures for AMI (cardiac catheterization, percutaneous coronary intervention, coronary artery bypass surgery) compared to those at urban hospitals.[4] • Rural facilities employ general cardiologists but are more likely to refer patients elsewhere for heart failure expertise.[5] • The mortality rate for pneumonia is significantly higher in rural areas compared to urban areas.[4]

Excess Days in Acute Care (EDAC) after Hospitalization for Acute Myocardial Infarction, Heart Failure, and Pneumonia
Closing Gaps of Care Considerations (cont. 1)

	Dual Medicare and Medicaid eligibility	• Those with dual Medicare-Medicaid eligibility have a higher risks of mortality from acute myocardial infarction.[6] • Hospitals with a higher proportion of dual-eligible beneficiaries provide lower rates of key heart failure care processes and have higher 30-day readmission rates.[7]
	Insurance status	• Uninsured individuals have higher in-hospital mortality and lower use of guideline-directed therapies for AMI compared to privately insured individuals.[8] • Patients enrolled in Medicare Advantage (MA) are more likely to be discharged home and less likely to be discharged to skilled nursing facilities or inpatient rehabilitation facilities compared with patients enrolled in fee-for-service (FFS) Medicare.[9]
	Language/ Literacy	• Low health literacy is common among HF patients and is linked to worse outcomes, including higher hospitalization and mortality rates.[10] • Patients with Limited English Proficiency (LEP) reported significantly more post-discharge problems than patients proficient in English across all measured domains including difficulty understanding discharge instructions, trouble obtaining prescriptions, and questions about follow-up care.[11]

Excess Days in Acute Care (EDAC) after Hospitalization for Acute Myocardial Infarction, Heart Failure, and Pneumonia
Closing Gaps of Care Considerations (cont. 2)

References

[1] Zong, M., Guan, X., Huang, W., Chang, J., & Zhang, J. (2023). Effect of Frailty on the Long-Term Prognosis of Elderly Patients with Acute Myocardial Infarction. Clinical interventions in aging, 18, 2021–2029. https://doi.org/10.2147/CIA.S433221

[2] Murad, K., & Kitzman, D. W. (2012). Frailty and multiple comorbidities in the elderly patient with heart failure: implications for management. Heart failure reviews, 17(4-5), 581–588. https://doi.org/10.1007/s10741-011-9258-y

[3] Li, S., Li, L., Wang, S., & Wu, H. (2025). Clinical characteristics and risk factors of hospital mortality in elderly patients with community-acquired pneumonia. *Frontiers in medicine*, *12*, 1512288. https://doi.org/10.3389/fmed.2025.1512288

[4]Loccoh, E. C., Joynt Maddox, K. E., 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://doi.org/10.1016/j.jacc.2021.10.045

[5] Rajagopalan, N., Leung, S. W., Craft, R. S., & Bailey, A. L. (2024). Improving Cardiovascular Health in Rural United States: Role of Academic Medical Centers. JACC. Advances, 3(7), 100950. https://doi.org/10.1016/j.jacadv.2024.100950

[6] Wang, Y., Leifheit, E. C., & Krumholz, H. M. (2022). Trends in 10-Year Outcomes Among Medicare Beneficiaries Who Survived an Acute Myocardial Infarction. JAMA cardiology, 7(6), 613–622. https://doi.org/10.1001/jamacardio.2022.0662

[7] Bahiru, E., Ziaeian, B., Moucheraud, C., Agarwal, A., Xu, H., Matsouaka, R. A., DeVore, A. D., Heidenreich, P. A., Allen, L. A., Yancy, C. W., & Fonarow, G. C. (2021). Association of Dual Eligibility for Medicare and Medicaid With Heart Failure Quality and Outcomes Among Get With The Guidelines-Heart Failure Hospitals. JAMA cardiology, 6(7), 791–800. https://doi.org/10.1001/jamacardio.2021.0611

[8] Vallabhajosyula, S., Kumar, V., Sundaragiri, P. R., Cheungpasitporn, W., Miller, P. E., Harsha Patlolla, S., Gersh, B. J., Lerman, A., Jaffe, A. S., Shah, N. D., Holmes, D. R., Jr, Bell, M. R., & Barsness, G. W. (2022). Management and Outcomes of Acute Myocardial Infarction-Cardiogenic Shock in Uninsured Compared With Privately Insured Individuals. Circulation. Heart failure, 15(5), e008991. https://doi.org/10.1161/CIRCHEARTFAILURE.121.008991

[9]Figueroa JF, Wadhera RK, Frakt AB, et al. Quality of Care and Outcomes Among Medicare Advantage vs Fee-for-Service Medicare Patients Hospitalized With Heart Failure. JAMA Cardiol. 2020;5(12):1349–1357. doi:10.1001/jamacardio.2020.3638

[10]Ionescu, R., Allen, L. A., Breathett, K., Fowler, B. K., Jackson, E. A., Kundrick, J., Ogunniyi, M. O., & Magnani, J. W. (2025). Health Literacy in Heart Failure: A Review of the Gaps and Challenges. JACC. Advances, 4(3), 101608. https://doi.org/10.1016/j.jacadv.2025.101608

[11] Malevanchik, L., Wheeler, M., Gagliardi, K., Karliner, L., & Shah, S. J. (2021). Disparities After Discharge: The Association of Limited English Proficiency and Postdischarge Patient-Reported Issues. *Joint Commission journal on quality and patient safety*, *47*(12), 775–782. https://doi.org/10.1016/j.jcjq.2021.08.013

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

Do you recommend including this measure in the Hospital Inpatient Quality Reporting Program?

A. Recommend (You may add considerations in the Zoom chat.)

B. Do not Recommend (Your rationale is required in the next tab.)

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

MUC2025-031

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

Item	Description
Measure Description	This measure estimates days spent in acute care within 30 days post discharge from an inpatient hospitalization for heart failure (HF). The acute care outcomes include 1) Emergency Department (ED) visits, 2) observation stays (OBSs), and 3) unplanned readmissions. Unplanned readmissions are defined using the planned readmission algorithm (PRA). ED visits are counted as 1 day and OBSs are counted by hours and rounded up to 1 day. CMS annually reports the measure for patients who are 65 years or older and enrolled in fee-for-service (FFS) Medicare or Medicare Advantage (MA) and hospitalized in non-federal hospitals or Veterans Health Administration (VA) facilities.
Measure Steward	CMS
CMS-Provided Rationale	Excess days in acute care after a hospitalization is an issue that affects patient outcomes and impacts the quality of care provided to patients. Measuring and reporting excess days in acute care provides transparency for consumers and informs health care providers about opportunities to improve care, strengthen incentives for quality improvement, and ultimately improve the quality of care (including better inpatient management of diabetes as well as better peri-discharge care quality) received by Medicare patients

Measure Type

Outcome

Level of Analysis

Facility

CBE Endorsement Status & History

Initially Endorsed in 2016; Endorsed in Spring 2021 during maintenance review.

Considered For

Hospital Inpatient Quality Reporting Program

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

Do you recommend including this measure in the Hospital Inpatient Quality Reporting Program?

A. Recommend (You may add considerations in the Zoom chat.)

B. Do not Recommend (Your rationale is required in the next tab.)

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

MUC2025-039

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

Item	Description
Measure Description	This measure estimates days spent in acute care within 30 days post discharge from an inpatient hospitalization for pneumonia. The acute care outcomes include 1) Emergency Department (ED) visits, 2) observation stays (OBSs), and 3) unplanned readmissions. Unplanned readmissions are defined using the planned readmission algorithm (PRA). ED visits are counted as 1 day and OBSs are counted by hours and rounded up to 1 day. CMS annually reports the measure for patients who are 65 years or older and enrolled in fee-for-service (FFS) Medicare or Medicare Advantage (MA) and hospitalized in non-federal hospitals or Veterans Health Administration (VA) facilities.
Measure Steward	CMS
CMS-Provided Rationale	Excess days in acute care after a hospitalization is an issue that affects patient outcomes and impacts the quality of care provided to patients. Measuring and reporting excess days in acute care provides transparency for consumers and informs health care providers about opportunities to improve care, strengthen incentives for quality improvement, and ultimately improve the quality of care (including better inpatient management of diabetes, as well as better peri-discharge care quality) received by Medicare patients.

Measure Type

Outcome

Level of Analysis

Facility

CBE Endorsement Status & History

Initially endorsed in 2016; Endorsed again in 2021 during maintenance.

Considered For

Hospital Inpatient Quality Reporting Program

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

Do you recommend including this measure in the Hospital Inpatient Quality Reporting Program?

A. Recommend (You may add considerations in the Zoom chat.)

B. Do not Recommend (Your rationale is required in the next tab.)

Next Steps

Dr. Meridith Eastman | Battelle

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PRMR Hospital Recommendation Group Measure Review Day 2

Meeting Agenda Day 2

10:00 AM	Welcome
10:20 AM	Measure Review
12:00 PM	Lunch
12:45 PM	Measure Review
5:00 PM	Adjourn

* All times listed in ET

Welcome

Dr. Meridith Eastman | Battelle

Roll Call and Disclosures of Interest

Kate Buchanan | Battelle

Hospital Recommendation Group Roll Call

Co-Chairs: Darlene Shelton and Julie Marcinek

Terry Adirim
Rosie Bartel
Marissa Carvalho
Thomas Ciesielski
Caitlin Gillooley
Michelle Doll
Geoff Dougherty
Nick Fitterman
Thomas Frederickson
Martin Hatlie
Sandi Hyde
Abigail Khan
Michael Lane
Stefanie Ledbetter
Merranda Logan
Tilithia McBride
Ann Marie McDonald
Ben McGaugh
Devika Nair
Hien Nguyen
Glorimar Ortiz
Mark Parker
Kathleen Rauch
Jessica Schumacher
Jeffrey Silberzweig
Christopher Wilson

Voting Test

Isaac Sakyi | Battelle

Hospital Harm - Postoperative Venous Thromboembolism

MUC2025-067

MUC2025-067 Hospital Harm - Postoperative Venous Thromboembolism

Item	Description
Measure Description	The proportion of inpatient encounters for patients age 18 and older, who have at least one surgical procedure performed inside the operating room during the encounter, and who suffer the harm of a postoperative venous thromboembolism (VTE) during the encounter or within 30 days after the first surgical procedure. This measure is adjusted by patient-level risk factors (bleeding disorders, cancer, respiratory operations, central venous catheter insertion, vascular surgeries, obesity, stroke, and history of VTE).
Measure Steward	CMS
CMS-Provided Rationale	Implementing this measure into CMS programs will incentivize hospitals to take steps to prevent VTEs and improve patient outcomes. Hospitals can take well-established, evidence-based strategies to reduce incidence of this outcome. Additionally, this measure furthers the goal of shifting toward outcome measures and away from process measures
Considered For	Hospital Inpatient Quality Reporting Program Hospital-Acquired Condition Reduction Program Medicare Promoting Interoperability Program

Measure Type

Outcome

Level of Analysis

Facility

CBE Endorsement Status & History

Measure was submitted for endorsement in the Fall 2025 measure evaluation cycle; The CBE has not yet reviewed or issued an endorsement decision

MUC2025-067 Hospital Harm - Postoperative Venous Thromboembolism
Closing Gaps of Care Considerations

	Age	• This measure is risk adjusted by age. • Patients 55 years and older are at increased risk of developing serious and potentially deadly blood clots in the form of venous thromboembolism (VTE).[1]
	Geography (urban vs. rural)	• The age-adjusted mortality rate from pulmonary embolism related deaths is higher among patients from rural settings than metropolitan areas.[2]
	Insurance status	• The average initial cost of VTE is approximately $3,000-9,500. The total costs related to VTE over 3 months, 6 months, and 12 months is $5,000, $10,000 and $33,000 on average, making care difficult to afford for those who are uninsured.[3]
	Language/ Literacy	• Health care providers may inadvertently communicate with patients diagnosed with VTE in ways that fail to inform them about the disease process, cause harm by unnecessarily escalating fear and concerns, and lead to ambiguity and uncertainty causing persistent anxiety.[4]

[1] (2024, May15) *Understanding Your Risk for Healthcare-Associated VTE (Blood Clots)*. Centers for Disease Control and Prevention. https://www.cdc.gov/blood-clots/risk-factors/ha-vte.html
[2] Takahashi, E. A., Sista, A. K., Addison, D., Bikdeli, B., Bishay, V. L., Gu, S., ... & American Heart Association Council on Cardiovascular Radiology and Intervention; Council on Cardiovascular and Stroke Nursing; Council on Clinical Cardiology; and Council on Peripheral Vascular Disease. (2025). Disparities in Current Pulmonary Embolism Management and Outcomes: A Scientific Statement From the American Heart Association. *Circulation*, *151*(15), e944-e955.
[3] Bui, M. H., Le, Q. C., Duong, D. H., Nguyen, T. S., Tran, B. G., Duong, T. D., Tran, T. H., Nguyen, H. C., Kieu, T. T. M., Nguyen, H. H., Hoang, L., Nguyen, T. B., Pham, T. V., & Hoang, T. H. X. (2020). Economic burden of venous thromboembolism in surgical patients: A propensity score analysis from the national claims database in Vietnam. *PloS one*, *15*(4), e0231411. https://doi.org/10.1371/journal.pone.0231411
[4] Hernandez-Nino, J., Thomas, M., Alexander, A. B., Ott, M. A., & Kline, J. A. (2022). Communication at diagnosis of venous thromboembolism: Lasting impact of verbal and nonverbal provider communication on patients. *Research and practice in thrombosis and haemostasis*, *6*(1), e12647. https://doi.org/10.1002/rth2.12647

Voting on MUC2025-067 Hospital Harm – Postoperative Venous Thromboembolism

Do you recommend including this measure in the Hospital Inpatient Quality Reporting Program?

A. Recommend (You may add considerations in the Zoom chat.)

B. Do not Recommend (Your rationale is required in the next tab.)

Voting on MUC2025-067 Hospital Harm – Postoperative Venous Thromboembolism *(cont. 1)*

Do you recommend including this measure in the Medicare Promoting Interoperability Program?

A. Recommend (You may add considerations in the Zoom chat.)

B. Do not Recommend (Your rationale is required in the next tab.)

Voting on MUC2025-067 Hospital Harm – Postoperative Venous Thromboembolism *(cont. 2)*

Do you recommend including this measure in the Hospital-Acquired Condition Reduction Program?

A. Recommend (You may add considerations in the Zoom chat.)

B. Do not Recommend (Your rationale is required in the next tab.)

Emergency Care Access & Timeliness (ECAT)

MUC2025-072

MUC2025-072 Emergency Care Access & Timeliness (ECAT)

Item	Description
Measure Description	This measure captures the proportion of Emergency Department (ED) visits where patients (all ages, all payers) experienced any one of four quality gaps in access: 1. The patient waited longer than 60 minutes (1 hour) after arrival to the ED to be placed in a treatment room or dedicated treatment area that allows for audiovisual privacy during history-taking and physical examination, or 2. The patient left the ED without being evaluated, or 3. The patient boarded (time from Decision to Admit order to ED departure for admitted patients) in the ED for longer than 240 minutes (4 hours), or 4. The patient had an ED length of stay (LOS) (time from ED arrival to ED departure as defined by the ED departure timestamp indicating when the patient physically left the ED) of longer than 480 minutes (8 hours).
Measure Steward	CMS

Measure Type

Intermediate Outcome

Level of Analysis

Facility

CBE Endorsement Status & History

Measure was Endorsed with Conditions in 2024†

†See conditions for endorsement in MUC2025-072 PA

MUC2025-072 Emergency Care Access & Timeliness (ECAT) *(cont.)*

Item	Description
CMS-Provided Rationale	CMS is considering including this quality measure in the Hospital Inpatient Quality Reporting Program as the measure supports the agency's quality improvement efforts to prevent harm and improve outcomes for patients by addressing the variation of access and timeliness to receiving care.*
Considered For	Hospital Inpatient Quality Reporting Program Hospital Value-Based Purchasing Program Medicare Promoting Interoperability Program

Measure Type
Intermediate Outcome
Level of Analysis
Facility
CBE Endorsement Status & History
Measure was Endorsed with Conditions in 2024†

*See full rationale in the MUC2025-072 PA
†See conditions for endorsement in MUC2025-072 PA

MUC2025-072 Emergency Care Access & Timeliness (ECAT)
Closing Gaps of Care Considerations

	Age	• Older patients waiting overnight in the emergency department (ED) for admission experience an increased risk of in-hospital mortality and morbidity.[1]
	Geography (urban vs. rural)	• Urban EDs often experience higher patient volumes, leading to overcrowding, longer wait times, and increased risk of patients leaving without being seen or experiencing prolonged boarding and length of stay.[2] • Rural EDs face staffing shortages, limited specialty coverage, and fewer treatment rooms.[2]
	Language/ Literacy	• Patients with a non-English language preference experience longer wait times to see a provider in the ED.[3]

[1] Roussel, M., Teissandier, D., Yordanov, Y., Balen, F., Noizet, M., Tazarourte, K., Bloom, B., Catoire, P., Berard, L., Cachanado, M., Simon, T., Laribi, S., Freund, Y., FHU IMPEC-IRU SFMU Collaborators, & FHU IMPEC−IRU SFMU Collaborators (2023). Overnight Stay in the Emergency Department and Mortality in Older Patients. *JAMA internal medicine*, *183*(12), 1378–1385. https://doi.org/10.1001/jamainternmed.2023.5961

[2] Mohr, N. M., Wu, C., Ward, M. J., McNaughton, C. D., Faine, B., Pomeranz, K., Richardson, K., & Kaboli, P. J. (2022). Transfer boarding delays care more in low-volume rural emergency departments: A cohort study. *The Journal of rural health : official journal of the American Rural Health Association and the National Rural Health Care Association*, *38*(1), 282–292. https://doi.org/10.1111/jrh.12559

[3] Rimawi, A., Sung, A., Pike, M., Lin, E., Haidar, D. A., Chen, C. M., ... & Fung, C. M. (2025). Increased Time to Provider for Patients With a Non-English Language Preference: A Retrospective Cohort Study. *JACEP Open*, *6*(5), 100239.

Voting on MUC2025-072 Emergency Care Access & Timeliness (ECAT)

Do you recommend including this measure in the Hospital Inpatient Quality Reporting Program?

A. Recommend (You may add considerations in the Zoom chat.)

B. Do not Recommend (Your rationale is required in the next tab.)

Voting on MUC2025-072 Emergency Care Access & Timeliness (ECAT) *(cont. 1)*

Do you recommend including this measure in the Medicare Promoting Interoperability Program?

A. Recommend (You may add considerations in the Zoom chat.)

B. Do not Recommend (Your rationale is required in the next tab.)

Voting on MUC2025-072 Emergency Care Access & Timeliness (ECAT) *(cont. 2)*

Do you recommend including this measure in the Hospital Value-Based Purchasing Program?

A. Recommend (You may add considerations in the Zoom chat.)

B. Do not Recommend (Your rationale is required in the next tab.)

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

MUC2025-055

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

Item	Description
Measure Description	The measure estimates a hospital-level 30-day, all-cause, risk-standardized readmission rate (RSRR) for patients aged 65 and older discharged from the hospital with a principal diagnosis of sepsis including post-procedural sepsis. Readmission is defined as unplanned readmission for any cause within 30 days of the discharge date for the index admission. Readmissions are classified as planned and unplanned by applying the planned readmission algorithm. CMS will report the measure for patients who are 65 years or older and enrolled in fee-for-service (FFS) Medicare or Medicare Advantage (MA) and are hospitalized in non-federal short-term acute care hospitals.
Measure Steward	CMS
CMS-Provided Rationale	Sepsis is a leading cause of death in hospitals. Each year, according to the Centers for Disease Control and Prevention (CDC), at least 1.7 million adults in the U.S. develop sepsis, and at least 350,000 die as a result. It is also one of the main reasons for hospital readmissions in the U.S.
Considered For	Hospital Inpatient Quality Reporting Program Hospital Readmissions Reduction Program

Measure Type
Outcome
Level of Analysis
Facility
CBE Endorsement Status & History
Under endorsement review in Fall 2025 cycle

Sepsis Measures
Closing Gaps of Care Considerations

	Age	• These measures are risk adjusted by age. • As people age, immune function declines, increasing susceptibility to sepsis.[1]
	Geography (urban vs. rural)	• Patients readmitted to a different hospital within 30 days after hospitalization for sepsis, which is more common in rural facilities, may experience higher in-hospital mortality, longer length of stay, and higher hospitalization costs.[2] • Compared to urban patients, rural patients have higher odds of in-hospital sepsis death.[3]
	Insurance status	• Sepsis survivors incur high health care costs that can persist for years after discharge from initial hospitalization,[4] imposing greater financial burdens on uninsured patients. • Patients on Medicaid have the highest odds of sepsis mortality.[3]
	Language/ Literacy	• For patients hospitalized with sepsis, limited English proficiency increased the odds of sepsis mortality.[5]

[1] Alhamyani, A. H., Alamri, M. S., Aljuaid, N. W., Aloubthani, A. H., Alzahrani, S., Alghamdi, A. A., Lajdam, A. S., Alamoudi, H., Alamoudi, A. A., Albulushi, A. M., & AlQarni, S. N. (2024). Sepsis in Aging Populations: A Review of Risk Factors, Diagnosis, and Management. *Cureus*, *16*(12), e74973. https://doi.org/10.7759/cureus.74973

[2] Lin, Z., Ni, J., Xu, J., Wu, Q., Cao, Y., Qin, Y., ... & He, J. (2022). Worse outcomes after readmission to a different hospital after Sepsis: a Nationwide cohort study. *The Journal of Emergency Medicine*, *63*(4), 569-581.

[3] Chang, J., Medina, M., & Kim, S. J. (2023). Is patients' rurality associated with in-hospital sepsis death in US hospitals?. *Frontiers in public health*, *11*, 1169209. https://doi.org/10.3389/fpubh.2023.1169209

[4] Chechulina, V., Sheikh, F., Lóser, M., Englesakis, M., Barrett, K., & Sepsis Canada (2025). Healthcare costs after sepsis: a systematic review. *Critical care (London, England)*, *29*(1), 381. https://doi.org/10.1186/s13054-025-05600-7

[5] Jacobs, Z. G., Prasad, P. A., Fang, M. C., Abe-Jones, Y., & Kangelaris, K. N. (2020). The Association between Limited English Proficiency and Sepsis Mortality. *Journal of hospital medicine*, *15*(3), 140–146. https://doi.org/10.12788/jhm.3334

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

Do you recommend including this measure in the Hospital Inpatient Quality Reporting Program?

A. Recommend (You may add considerations in the Zoom chat.)

B. Do not Recommend (Your rationale is required in the next tab.)

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

Do you recommend including this measure in the Hospital Readmissions Reduction Program?

A. Recommend (You may add considerations in the Zoom chat.)

B. Do not Recommend (Your rationale is required in the next tab.)

Lunch Break

Please return by 12:45 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!

Hospital Sepsis Program Core Elements Score

MUC2025-047

MUC2025-047 Hospital Sepsis Program Core Elements Score

Item	Description
Measure Description	Annual, non-weighted score, assessing acute care hospitals on their leadership support, personnel resources, implementation of quality improvement tools and practices to improve the recognition and care of patients with sepsis. Measure score = Sum of Hospital Sepsis Program Priority Examples in use by hospital.
Measure Steward	Centers for Disease Control and Prevention (CDC)
CMS-Provided Rationale	Sepsis is a leading cause of death in hospitals. Each year, according to the Centers for Disease Control and Prevention (CDC), at least 1.7 million adults in the U.S. develop sepsis, and at least 350,000 die as a result.
Considered For	Hospital Inpatient Quality Reporting Program

Measure Type
Structure
Level of Analysis
Facility
CBE Endorsement Status & History
Not Endorsed; Never submitted

Voting on MUC2025-047 Hospital Sepsis Program Core Elements Score

Do you recommend including this measure in the Hospital Inpatient Quality Reporting Program?

A. Recommend (You may add considerations in the Zoom chat.)

B. Do not Recommend (Your rationale is required in the next tab.)

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

MUC2025-045

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

Item	Description
Measure Description	Annual risk-adjusted standardized mortality ratio (SMR) of adult inpatients with community-onset sepsis who died during their hospitalization or were discharged to hospice. SMR is reported annually and is calculated by dividing the number of observed community-onset sepsis deaths by the number of predicted community-onset sepsis deaths.
Measure Steward	CDC
CMS-Provided Rationale	Sepsis is a leading cause of death in hospitals. Each year, according to the Centers for Disease Control and Prevention (CDC), at least 1.7 million adults in the U.S. develop sepsis, and at least 350,000 die as a result. It is also one of the main causes of hospital readmissions.
Considered For	Hospital Inpatient Quality Reporting Program Hospital Value-Based Purchasing Program

Measure Type
Outcome
Level of Analysis
Facility
CBE Endorsement Status & History
Not Endorsed; Never submitted

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

Do you recommend including this measure in the Hospital Inpatient Quality Reporting Program?

A. Recommend (You may add considerations in the Zoom chat.)

B. Do not Recommend (Your rationale is required in the next tab.)

Voting on MUC2025-045 Adult Community-Onset (CO) Sepsis Standardized Mortality Ratio (SMR) *(cont. 1)*

Do you recommend including this measure in the Hospital Value-Based Purchasing Program?

A. Recommend (You may add considerations in the Zoom chat.)

B. Do not Recommend (Your rationale is required in the next tab.)

Dialysis Facility Discussion of Patient Life Goals

MUC2025-011

MUC2025-011 Dialysis Facility Discussion of Patient Life Goals

Item	Description
Measure Description	Dialysis Facility Discussion of Patient Life Goals is a patient reported outcome performance measure (the D-PaLS PRO-PM). The D-PaLS PRO-PM is a patient-specific measure that can be used to generate a t-score that is indicative of patient satisfaction with their care team about life goals discussions during the treatment planning and ongoing treatment process. The D-PaLS PRO-PM uses the patient specific scores to generate a performance-based facility level score. The performance-based measure is the percentage of adult chronic dialysis patients at a given ESRD facility that have a t-score of greater than 40.
Measure Steward	CMS

Measure Type

PRO-PM or Patient Experience of Care

Level of Analysis

Facility

CBE Endorsement Status & History

Not Endorsed in the Spring 2023 cycle based on concerns that the evidence provided did not show a clear patient desire for this type of measurement and there was a lack of alignment with patient-preferred outcomes

MUC2025-011 Dialysis Facility Discussion of Patient Life Goals *(cont.)*

Item	Description
CMS-Provided Rationale	CMS is considering adding the Dialysis Facility Discussion of Patient Life Goals (D-PaLS) measure to the End-Stage Renal Disease Quality Incentive Program (ESRD QIP) as a new clinical quality measure. This patient-reported outcome measure reports patients' satisfaction with how well their care team discussed life goals as part of treatment planning using the Patient Life Goals Survey instrument and allows facility-level comparison of patient satisfaction around discussion of life goals by generation of a t-score. This measure will fill a gap in the Patient and Family Engagement domain.
Considered For	End-Stage Renal Disease Quality Incentive Program

Measure Type

PRO-PM or Patient Experience of Care

Level of Analysis

Facility

CBE Endorsement Status & History

Not Endorsed in the Spring 2023 cycle based on concerns that the evidence provided did not show a clear patient desire for this type of measurement and there was a lack of alignment with patient-preferred outcomes

MUC2025-011 Dialysis Facility Discussion of Patient Life Goals

Closing Gaps of Care Considerations

	Age	• Older adults are more likely to have multiple comorbidities and frailty, so dialysis care should be tailored to these needs.[1]
	Geography (urban vs. rural)	• Rural patients may have fewer dialysis centers, longer travel distances, and less frequent access to nephrologists.[2]
	Insurance status	• Treatment plans for those who are uninsured may differ due to increased cost of care.[3]
	Language/ Literacy	• Patients with limited English proficiency reported poorer communication with the dialysis care team.[4]

[1] Satish, A., Agrohi, J., Rangaswamy, D., Prabhu, R. A., Nagaraju, S. P., Rao, I. R., Bhojaraja, M. V., & Shenoy, S. V. (2025). Dialysis in the Elderly: A Practical Guide for the Clinician. *International journal of nephrology*, *2025*, 9538115. https://doi.org/10.1155/ijne/9538115

[2] Adler, J. T., Husain, S. A., Xiang, L., Rodrigue, J. R., & Waikar, S. S. (2022). Initial Home Dialysis Is Increased for Rural Patients by Accessing Urban Facilities. *Kidney360*, *3*(3), 488–496. https://doi.org/10.34067/KID.0006932021

[3] Iorember, F. M., & Bamgbola, O. F. (2022). Structural Inequities and Barriers to Accessing Kidney Healthcare Services in the United States: A Focus on Uninsured and Undocumented Children and Young Adults. *Frontiers in pediatrics*, *10*, 833611. https://doi.org/10.3389/fped.2022.833611

[4] Martinez, A., Warner, A., Powe, N. R., Fernandez, A., & Tuot, D. S. (2024). Association between English Proficiency and Kidney Disease Knowledge and Communication Quality among Patients with ESKD. *Kidney360*, *5*(4), 560–568. https://doi.org/10.34067/KID.0000000000000398

Voting on MUC2025-011 Dialysis Facility Discussion of Patient Life Goals

Do you recommend including this measure in the End-Stage Renal Disease Quality Incentive Program?

A. Recommend (You may add considerations in the Zoom chat.)

B. Do not Recommend (Your rationale is required in the next tab.)

Facility Level Percentage of Chronic Hyperphosphatemia in Dialysis Patients

MUC2025-064

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

Item	Description
Measure Description	Percentage of adult dialysis patients with a 6-month rolling average phosphorus value greater than or equal to 6.5 mg/dL.
Measure Steward	CMS
CMS-Provided Rationale	The purpose of this measure is to focus quality efforts on those patients with significant, chronic elevations in phosphorus who would benefit from additional intervention, as improvement in chronic hyperphosphatemia can improve cardiovascular complications, fracture, hospitalizations, and mortality. The intent would be to replace the current Hypercalcemia reporting measure with this new measure while maintaining compliance with statutory requirements to include a bone and mineral metabolism measure in the ESRD QIP measure set.
Considered For	End-Stage Renal Disease Quality Incentive Program

Measure Type

Intermediate Outcome

Level of Analysis

Facility

CBE Endorsement Status & History

Endorsed in 2024

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

Do you recommend including this measure in the End-Stage Renal Disease Quality Incentive Program?

A. Recommend (You may add considerations in the Zoom chat.)

B. Do not Recommend (Your rationale is required in the next tab.)

Break

Please return by 3:15 PM

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

MUC2025-023

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

Item	Description
Measure Description	This measure assesses facility level compliance with administration of the CollaboRATE Shared Decision-Making tool to patients undergoing outpatient or ambulatory surgery. To be compliant, facilities must offer 95% of patients the option to complete the CollaboRATE survey within 1 week of the shared decision making conversation. CollaboRATE has been administered as a paper handout, via mail, electronic mail, computer or web interface, voice recorded telephone interviews, SMS text messages, and through MyChart EHR integration. It is available in 11 different languages, as well as for use in pediatrics, and patients with special considerations such as those with proxies or who are unable to speak for themselves.*
Measure Steward	American College of Surgeons

Measure Type

PRO-PM or Patient Experience of Care

Level of Analysis

Facility

CBE Endorsement Status & History

Endorsed in 2019; Measure developer will pursue maintenance of endorsement in Spring 2026

*See full description in MUC2025-023 PA

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

Item	Description
CMS-Provided Rationale	CMS believes shared decision-making is important in engaging patients in treatment decisions and supports shared decision-making in elective outpatient surgeries. Use of this survey tool has shown to improve patient satisfaction and health outcomes. This brief three-question survey can be administered at any point after the shared decision-making conversation and before the surgical procedure takes place, allowing for flexibility in how facilities incorporate this survey and opportunity to collaborate with surgeons to ensure the completion of the survey.
Considered For	Ambulatory Surgical Center Quality Reporting Program Hospital Outpatient Quality Reporting Program

Measure Type

PRO-PM or Patient Experience of Care

Level of Analysis

Facility

CBE Endorsement Status & History

Endorsed in 2019; Measure developer will pursue maintenance of endorsement in Spring 2026

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

Closing Gaps of Care Considerations

	Age	• Elderly patients or those with disabilities may require assistance or proxy support to complete the survey.[1]
	Geography (urban vs. rural)	• Certified electronic health record (EHR) adoption rates were significantly lower among rural physicians. Urban facilities are more likely to have robust technological infrastructure to administer the CollaboRATE survey electronically.[2]
	Language/ Literacy	• The tool is available in 11 different languages.

[1] Baidoo, S., Salihu, O. S., & Salihu, E. Y. (2024). Challenges and Recommendations for Proxy Reporting in Aging Research: A Brief Commentary. *Cureus*, *16*(12), e76587. https://doi.org/10.7759/cureus.76587

[2] Anzalone, A. J., Geary, C. R., Dai, R., Watanabe-Galloway, S., McClay, J. C., & Campbell, J. R. (2025). Lower electronic health record adoption and interoperability in rural versus urban physician participants: a cross-sectional analysis from the CMS quality payment program. *BMC health services research*, *25*(1), 128. https://doi.org/10.1186/s12913-024-12168-5

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

Do you recommend including this measure in the Ambulatory Surgical Center Quality Reporting Program?

A. Recommend (You may add considerations in the Zoom chat.)

B. Do not Recommend (Your rationale is required in the next tab.)

Voting on MUC2025-023 CollaboRATE Shared Decision-Making Tool for Ambulatory or Outpatient Surgery Patients (Surgical CollaboRATE OAS-PM) *(cont. 1)*

Do you recommend including this measure in the Hospital Outpatient Quality Reporting Program?

A. Recommend (You may add considerations in the Zoom chat.)

B. Do not Recommend (Your rationale is required in the next tab.)

Malnutrition Care Score

MUC2025-065

MUC2025-065 Malnutrition Care Score

Item	Description
Measure Description	Composite: This measure assesses the percentage of eligible encounters of adults aged 18 years and older at the start of the eligible encounter during the measurement period, with a length of stay equal to or greater than 24 hours, who received optimal malnutrition care where care performed was appropriate to the patient's level of malnutrition risk and severity. Malnutrition care best practices recommend that for each eligible encounter, adult inpatients are: 1. screened for malnutrition risk or for a dietitian referral order to be placed, 2. assessed by a registered dietitian (RD) or registered dietitian nutritionist (RDN) to confirm findings of malnutrition risk, and if identified with a "moderate" or "severe" malnutrition status in the current performed nutrition assessment, 3. receive a "moderate" or "severe" malnutrition diagnosis by a physician or eligible clinician as defined by the Centers for Medicare & Medicaid Services (CMS), and 4. have a current nutrition care plan performed by an RD/RDN.*
Measure Steward	The Academy of Nutrition and Dietetics

*See full description and conditions for endorsement in MUC2025-065 PA

Measure Type
Intermediate Outcome
Level of Analysis
Facility
CBE Endorsement Status & History
Endorsed with Conditions* in 2024

MUC2025-065 Malnutrition Care Score *(cont.)*

Item	Description
CMS-Provided Rationale	CMS is considering adding this measure to the PCHQR Program in alignment with existing use in the Hospital Inpatient Quality Reporting (IQR) Program (CBE 3592e). We believe extending adoption to another program will help promote better nutrition, an important component of American health, as well as enable better quality comparisons with hospitals in the Inpatient Prospective Payment System (IPPS). Identification and remediation of malnutrition risks prompted by this measure promotes a shift away from "sick care" by helping identify at-risk patients, encouraging continuity of care, reducing the risk of future readmissions, and improving quality of life.
Considered For	Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program

Measure Type

Intermediate Outcome

Level of Analysis

Facility

CBE Endorsement Status & History

Endorsed with Conditions in 2024*

*See conditions for endorsement in MUC2025-065 PA

MUC2025-065 Malnutrition Care Score
Closing Gaps of Care Considerations

	Age	• Malnutrition in older adults is common, under-recognized, and linked to higher mortality, morbidity, functional decline, and poorer quality of life.[1]
	Geography (urban vs. rural)	• Urban health care facilities are more likely to staff a dietician/nutritionist.[2]
	Insurance status	• Medicare and most other insurers use a payment model based on medical diagnoses, including malnutrition, to reimburse hospitals for a patient's stay. An insurer may issue a denial for any diagnostic code if they believe the medical record documentation submitted with the claim is insufficient to support application of the code.[3]
	Language/ Literacy	• Patients have differing understanding, interpretation of, and identification with malnutrition risk and malnutrition terminology.[4]

[1] Norman, K., Haß, U., & Pirlich, M. (2021). Malnutrition in Older Adults-Recent s and Remaining Challenges. *Nutrients*, *13*(8), 2764. https://doi.org/10.3390/nu13082764
[2] Abel, L. N., & Tandoh, M. A. (2025). Assessing Preparedness for Nutritional Emergencies in Rural and Urban Healthcare Facilities: A Hospital-Based Cross-Sectional Study. *Health science reports*, *8*(3), e70594. https://doi.org/10.1002/hsr2.70594
[3] Oblein, J., & Doley, J. (2025). Malnutrition Coding Denials in the Acute Care Setting. *Journal of the Academy of Nutrition and Dietetics*, *125*(9S), S48–S52. https://doi.org/10.1016/j.jand.2025.05.014
[4] Mackay, S., Rushton, A., Bell, J., & Young, A. (2025). The perception and understanding of the terminology used to describe malnutrition from the perspective of patients and health workers: a meta-synthesis of qualitative studies. *Journal of the Academy of Nutrition and Dietetics*, *125*(7), 984-1008. https://doi.org/10.1016/j.jand.2024.10.024

Voting on MUC2025-065 Malnutrition Care Score

Do you recommend including this measure in the Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program?

A. Recommend (You may add considerations in the Zoom chat.)

B. Do not Recommend (Your rationale is required in the next tab.)

Advance Care Planning (ACP)

MUC2025-020

MUC2025-020 Advance Care Planning (ACP)

Item	Description
Measure Description	Percentage of patients aged 18 years and older at the start of the measurement period with one or more inpatient encounters during the measurement period who have an advance care planning document or documentation of an advance care planning discussion resulting in a documented decision in the electronic health record (EHR) by the time of hospital discharge for at least one hospital encounter during the measurement period.
Measure Steward	CMS

Measure Type
Process
Level of Analysis
Facility
CBE Endorsement Status & History
Not Endorsed; Never submitted

MUC2025-020 Advance Care Planning (ACP) *(cont.)*

Item	Description
CMS-Provided Rationale	CMS is considering adding this measure to the Hospital Inpatient Quality Reporting Program, the PPS-Exempt Cancer Hospital Quality Reporting Program (PCHQR), and the Promoting Interoperability Program to promote better person-centered care through wider adoption of advanced care planning documentation. This also promotes CMS initiatives around improving the ability to age with dignity. This measure complements the Documentation of Goals of Care Discussions Among Cancer Patients (PCH-42) currently in the PCHQR Program by expanding these important discussions to a broader scope of care situations, a much larger patient population, and promoting interoperable electronic record keeping.*
Considered For	Ambulatory Surgical Center Quality Reporting Program End-Stage Renal Disease Quality Incentive Program Hospital Inpatient Quality Reporting Program Hospital Outpatient Quality Reporting 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

Measure Type
Process
Level of Analysis
Facility
CBE Endorsement Status & History
Not Endorsed; Never submitted

 *See full CMS-Provided Rationale in MUC2025-020 PA

MUC2025-020 Advance Care Planning (ACP)
Closing Gaps of Care Considerations

	Age	• Advanced care planning in older populations may increase potentially burdensome care at end of life, highlighting the importance of aligning ACP with the patients' true preferences.[1]
	Geography (urban vs. rural)	• Because ACP initiatives are often sponsored by urban- or suburban-based health care institutions, rural populations are less likely to have access to ACP discussions facilitated by a health care practitioner.[2]
	Dual Medicare and Medicaid eligibility	• Care is typically fragmented for patients dually eligible for Medicare and Medicaid because they are administered separately and cover different services.[3] • Integrated models such as Program of All-Inclusive Care for the Elderly (PACE), Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs), and Medicare-Medicaid Plans (MMPs) have been developed to coordinate care, but only a small fraction of patients are currently enrolled in integrated models.[3]

[1] Wolff JL, Scerpella D, Giovannetti ER, Roth DL, Hanna V, Hussain N, Colburn JL, Saylor MA, Boyd CM, Cotter V, McGuire M, Rawlinson C, Sloan DH, Richards TM, Walker K, Smith KM, Dy SM; SHARING Choices Investigators. Care Planning, End-of-Life Preferences, and Burdensome Care: A Pragmatic Cluster Randomized Clinical Trial. JAMA Intern Med. 2025 Feb 1;185(2):162-170. doi: 10.1001/jamainternmed.2024.6215. PMID: 39621341; PMCID: PMC11612918.
[2] Fink, R. M., Kline, D. M., Bailey, F. A., Handel, D. L., Jordan, S. R., Lum, H. D., & Fischer, S. M. (2020). Community-Based Conversations about Care Planning for Underserved Populations Using Lay Patient Navigators. Journal of palliative medicine, 23(7), 907–914. https://doi.org/10.1089/jpm.2019.0470
[3] Roberts, E. T., Johnston, K. J., & Figueroa, J. F. (2023). Integrating Medicare and Medicaid Coverage for Dual Eligibles-Recommendations for Reform. JAMA, 330(5), 409–410. https://doi.org/10.1001/jama.2023.8879

MUC2025-020 Advance Care Planning (ACP)
Closing Gaps of Care Considerations (cont. 1)

	Insurance status	• Patients with Medicare insurance are more likely than those with non-Medicare insurance to have ACP documentation in the EHR preoperatively.[4]
	Language/ Literacy	• Patients with limited English proficiency (LEP) experience barriers in end-of-life decision-making and care planning.[5] • These barriers include prolonged intensive care unit (ICU) stays, death in the ICU, increased and aggressive interventions at end of life, increased use of restraints, lower rates of comfort measures only, and do-not-resuscitate orders despite imminent death.[5]

[4] Colley, A., Lin, J. A., Pierce, L., Finlayson, E., Sudore, R. L., & Wick, E. (2022). Missed Opportunities and Health Disparities for Care Planning Before Elective Surgery in Older Adults. JAMA surgery, 157(10), e223687. https://doi.org/10.1001/jamasurg.2022.3687
[5] Barwise, A., Balls-Berry, J., Soleimani, J., Karki, B., Barrett, B., Castillo, K., Kreps, S., Kunkel, H., Vega, B., Erwin, P., Espinoza Suarez, N., & Wilson, M. E. (2020). Interventions for End-of-Life Decision Making for Patients with Limited English Proficiency. Journal of immigrant and minority health, 22(4), 860–872. https://doi.org/10.1007/s10903-019-00947-w

Voting on MUC2025-020
Advance Care Planning (ACP)

Do you recommend including this measure in the Ambulatory Surgical Center Quality Reporting Program?

A. Recommend (You may add considerations in the Zoom chat.)

B. Do not Recommend (Your rationale is required in the next tab.)

Voting on MUC2025-020
Advance Care Planning (ACP) *(cont. 1)*

Do you recommend including this measure in the End-Stage Renal Disease Quality Incentive Program?

A. Recommend (You may add considerations in the Zoom chat.)

B. Do not Recommend (Your rationale is required in the next tab.)

Voting on MUC2025-020
Advance Care Planning (ACP) *(cont. 2)*

Do you recommend including this measure in the Hospital Inpatient Quality Reporting Program?

A. Recommend (You may add considerations in the Zoom chat.)

B. Do not Recommend (Your rationale is required in the next tab.)

Voting on MUC2025-020
Advance Care Planning (ACP) *(cont. 3)*

Do you recommend including this measure in the Hospital Outpatient Quality Reporting Program?

A. Recommend (You may add considerations in the Zoom chat.)

B. Do not Recommend (Your rationale is required in the next tab.)

Voting on MUC2025-020
Advance Care Planning (ACP) *(cont. 4)*

Do you recommend including this measure in the Hospital Value-Based Purchasing Program?

A. Recommend (You may add considerations in the Zoom chat.)

B. Do not Recommend (Your rationale is required in the next tab.)

Voting on MUC2025-020
Advance Care Planning (ACP) *(cont. 5)*

Do you recommend including this measure in the Inpatient Psychiatric Facility Quality Reporting Program?

A. Recommend (You may add considerations in the Zoom chat.)

B. Do not Recommend (Your rationale is required in the next tab.)

Voting on MUC2025-020
Advance Care Planning (ACP) *(cont. 6)*

Do you recommend including this measure in the Medicare Promoting Interoperability Program?

A. Recommend (You may add considerations in the Zoom chat.)

B. Do not Recommend (Your rationale is required in the next tab.)

Voting on MUC2025-020
Advance Care Planning (ACP) *(cont. 7)*

Do you recommend including this measure in the Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program?

A. Recommend (You may add considerations in the Zoom chat.)

B. Do not Recommend (Your rationale is required in the next tab.)

Voting on MUC2025-020
Advance Care Planning (ACP) *(cont. 8)*

Do you recommend including this measure in the Rural Emergency Hospital Quality Reporting Program?

A. Recommend (You may add considerations in the Zoom chat.)

B. Do not Recommend (Your rationale is required in the next tab.)

Feedback on PRMR Process

Dr. Meridith Eastman | Battelle

Committee Reflections

Open discussion considering topics like:

- Announcements and communications
- Committee workspace
- PAs and public comments
- Committee Member Education Meeting
- PRMR 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 PRMR 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.

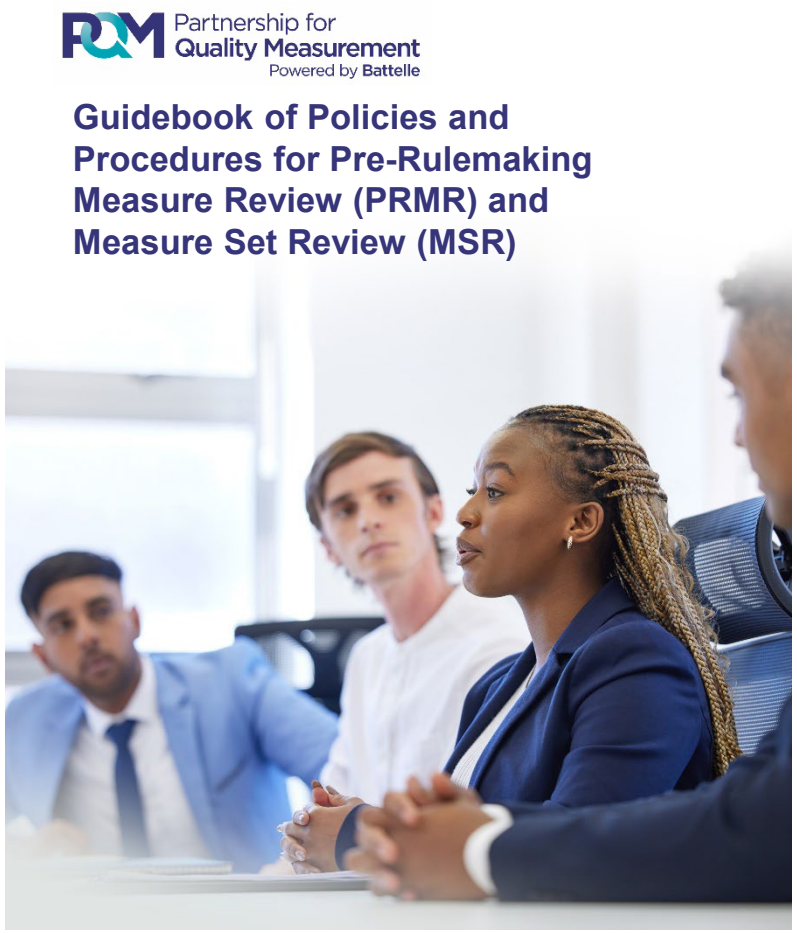
2025-2026 Key PRMR Dates

Event	Dates
Roundtable Administrative Priorities for Quality Measurement Discussion	1/14/2026 *9:00-11:30 AM ET*
Final MUC Recommendations Spreadsheet published on PQM website	1/30/2026
Final MUC Recommendations Spreadsheet public comment period	2/2/2026-2/16/2026
Final PRMR Hospital Recommendation Group Meeting Summary and Recording published on PQM website	2/11/2026
Final MUC Recommendations Report published on PQM website	2/25/2026

Resources

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

Become a PQM member – it's free!



Questions or Comments?

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

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