Partnership for Quality Measurement
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National Consensus Development and Strategic Planning for Health Care Quality Measurement

2025-2026 Pre-Rulemaking Measure Review (PRMR) Roundtable Discussion Final Summary

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Roundtable: Administration Priorities for Quality Measurement

Battelle staff convened members from the three Pre-Rulemaking Measure Review (PRMR) committees (Hospital, Clinician, and Post-Acute Care/Long Term Care [PAC/LTC]) on January 14, 2026, for a roundtable discussion.

The goal of this meeting was to collect feedback on quality measures aligned with Centers for Medicare & Medicaid (CMS) Administration priorities and the Make American Healthy Again (MAHA) framework for potential use in future CMS programs. The first of its kind, this meeting was intended to guide CMS in future measure development and strategy planning. CMS sought feedback from a large and diverse mix of stakeholders, including patients. This summary provides an overview of the meeting.

Figure 1. Roundtable Meeting Attendance

Meeting participants joined virtually through the Zoom meeting platform. Figure 1 outlines overall meeting attendance. Committee members from the Hospital, Clinician, and PAC/LTC committees discussed five roundtable measures. CMS and Battelle's Partnership for Quality Measurement (PQM) representatives also attended the meeting.

CMS Opening Remarks and Overview of Administration Priorities for Quality Measurement

Brenna Rabel, MPH, technical director of the Partnership for Quality Measurement, welcomed attendees to the meeting and introduced her Battelle co-facilitator Meridith Eastman, PhD, MSPH, PRMR and Measure Set Review (MSR) task lead. After a brief overview of the day's objectives and agenda, Ms. Rabel invited CMS staff to provide opening remarks. CMS participants included Dr. Michelle Schreiber, deputy director of the Center for Clinical Standards and Quality (CCSQ) and the director of the Quality Measurement and Value-Based Incentives Group (QMVIG) at CMS; Dr. Susannah Bernheim, MD, MHS, chief quality officer and acting chief medical officer at the CMS Innovation Center; and Dr. Tara McMullen, PhD, MPH, FGSA, deputy director, Division of Quality Measurement (DQM), CCSQ, CMS.

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CMS staff emphasized the administration's commitment to patient-centered care approaches, focusing on primary, secondary, and tertiary prevention; patient empowerment; nutrition; physical activity; and overall well-being and quality of life within the MAHA framework. Dr. Schreiber highlighted CMS's interest in receiving interested parties' perspectives on prevention strategies across the HHS and CMS, including feedback on measures currently in use that might be expanded to other programs and on new measure concepts not yet implemented. Dr. Bernheim noted that the Innovation Center's strategy includes prevention as a key tenet, with quality measurement central to driving improvements in prevention. She explained that this meeting would facilitate discussion to inform directions for new measures in Innovation Center models.

Dr. McMullen thanked Battelle and stated that the discussion would focus on measure concepts aligned with administration priorities and the MAHA framework to guide measure development strategies; align efforts across programs; and advance effective prevention, wellness, and improved outcomes. Rather than solely focusing on disease treatment, the MAHA framework emphasizes a patient-centered care approach that prioritizes prevention empowerment and long-term well-being. Figure 2 shows how the framework integrates primary, secondary, and tertiary prevention strategies to optimize population health outcomes. The framework reinforces the role of physical activity and nutrition as central components of preventive care supported by evidence-based approaches in lifestyle and functional medicine, mental and behavioral health interventions, and the mitigation of upstream drivers of health. This model operationalizes prevention across the continuum, aligning clinical, behavioral, and social interventions to enhance beneficiary outcomes.

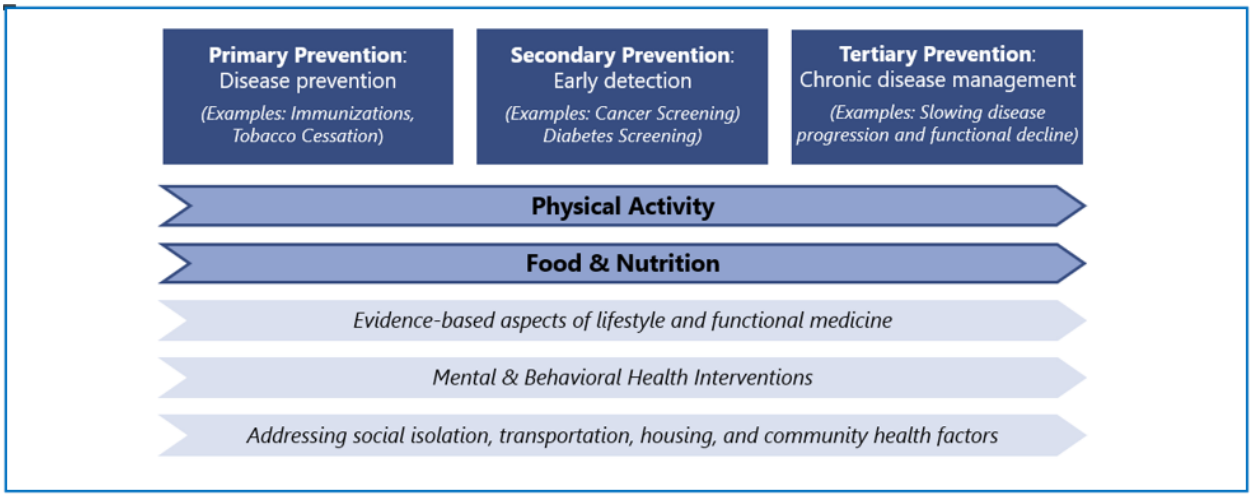

Figure 2. MAHA Prevention Framework

Speaking on efforts underway to support the MAHA framework, CMS shared that internal working groups are identifying levers, interventions, whole-person approaches, and measurement strategies for well-being and wellness. CMS has launched the 13th Scope of Work to support health care quality improvement and the MAHA initiative and the MAHA Enhancing Lifestyle and Evaluating Value-Based Approaches Through Evidence (ELEVATE) Model under the CMS Innovation Center (CMMI) 2025 strategy, emphasizing evidence-based prevention, patient empowerment, choice, and competition. CMMI has emphasized five key

prevention domains: absence of disease, the reduction of disease progression, function/health status/well-being, adverse events and acute care utilization, and time at home to support a shift toward prevention and whole-person care. Finally, CMS conducted an environmental scan of existing and in-use measures to inform the discussion and identify high-priority opportunities for alignment across CMS programs and models. The five measures and measure concepts identified for committee input, alignment, and support of MAHA framework for this discussion include Discharge Function Score, Low Density Lipoprotein Cholesterol (LDL-C) Monitoring and Management, Malnutrition Care Score, Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan, and Well-Being Signs.[1]

Roundtable Discussion

After opening remarks, Battelle facilitators outlined the procedures for discussing the measure concepts, noting that there were 71 public comments, including 24 spoken comments and 47 written comments. The discussion prioritized assessing alignment with MAHA priorities, identifying cross-CMS program applicability, and identifying measurement gaps.

Discharge Function Score

Overview: The Discharge Function Score is an outcome measure assessed at the facility level that evaluates whether patients achieve a discharge function score at or above an expected, risk-adjusted level. It is currently implemented in the Home Health Quality Reporting Program, Inpatient Rehabilitation Facility Quality Reporting Program, Long-Term Care Hospital Quality Reporting Program, Skilled Nursing Facility Value-Based Purchasing Program, Nursing Home Quality Initiative, Nursing Home Five-Star Program, Home Health Value-Based Purchasing Program, and Skilled Nursing Facility Quality Reporting Program. The measure supports standardized functional outcome measurement across care settings consistent with the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) and uses patient demographics and admission clinical characteristics for risk adjustment. The measure aligns with the MAHA initiative through its focus on physical activity and functional outcomes.

CMS staff introduced the Discharge Function Score as a cross-setting outcome measure that reports the percentage of patients or residents who meet or exceed an expected discharge function score. They explained that the expected or predicted score is calculated using patient demographics and admission clinical characteristics. CMS emphasized the measure's flexibility to be applied consistently across care settings while accommodating variation in patient acuity and functional status and noted potential applicability beyond post-acute care. CMS sought input on the measure's concept and content, including feedback to inform future development of a global measure of function and broader use to assess provider quality across settings.

Measure Discussion: Committee members expressed support for standardizing functional status information across settings to create a consistent, comparable picture of patient function.

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[1] Although the Percent of Residents Who Received an Antipsychotic Medication (LS) measure was initially included in the roundtable set for public comment, it was subsequently removed from further discussion because it did not align with CMS prevention priorities.

Committee members emphasized the need to ensure fairness and transparency in risk adjustment and baseline determination. They asked for more detail on covariates, social risk factors, and risk adjustment model transparency and noted that assessing baseline function in acutely ill patients can be difficult and that variability in staff assessments can affect reliability and perceptions of change. Members noted that methodological issues such as how "not attempted" items are handled and the use of bootstrapping could potentially distort results for patients with less functionality. Committee members also cautioned that measurement alone will not drive improvement and asked for clearer links between the measure and outcomes such as mortality and readmissions.

Committee members warned that the data collection demands could be burdensome and urged CMS to ensure comparability across settings and fair adjustment for complex patient populations. Members had feasibility concerns including staffing needs (particularly therapy resources for short stays), dependence on complex scoring software, inter-rater variability, and risks of misinterpretation in public reporting. Committee members questioned the measure's readiness for digital implementation, alignment with United States Core Data for Interoperability (USCDI) standards, and whether the measure could function as an electronic clinical quality measure (eCQM) without increasing burden. There were mixed views on expansion: several committee members favored a staged, evidence-based rollout starting with elective or same-day surgeries, testing alternative or setting-appropriate instruments such as Activity Measure for Post-Acute Care (AM-PAC) or 36-Item Short Form Health Survey (SF-36), and adding indicators of community function, physical activity, and shared decision-making, recognizing that preserving baseline function may be a meaningful outcome for some conditions. They also requested clarity on endorsement status, program use, and equitable inclusion of patients with low baseline function in broader quality initiatives.

Additional Considerations and Future Directions:

- Committee members urged caution against adding exclusions by disease state (e.g., Parkinson's) and suggested to the developer design the measure to assess return to baseline instead of excluding these groups.
- Committee members expressed concern that unclear exclusions and risk adjustment could incentivize avoiding patients at higher risk rather than appropriately adjusting for them.

Low Density Lipoprotein Cholesterol (LDL-C) Monitoring and Management

Overview: This measure is assessed at the clinician level and targets LDL-C monitoring and management for adults with clinical atherosclerotic cardiovascular disease (ASCVD), with an emphasis on achieving guideline-directed LDL-C control (commonly <70mg/dL) through pharmacologic therapy and lifestyle interventions. The measure is positioned as an intermediate outcome for secondary prevention within cardiovascular health, with considerations for implementation across outpatient and post-acute/long-term care settings. CMS contrasted this approach with existing Merit-based Incentive Payment System (MIPS) measures that evaluate appropriate statin use among defined risk groups, noting that the proposed measure examines the result of therapy whether achieved through medications, diet, or exercise rather than only prescriptions. CMS highlighted that the measure aligns with the MAHA priorities by supporting prevention of future cardiovascular events and managing an established chronic condition.

Measure Discussion: Committee members discussed broadening the measure's scope beyond patients with established ASCVD to support earlier identification and intervention.

Several committee members supported including individuals with high LDL-C or additional risk factors such as diabetes or family history, suggesting either a two-part structure for primary and secondary prevention or the development of a complementary upstream measure. Committee members agreed that LDL-C levels below 70 mg/dL remain well supported for secondary prevention but cautioned against rigid thresholds for primary prevention due to variable evidence and patient differences. They favored approaches emphasizing appropriate therapy use, treatment intensification, and risk-stratified targets.

Committee members underscored the influence of social and behavioral factors on cardiovascular health. They recommended explicitly accounting for non-medical drivers of health such as access to healthy food, safe environments for activity, affordability of medications, caregiver support, and reliable internet access. They called for alignment between quality measures and payment policies to support affordability of both statins and non-statin therapies. They also noted the importance of accommodating medication intolerance, side effects, and competing clinical priorities. Committee members highlighted the importance of ensuring appropriate exclusion criteria, such as frailty, advanced illness, and documented intolerance. Committee members identified attribution at the individual clinician level as a key challenge in team-based care, where multiple clinicians contribute to management and in settings with short stays relative to a 12-month measurement window.

Additional Considerations and Future Directions:

- Committee members encouraged CMS to clarify ASCVD diagnostic criteria (potentially aligning with Healthcare Effectiveness Data and Information Set [HEDIS]) and evaluate options for expanding the denominator to include primary prevention populations.
- Committee members urged CMS to harmonize with existing measures to include frailty, advanced illness, and medication intolerance exceptions.
- The American Heart Association (AHA) stated that measure specifications will be revisited for updates following the release of their forthcoming dyslipidemia guideline in Q1 2026.

Malnutrition Care Score

Overview: This measure is a composite digital eCQM focused on nutrition and was endorsed in 2024. The measure is included on the 2025 MUC List, targeting inclusion in the Prospective Payment System- (PPS-) Exempt Cancer Hospital Quality Reporting Program. The measure evaluates the quality and completeness of malnutrition care, specifically across four components: risk screening, nutrition assessment, malnutrition diagnosis, and nutrition care planning. The score reflects the completion of appropriate steps based on patient risk and status, aiming to promote early identification and coordinated, multidisciplinary nutrition care. This measure applies to adult inpatient hospitalizations lasting 24 hours or more for patients aged 18 and older, with hospice encounters excluded. CMS clarified that they already implemented the measure in the Hospital Inpatient Quality Reporting (IQR) Program and the Medicare Promoting Interoperability Program. The eligible population was expanded from age 65 and older to age 18 and older in the fiscal year (FY) 2025 final rule. CMS noted that the measure supports early identification of patients at risk for malnutrition, multidisciplinary nutrition care, continuity of care across transitions, and improvement in quality of life.

Measure Discussion: Committee members broadly supported the importance of identifying and addressing malnutrition during inpatient stays, noting its alignment with whole-person health and prevention goals. Several committee members urged consideration of expanding the

measure beyond acute inpatient hospitals to outpatient settings, home health, and PAC/LTC to better reflect continuity of care. Some members had concerns around feasibility centered on resource burden and workforce constraints, particularly the availability of registered dietitians (RDs) in rural communities and critical access hospitals. While telehealth can help bridge these gaps, participants noted it may not be available continuously, creating implementation challenges for short-stay patients. Committee members emphasized the complexity of implementing the measure as an eCQM and stressed aligning measurement with payment policy, because nutrition support is often not covered post-discharge.

Multiple committee members emphasized social determinants of health (SDOH), especially food insecurity and food deserts as key drivers of malnutrition that limit the impact of inpatient interventions once patients return home. They cautioned that without attention to access, affordability, caregiver support, dental care, and transportation, screening and care planning alone may not improve outcomes. Some noted inpatient issues such as prolonged or inappropriate “nil per os” (NPO) status and unmet assistance needs at mealtime that the measure does not directly capture but affect nutrition care.

The committee raised concerns about public reporting and attribution, warning of potential misunderstanding if hospitals are perceived as responsible for long-term nutrition outcomes that extend beyond their control. Committee members recommended standardized data capture (e.g., USCDI), improved electronic health record (EHR) vendor support for discrete fields and reporting, and better sharing of nutrition information across settings to support continuity of care. The developer underscored that RD-led assessments and individualized care plans incorporate SDOH and are coordinated with interdisciplinary teams and that digital engagement with dietitians can supplement local staffing where feasible.

Additional Considerations and Future Directions:

- Committee members suggested pairing the measure with an outcome or follow-up indicator (e.g., patient/caregiver understanding of the plan, post-discharge access to nutrition support) to mitigate the risk of “checklist compliance” without meaningful patient impact.
- Committee members encouraged expansion to psychiatric hospitals and other settings with setting-specific guidance, and suggested exclusions and person-centered criteria, particularly for terminal diagnoses or goals that are not focused on consuming food orally.

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

Overview: This process measure is an eCQM assessed at the clinician level that is currently in use in MIPS and the Medicare Shared Savings Program. The measure promotes routine BMI screening in adults and appropriate follow-up plans when BMI is outside the normal range and supports early identification of obesity-related risk and referral to evidence-based interventions. The measure counts patients with documented BMI, and when abnormal, there is a documented follow-up plan, which may include counseling, referral, or treatment aligned with clinical guidelines. CMS noted that patients who refuse measurement are captured via denominator exceptions and are not expected to have a follow-up plan.

Measure Discussion: The committee acknowledged the public health importance of addressing obesity and overweight status, while highlighting significant limitations of BMI as a standalone indicator. Multiple committee members noted misclassification risks for older adults, athletes, and individuals with higher muscle mass or differing body composition and pointed to

emerging definitions of obesity that are not based solely on BMI or that account for visceral adiposity. Several committee members urged adding complementary assessments (e.g., waist-to-hip ratio, anthropometrics, body fat percentage) and recognizing low BMI/frailty as an important risk state. Others shared experiences of weight-related bias, particularly among women, and urged integrating mental health screening, given the influence of depression and other behavioral health conditions on weight management. Committee members also noted medication-related weight changes can affect BMI and asked whether the measure allows documentation of such contributors. Regarding follow-up plans, the committee suggested leveraging tools such as the Malnutrition Care Score to promote care planning when registered dietitians are not available and considering policies that support hybrid/remote dietitian services in resource-constrained settings.

Committee members requested clarity on the tool used to classify BMI status and proposed a second verification step before labeling someone overweight. Views differed on the net benefit of BMI screening, with some arguing that BMI remains a useful entry point despite imperfections, while others urged against advancing a metric viewed as imprecise without concurrent improvements.

Committee members raised concerns around limited claims-based data (e.g., inconsistent capture of Z-codes for BMI) and coverage variability for pharmacotherapy (e.g., GLP-1s) that could affect comparability.

Additional Considerations and Future Directions:

- Committee members encouraged CMS to consider whether linkages with nutrition assistance program data could inform strategies on obesity and malnutrition.
- Committee members suggested that CMS also include a low-BMI threshold for actionability and provide clear guidance on acceptable classification tools.
- Committee members encouraged integration of mental health screening and counseling within follow-up plans to support sustained behavior change and reduce stigma.

Well-Being Signs (WBS)

Overview: This patient-reported outcome performance measure (PRO-PM) assesses whole-person well-being, focusing on what matters most to patients, and expands quality measurement beyond disease-specific outcomes. CMS indicated they are considering the Well-Being Signs concept broadly across programs and sought input on its potential uses and specifications as a concept of well-being. They acknowledged use of the measure within the Veterans Health Administration (VHA), including use in pain clinics to support shared decision-making and care planning. CMS emphasized interest in patient-centered measurement that does not focus solely on disease state and captures what matters to patients. They invited feedback on burden, harmonization with existing instruments, and digital implementation to enable broader adoption.

Measure Discussion: Committee members broadly supported the intent to incorporate the patient voice and focus on whole-person health. Many participants noted strong alignment with the Age-Friendly Health Systems 4Ms (“What Matters, Medication, Mentation, Mobility”), Patient Priorities Care, and MAHA’s emphasis on outcomes that matter to patients. VHA representatives reported successfully using the measure to facilitate shared decision-making and care planning, and several committee members highlighted value for patients with complex or rare conditions

whose priorities may not be reflected in disease-specific metrics. Others emphasized that only patients can provide this information and that WBS captures a concept distinct from traditional quality-of-life measures. Committee members stressed that eliciting honest input requires relationships, feedback loops, and access to social work or case management when possible.

Committee members encouraged team-based approaches to distribute responsibilities across care teams and recommended using existing encounters to limit added burden. Some committee members observed the current measure concept appears to assess completion or collection of patient input rather than improvement over time or action taken in response to results. They recommended clarifying whether the measure assesses change against a baseline, requires clinician action, or remains a process indicator. Concerns arose that completion rates alone do not reflect quality outcomes and could lead to "check-the-box" behavior without benefit to patients.

Many committee members expressed concern about survey fatigue, literacy barriers, low response rates, and administrative costs. They recommended integrating the measure into existing surveys such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) or Health Outcomes Survey (HOS) with case-mix adjustment rather than creating a separate instrument. Others suggested incorporating it into clinical workflows (e.g., Medicare Annual Wellness Visit or Chronic Care Management) to support in-visit discussions, rather than post-visit surveys, if the goal is to prompt conversation and care planning. Committee members also noted potential overlap with Patient Health Questionnaire-9 (PHQ-9) and related mood assessments already collected in certain settings and requested clarification on whether Well-Being Signs would replace, complement, or add to existing instruments and whether correlations with PHQ-9 have been examined.

While the developer reported validation evidence, participants asked for testing in larger, diverse populations and across health systems with varying payer mixes and EHRs before inclusion in payment programs. They also raised concerns about aggregation and interpretation across heterogeneous patient panels and life stages, recommending stratification and careful methodological design.

Additional Considerations and Future Directions:

- Committee members requested provision of details on operationalization (e.g., Fast Healthcare Interoperability Resources [FHIR] profiles, USCDI elements) and reduce provider burden and enable cross-program harmonization.
- Committee members urged CMS to ensure actionability and non-punitive use.

Closing Acknowledgements

Ms. Rabel thanked all attendees for their active and enthusiastic participation. She sought feedback from attendees on what went well during this meeting and areas of improvement for future consideration. Dr. Schreiber acknowledged the diverse perspectives within the committee and expressed appreciation for the committee members' dedication to improving health care quality. She emphasized that CMS values and listens closely to the committee's input.

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