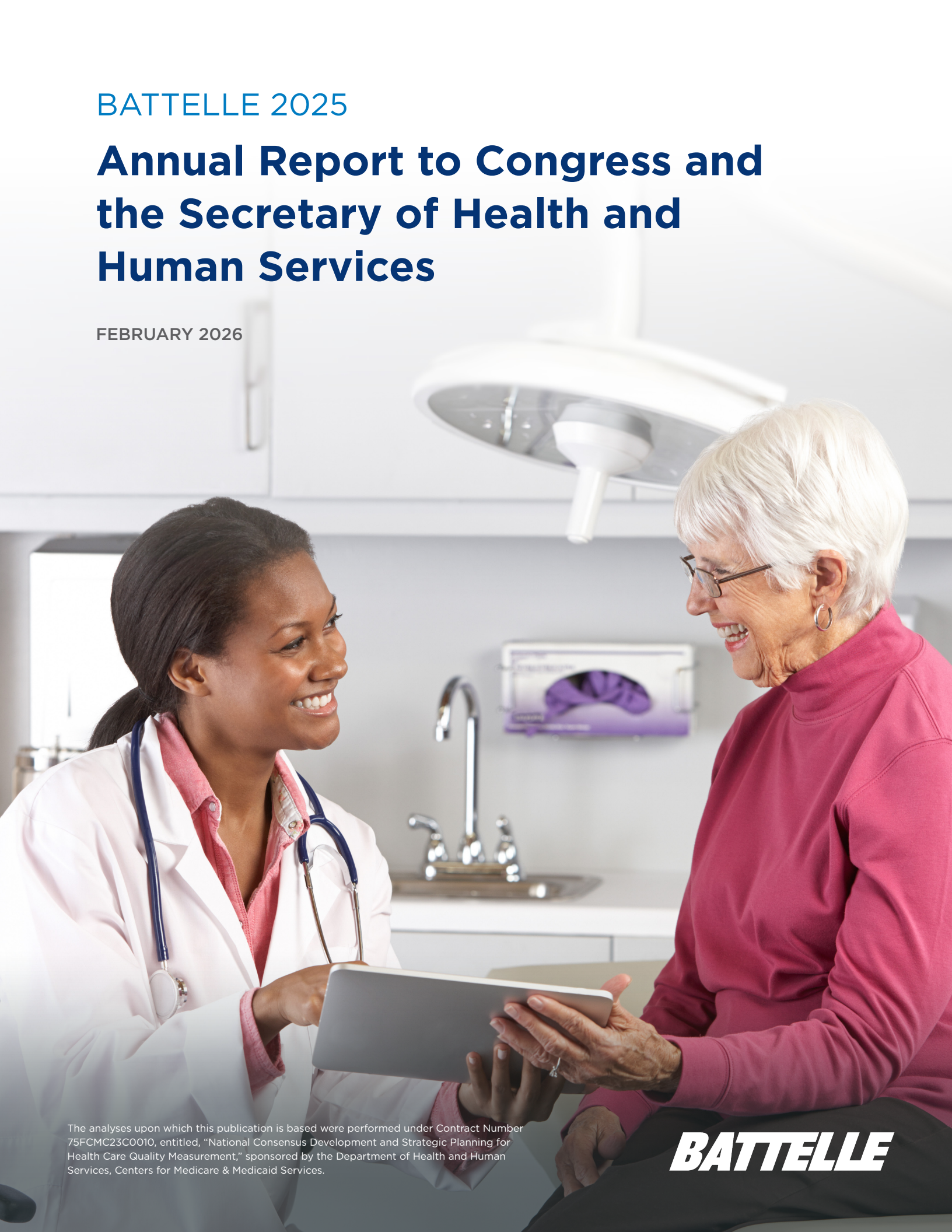
BATTELLE 2025

Annual Report to Congress and the Secretary of Health and Human Services

FEBRUARY 2026



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BATTELLE

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EXECUTIVE SUMMARY

BACKGROUND

Battelle, the world's largest independent, not-for-profit applied science and technology organization, has over 35 years of experience advancing the science and translation of health care quality. As a certified consensus-based entity (CBE), Battelle launched the Partnership for Quality Measurement (PQM) to convene individuals from across the continuum of care to review measures based on their expertise and lived experiences. The purpose of this report is to provide Congress and the Secretary of the Department of Health and Human Services (HHS) with an update on the work Battelle accomplished from January 1, 2025, to December 31, 2025.

ACCOMPLISHMENTS

In 2025, Battelle's CBE strengthened the transparency, rigor, and efficiency of the national quality measurement system. Over the year, Battelle engaged more than 469 committee members to review 165 measures as part of our Endorsement & Maintenance (E&M), Pre-Rulemaking Measure Review (PRMR), and Measure Set Review (MSR).

Additionally, Battelle facilitated the review of 173 measures across seven workgroups under the Core Quality Measures Collaborative (CQMC).

This year marked significant progress in expanding the scientific and technical foundations of measurement science. Battelle launched and advanced projects to:

- **Create a 5-year strategic framework** to guide sustained innovation, accountability, and relevance, ensuring the CBE continues to deliver meaningful and science-based recommendations to the Centers for Medicare & Medicaid Services (CMS) and Congress.
- **Evaluate the readiness and reliability of digital measures**, including structured frameworks to assess data quality, interoperability, and implementation feasibility.

CBE ANNUAL TIMELINE

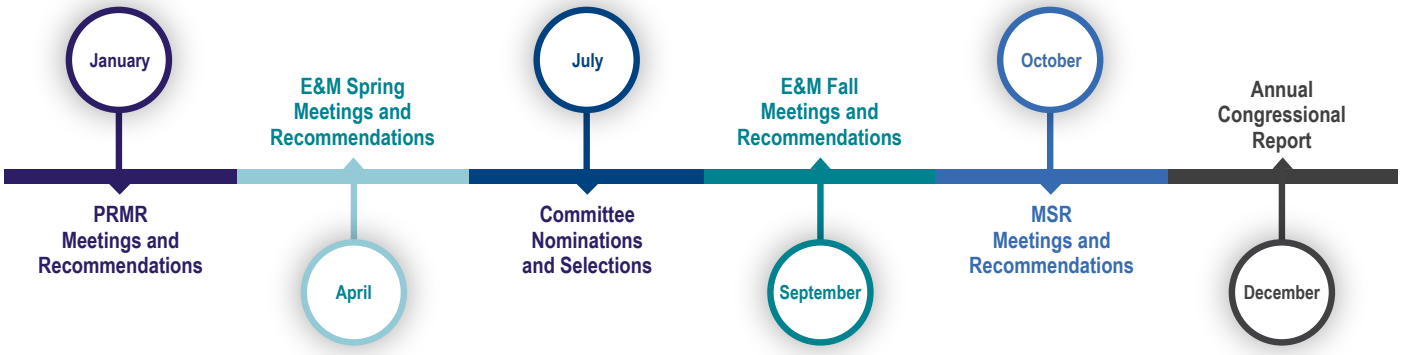

Figure 1. CBE Annual Timeline

- **Explore the responsible use of artificial intelligence** to reduce burden in measurement development and evaluation.
- **Improve decision-making tools for committee members**, ensuring consistent application of scientific, clinical, and usability criteria, while staying patient and clinician focused.

Collectively, these efforts enhance the ability to identify high-value measures, improve alignment across programs, and accelerate adoption of modern data-driven measurement approaches. They also position the CBE to continue leading national efforts to modernize quality measurement in ways that reduce burden, close care gap, and reflect real-world performance.

Partnership for Quality Measurement
Powered by Battelle

PQM MEMBERSHIP

The Partnership for Quality Measurement (PQM) continued to represent a broad national cross-section of perspectives in CBE activities this year. PQM includes 1,900 individual and organizational members across multiple healthcare sectors. Although members are not required to report a profession or area of interest, Figure 2 shows a breakdown of members by these categories as disclosed. Membership is free and open to all interested stakeholders to support transparent and accessible participation in the consensus process.

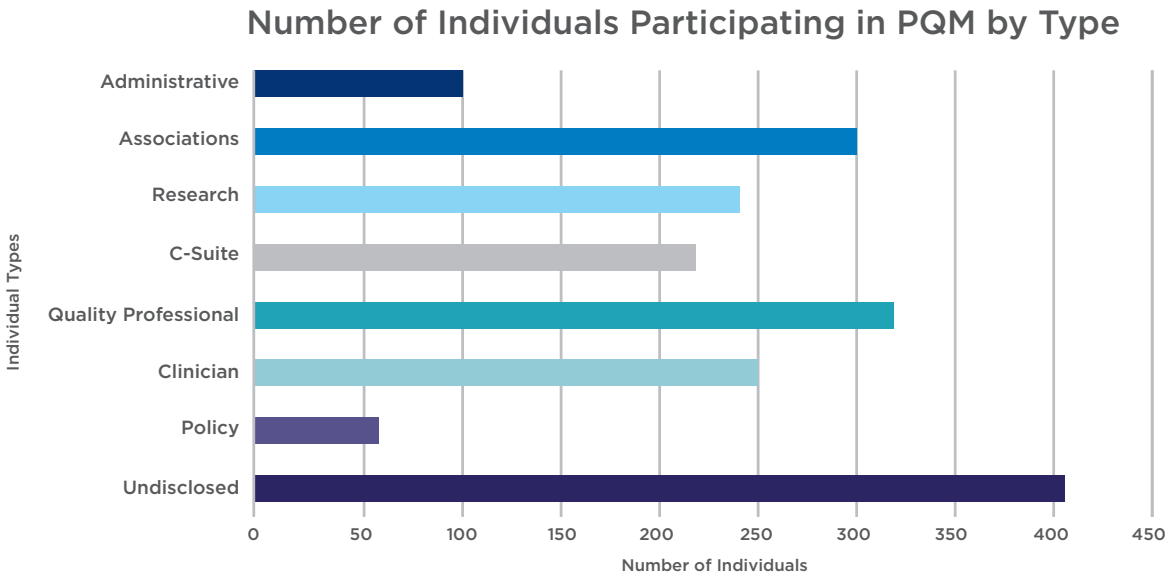

Figure 2. Number of Individuals Participating in PQM by Type

CORE PROCESSES

As part of the National Consensus Development Contract, Battelle oversees four core tasks.

Endorsement and Maintenance (E&M): evaluates whether a quality measure is safe, effective, and likely to improve health outcomes.

Pre-Rulemaking Measure Review (PRMR): provides recommendations on whether a measure should be added to a CMS program based on whether the measure is reasonable, necessary, and appropriate for a specific program context and beneficiary population.

Measure Set Review (MSR): assesses existing CMS program measure sets to identify opportunities for measure removal. MSR evaluates the trade-offs between measure benefit and burden.

Core Quality Measures Collaborative (CQMC): convenes stakeholders to maintain and update core measure sets that support national alignment across public and private sectors.

THE FOUR DISTINCT PROCESSES

E&M	PRMR	MSR	CQMC
Consensus-based endorsement of measures	***Recommendation to add measure to CMS program***	***Recommendation to remove measure from CMS program***	***Cross-payer measure alignment***
Review clinical quality and cost/resource use measures submitted for initial endorsement or routine maintenance. Determine whether measures are: • Safe and effective • Likely to increase desired outcomes and unlikely to result in negative unintended consequences	Review measures submitted to CMS as part of the pre-rulemaking process. Determine whether measures are: • Reasonable and necessary • Suitable in the context of the specific CMS value-based program(s) and population of CMS entities and beneficiaries	Review measures within the CMS portfolio of active measures. Assess: • Whether measures align with CMS's current needs and priorities • The trade-offs in measure implementation, experience, benefit, and burden within a measure domain	Battelle partners with CMS and AHIP as part of a public-private partnership, tasked with the development and maintenance of core sets of measures to assess the quality of health care in the U.S. Maintain core sets that: • Identify high-value, high-impact, evidence-based measures • Align measures across public and private payers

Figure 3. The Four CBE Core Tasks

ENDORSEMENT AND MAINTENANCE (E&M)

Battelle's E&M process evaluates the safety, effectiveness, and continued value of measures in the CBE measure portfolio. E&M measures span care settings and patient populations. E&M committees assess the measures for reliability, validity and relevance using five key domains:

- **Importance:** assesses whether the measure is evidence based and necessary to improve health care quality and cost.
- **Closing Care Gaps:** considers whether the measure can identify differences in care across patient subpopulations to support targeted improvement.
- **Feasibility:** reviews whether the required data are available or can be collected with minimal burden.
- **Scientific Acceptability:** examines whether the measure produces credible and consistent results.
- **Use and Usability:** assesses the use of the measure for accountability and quality improvement across care settings and patient populations.

Using these criteria, the committee reviews and provides a recommendation to Battelle on endorsement status.

FEEDBACK RELATED TO E&M

"We see and appreciate the tremendous effort the staff put into running these processes and meetings with high integrity, efficiency, and rigor. Appreciate all of you and also the time and guidance you've been willing to give to our team across the last couple of cycles to help us prepare."

-Measure Developer

Importance of E&M

Battelle's E&M process provides a credible and transparent method for determining whether measures meet rigorous, evidence-based criteria required for endorsement. The process ensures endorsed measures reflect high-quality science, support consistent use across the health care system, and maintain trust among clinicians, patients, purchasers, and federal partners.

Recommendations and Voting Outcomes

Across two E&M cycles, Fall 2024 and Spring 2025, measure developers and stewards submitted 92 measures; the E&M committees reviewed 59. Of those measures:

- 21 were endorsed.
- 33 were conditionally endorsed.
- 5 were not endorsed or endorsement removed.

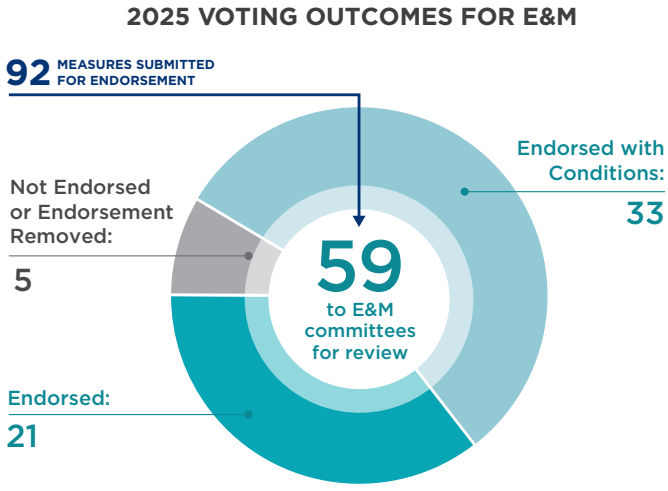

Figure 4. 2025 E&M Voting Outcomes

PRE-RULEMAKING MEASURE REVIEW (PRMR)

Battelle conducts the PRMR process to provide consensus-based recommendations on the value of adding measures to CMS programs. PRMR evaluates each measure across three domains:

- **Meaningfulness:** assesses if the measure meets criteria for importance, scientific soundness, feasibility, and usability for the intended population and program.
- **Appropriateness of Scale:** examines if the measure is applied in a way that maximizes its value across different segments of the target population.
- **Time-to-Value Realization:** determines if available evidence demonstrates a clear and feasible path from measurement to meaningful improvement in performance.

Using this criteria, the PRMR committee provides a recommendation to CMS on adding a specific measure to add to a CMS program.

Importance of PRMR

PRMR provides CMS with transparent, evidence-informed recommendations on the reasonableness and necessity of measures proposed for program use. This process enhances clarity and consistency in federal measure-selection decisions and broadens the perspectives available to CMS by incorporating structured input from clinicians, patients, and other stakeholders who would be most affected by the use of these measures.

Recommendations and Voting Outcomes

2024-2025 PRMR committees had 155 members, including 19 patients and 55 clinicians. Battelle received 239 written comments on Measures under Consideration (MUC) measures from 234 professional organizations and 56 patients/patient representatives. Three public listening sessions drew 359 attendees.

During this cycle, which ended February 2025, the PRMR committee provided recommendations on 52 measures:

- 27 measures were recommended; 17 of which were recommended with conditions, 10 with no conditions.
- 5 measures were not recommended.
- 20 measures did not reach consensus.

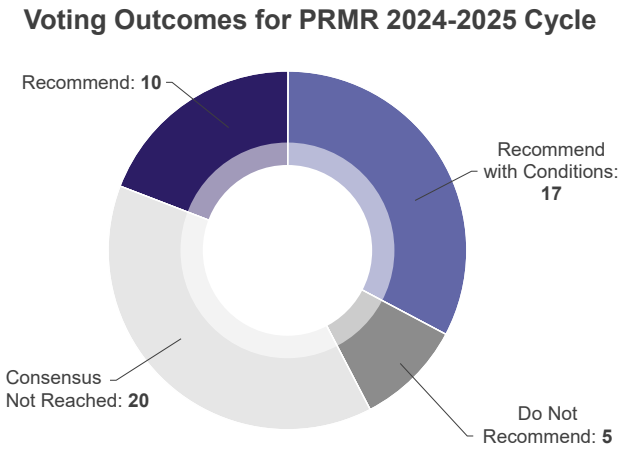

Figure 5. 2025 PRMR Voting Outcomes

Figure 6. PRMR Committee Members

MEASURE SET REVIEW (MSR)

Battelle conducts the MSR process to review measures currently used in CMS programs and provide consensus-based recommendations on their continuation or removal. MSR applies updated evidence, evolving improvement priorities, and implementation experience to ensure measures remain streamlined and aligned and remain well-suited for value-based care.

The MSR process evaluates measures across three domains:

- **Meaningfulness:** assesses if the measure continues to meet criteria for importance, feasibility, scientific acceptability, and usability across relevant programs and populations.
- **Data Stream Parsimony:** identifies opportunities to reduce redundancy, eliminate duplicative data streams, and improve alignment to lessen burden on implementers.
- **Patient Journey:** examines if the measure continues to function as intended across the patient journey and remains consistent with the measure's impact model.

Using this criteria, the MSR committee provides a recommendation to CMS to retain or remove a measure from a CMS program.

The **PRMR process** makes consensus recommendations about measures on the MUC List.

The **MSR process** builds consensus around measure continuation to optimize the CMS measure portfolio in the value-based programs.

COMMITTEE MEMBER FEEDBACK FROM THE 2025 MSR RECOMMENDATION GROUP MEETING

"I am honored to be a part of this meeting for the first time and really enjoyed this process."

"Love seeing the continuous improvement in the [committee feedback] process over the past few years. You've done a great job incorporating feedback and making the [committee feedback] process more meaningful and user friendly."

Importance of MSR

MSR grounds recommendations in updated evidence and real-world implementation experience so CMS programs can have fewer, clearer, and more impactful measures. This process supports alignment across programs, reduces unnecessary data collection burden, and preserves a portfolio that reflects current priorities and patient needs.

Recommendations and Voting Outcomes

The MSR Recommendations Group reviewed 21 measures across six CMS programs. Following deliberation:

- 15 measures were recommended for continued use.
- 6 measures were not recommended for continued use.

2025 VOTING OUTCOMES FOR MSR

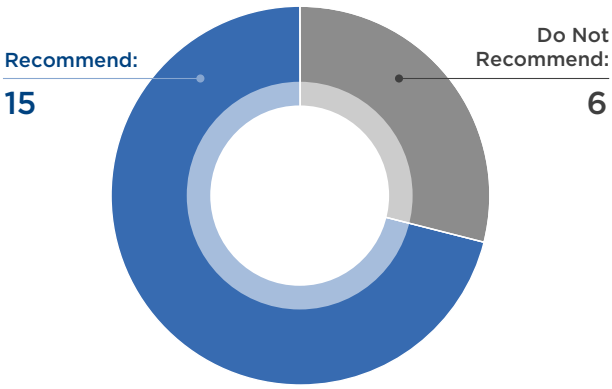

Figure 7. 2025 MSR Voting Outcomes

CORE QUALITY MEASURES COLLABORATIVE (CQMC)

CQMC is a broad based coalition of health care leaders that facilitates cross payer measure alignment through development and maintenance of core sets of measures. Core sets are organized around specific conditions or topics and can be implemented as a full set or individually, depending on user needs and context.

Importance of CQMC

CQMC's work promotes alignment, efficiency, and focus on outcomes that matter to patients. By streamlining and harmonizing measures across payers and programs, core sets help reduce measurement burden, support high-value care, and enhance the ability of the health care system to deliver better care, better health, and better value across the health system.

Updates

In 2025, the CQMC continued ongoing maintenance and enhancement of core measure sets by conducting both light and full maintenance reviews across clinical areas. CQMC also refined its annual update process to align with evolving clinical guidelines, data quality, and risk adjustment methods.

SUMMARY

In 2025, Battelle's CBE work advanced national quality measurement by conducting rigorous evaluations, providing consensus-based recommendations, and promoting alignment across programs and stakeholders. These efforts ensure that endorsed measures, recommended measures, and core sets remain scientifically sound, meaningful, and feasible, while reducing unnecessary burden. The CBE remains well-positioned to continue leading initiatives that improve measurement, support better health outcomes, and provide actionable insights to inform federal quality programs.

1.0 Introduction

1.1 Background

Battelle is the world's largest independent, non-profit applied science and technology organization, renowned for its commitment to innovation and excellence. Its mission is to translate scientific discoveries and technological advances into tangible societal benefits. Since 2023, Battelle has held the Centers for Medicare & Medicaid Services (CMS) National Consensus Development and Strategic Planning for Health Care Quality Measurement contract (NCDC).

STATUTORY AUTHORIZATIONS & REQUIREMENTS

The Medicare Improvement for Patients and Providers Act of 2008 (MIPPA) added section (§) 1890 of the Social Security Act (SSA) and requires the Secretary of the Department of Health and Human Services (HHS) to contract with a consensus-based entity (CBE) to synthesize evidence and convene key stakeholders to make recommendations focused on improving performance within the health care system. These activities include reviewing and endorsing standardized health care performance measures and reviewing previously endorsed measures through a maintenance review process. Section 3014 of the Patient Protection and Affordable Care Act (the Affordable Care Act, or ACA) expanded the duties of the CBE to include convening stakeholder groups. These groups provide input on the selection of quality measures used in reporting performance information to the public and in specific value-based performance programs. A further evolution of the CBE's role has included the recent addition of convening stakeholders to provide CMS with guidance on which measures should be considered for removal from its programs.

The scope of the NCDC aligns with the requirements listed in §1890 of the Social Security Act.

Battelle established the Partnership for Quality Measurement (PQM) to convene a national community to review clinical quality measures (CQMs) based on members' expertise and lived experiences. PQM brings together patients and caregivers, clinicians, health plans, health systems, measure developers, policymakers, implementers, and health information technology (IT) experts. Working with CMS and PQM committees, Battelle conducts four core processes as well as yearly initiatives. The core tasks are:

- **Endorsement and Maintenance (E&M):** convenes committees to evaluate clinical quality and cost/resource use measures for initial endorsement or maintenance by assessing safety, effectiveness, and risks of unintended harm in accountability use.
- **Pre-Rulemaking Measure Review (PRMR):** reviews measures under consideration for CMS value-based programs to determine whether they are reasonable and necessary for the intended use.
- **Measure Set Review (MSR):** examines active CMS program measures to confirm alignment with current priorities; recommends removal or replacement when not aligned.
- **Core Quality Measures Collaborative (CQMC):** partners with CMS and AHIP (formerly known as the American Health Insurance Partnership) in a public-private effort to align measures across payers and reduce clinician reporting burden.

1.2 Partnership for Quality Measurement (PQM)

Battelle established PQM to convene a national community that advises on clinical quality measures and supports CBE duties. PQM brings together patients and caregivers; clinicians and health systems; payers (health plans); measure developers, stewards, and researchers; policymakers and implementers; and health IT experts.

PQM's vision is a review process that is reliable, transparent, attainable, and meaningful. To reduce participation barriers, PQM membership is free to both individuals and organizations.

PQM invites nominations from its members through open calls and selects committee members to ensure a balanced mix of stakeholders with relevant expertise. Committee members apply firsthand experience and professional expertise to assess quality and cost and resource use measures for endorsement or use in CMS programs. In 2025, 437 committee members served across 10 multi-stakeholder committees. Figure 8 shows sector representation.

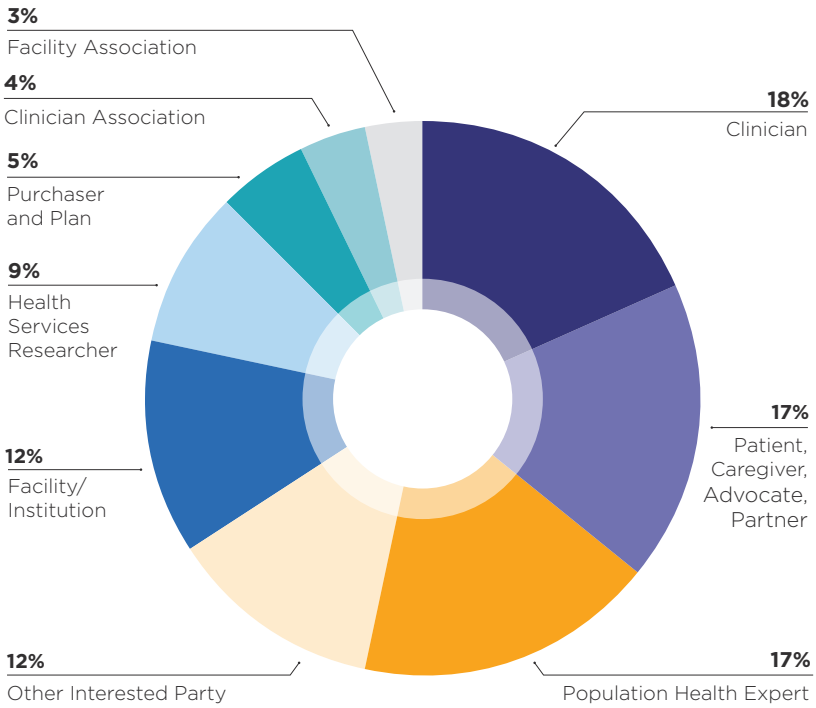

Figure 8. Proportional Representation of Health Care Sectors in PQM Committees and Other Groups in 2025

1.3 Importance of the CBE

The CBE provides a transparent, evidence-informed, and standardized approach to developing and evaluating performance measures used in the U.S. health care system. Its work ensures that measures are scientifically sound, meaningful, and implementable, balancing potential benefits to patients, clinicians, and the health system with practical burdens of data collection and reporting.

1.4 Audience

The primary audiences for this report are Congress, the Secretary of the U.S. Department of Health and Human Services (HHS), CMS, and other federal staff and officials. Secondary audiences include stakeholders engaged in health care quality measurement and value-based care across the delivery system.

1.5 Report Organization

Pursuant to §1890(b)(5)(A), the CBE must submit a report to Congress and the Secretary of HHS by March 1 of each year. Table 1 depicts the required content of the report and where it is located.

Table 1. Contents of the 2025 Annual Report to Congress and the Secretary of HHS

ELEMENT	SECTION
The implementation of quality and efficiency measurement initiatives and the coordination of such initiatives with quality and efficiency initiatives implemented by other payers	3.0
Recommendations on an integrated national strategy and priorities for health care performance measurement;	2.0
Performance of the CBE's duties required under its contract with the Secretary	1.0
Gaps in endorsed quality and efficiency measures, including measures that are within priority areas identified by the Secretary under the national strategy established under §399HH of the Public Health Service Act (National Quality Strategy), and where quality and efficiency measures are unavailable or inadequate to identify or address such gaps	3.7
Areas in which evidence is insufficient to support endorsement of quality and efficiency measures in priority areas identified by the Secretary under the National Quality Strategy, and where targeted research may address such gaps	3.3
The convening of multi-stakeholder groups to provide input on: (1) the selection of quality and efficiency measures from among such measures that have been endorsed by the CBE and such measures that have not been considered for endorsement by the CBE but are used or proposed to be used by the Secretary for the collection or reporting of quality and efficiency measures; and (2) national priorities for improvement in population health and the delivery of health care services for consideration under the National Quality Strategy	4.0, 5.0
An itemization of financial information for the previous fiscal year ending September 30, including	8.0
Annual revenues of the entity	8.1
Annual expenses of the entity	8.1
A breakdown of the amount awarded per contracted task order and the specific projects funded in each task order assigned to the entity	8.2
Any updates or modifications to internal policies and procedures of the entity as they relate to the duties of the CBE	9.0
Any modifications to the disclosure of interests and conflicts of interests for committees, workgroups, task forces, and advisory panels of the entity	9.0
Roster on all committee members	Appendix

2.0 Foundations for a National Strategy

Pursuant to §1890(b)(1) of the Social Security Act (SSA), the CBE must "synthesize evidence and convene key stakeholders to make recommendations, with respect to activities conducted under this Act, on an integrated national strategy and priorities for health care performance measurement in all applicable settings. In making such recommendations, the entity shall (A) ensure that priority is given to measures— (i) that address the health care provided to patients with prevalent, high-cost chronic diseases; (ii) with the greatest potential for improving the quality, efficiency, and patient-centeredness of health care; and (iii) that may be implemented rapidly due to existing evidence, standards of care, or other reasons; and (B) take into account measures that— (i) may assist consumers and patients in making informed health care decisions; (ii) address health disparities across groups and areas; and (iii) address the continuum of care a patient receives, including services furnished by multiple health care providers or practitioners and across multiple settings."

2.1 CBE Quality Measurement Strategy

CBE Strategy Overview

In 2025, Battelle launched a process to develop a 5-year strategic plan for the CMS-funded CBE. The plan is intended to be agnostic of the funded entity and focus on the purpose of the CBE's work. Battelle's strategy prioritizes quality measurement in areas where it can drive the greatest impact on health system change—specifically, where the underlying mechanisms are not yet well understood ('high uncertainty') but there is strong potential for improvement through behavioral or structural changes ('high potential for improvement').

A 5-year strategic plan provides a clear forward-looking roadmap that defines the CBE's priorities, goals, and actions over time. Its purpose is to translate mission and vision into measurable outcomes, ensuring that day-to-day activities in long-term investments align with the CBE's core purpose and the evolving needs of its stakeholders.

This document strives to:

- **Set and communicate direction:** Establish a shared vision for the entity's role and impact within the national quality measurement ecosystem.
- **Guide decision-making:** Provide a framework for allocating resources, prioritizing initiatives, and adapting to emerging challenges.
- **Ensure accountability and transparency:** Define measurable goals and progress indicators that demonstrate value to funders and partners in the public.
- **Strengthen sustainability:** Identify opportunities to innovate, expand engagement, and remain relevant amid policy, technology, and system change.

Ultimately, the strategic plan aligns the CBE's mission with a dynamic health policy environment balancing stability, transparency, and innovation over time. Battelle will provide annual updates on actions and accomplishments related to the CBE strategy.

CBE Strategy Updates

Battelle aims to advance the requirements of §1890 by leveraging CBE processes to promote sustainable health system change through better integration and alignment of quality measurement and quality improvement. Historically, the lack of such alignment has been a major driver of the perceived burden of quality measurement.

Through the CBE Quality Measurement Strategy, Battelle aims to reduce the perceived burden of quality measurement by concentrating resources on collecting, reporting, and using data that drive the greatest health system improvements. This strategy prioritizes areas with both high potential for impact (where improving performance to benchmarks would significantly reduce poor outcomes) and high potential for reducing uncertainty (where low-performing clinicians or facilities lack clarity on how to improve or overcome barriers). Measurement enables learning from high performers and identifying obstacles for low performers, supporting targeted improvement efforts.

In 2024, Battelle began reviewing individual measures as part of our assessment of the measurement portfolio. We now encourage measure developers to submit data showing performance score distributions by decile (the "Importance" table) and to provide a logic model with evidence explaining how high-performing clinicians or facilities achieve their results. Early implementation of this strategy has significantly influenced the number of measures endorsed or recommended through CBE processes. Long-standing measures must demonstrate high impact to remain in use. Some developers have struggled to provide the required logic model and evidence, a challenge that may disproportionately affect community-based developers or those working on pediatric or post-acute care measures. Battelle monitors this closely and offers technical assistance as needed.

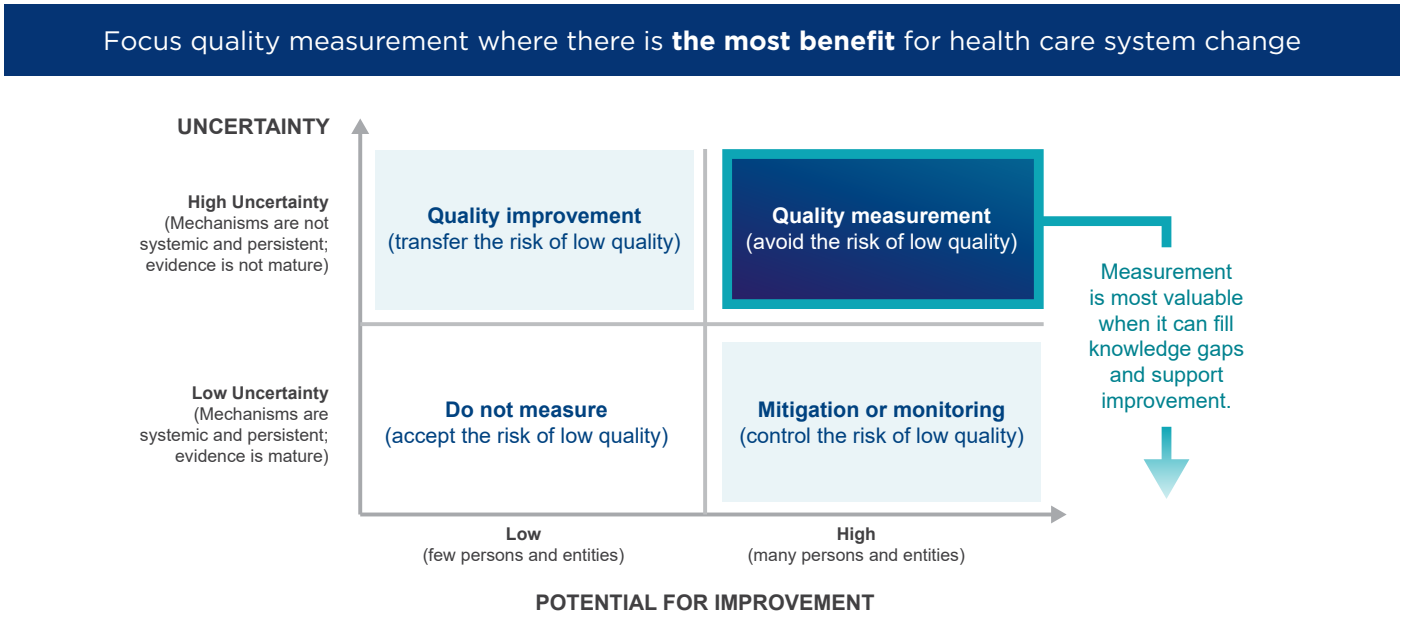

Figure 9. Strategy for Focusing Quality Measurement

Table 2. Assessing the Burden of Quality Data Collection, Reporting, and Use

Burden Category	Description
Data Entry Costs/Workflow Modification Costs	Time spent entering information or modifying workflows exclusively for quality reporting
Quality Review Costs	Costs associated with reviewing quality
Metric Tracking Costs	Expenses for tracking quality metric specifications
Development Costs	Costs of developing and implementing data collection processes
Data Collection & Validation	Resources used in collecting and validating data
Vendor Fees and Proprietary Fees	Includes both survey implementation fees, electronic health record (EHR) vendor fees for modifying templates, and any other proprietary (licensing) fees
Training & Support Costs	Training staff to use new systems or follow new protocols
Technology & Infrastructure	Expenses related to technological infrastructure, software, or tools required for data collection and reporting
Miscellaneous Costs	Any other indirect costs related to administrative support, overhead, etc.

While impact and risk assess the benefits of measurement, Battelle also evaluates the burden of collecting, reporting, and using quality data. In literature, burden is defined as effort not directly related to patient care; data collected for patient care are not considered a burden. Recent studies increasingly examine the data burden, and Battelle will request additional details, including costs for workflow changes, data validation, and IT (e.g., system modifications, licensing). A small but consistent body of research estimates the direct costs of quality data collection and reporting, which can inform objective benefit-burden trade-off assessments. To advance this work, Battelle will pilot metrics to evaluate return on investment in quality measurement.

2.2 CBE Measure Portfolio

Battelle's online Submission Tool and Repository (STAR) is a searchable database and measure submission portal for endorsement review. Battelle regularly updates STAR, which includes key details for each measure—such as CBE ID, endorsement status, cycle, specifications, testing data, public comments, staff preliminary assessments, and committee reviews—ensuring transparency and accessibility throughout the endorsement process.

As of October 2025, the CBE portfolio included 337 endorsed clinical quality measures, representing a **net reduction of 67 measures** from the previous year. This reduction reflects a net effect of measure retirement and removal of endorsement by stewards and is a strategic effort to streamline the portfolio by focusing on rigor and relevance. While independent of CMS priorities, these efforts support CMS's goal of reducing provider burden and advancing high-impact measurement. The current portfolio includes:

- 169 outcome measures
- 129 process measures
- 15 cost measures
- 16 composite measures
- 8 structure measures
- 37 electronic clinical quality measures (eCQMs)

The portfolio's 37 eCQMs reflect the growing emphasis on digital transformation in quality measurement. eCQMs reduce burden by automating data capture from electronic health records (EHRs), minimizing manual chart abstraction and reporting. This increase in eCQMs directly supports CMS' goals for interoperability and improves provider efficiency, enhances the timeliness and accuracy of quality data. By supporting the transition to digital formats, the CBE advances CMS's goals for interoperability, real-time performance monitoring, and scalable quality improvement.

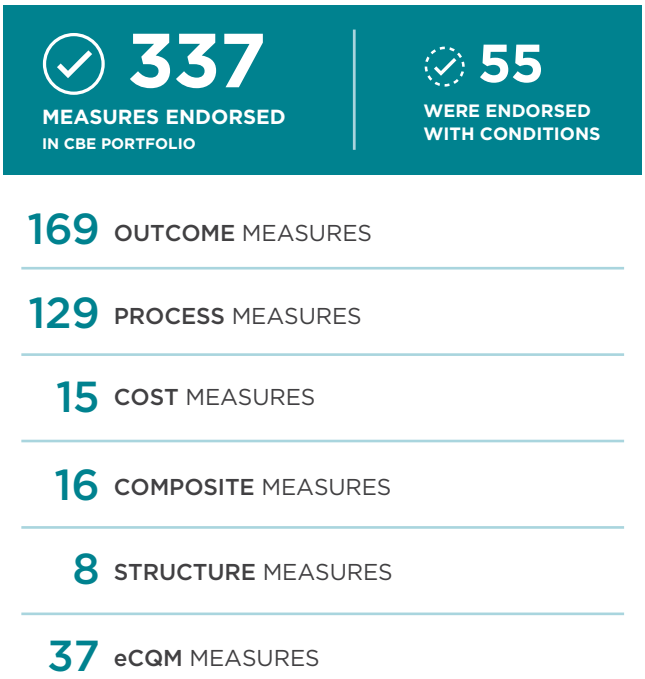

Figure 10. CBE Portfolio as of October 2025

Beyond initial E&M reviews, the CBE proactively engages measure developers and stewards to understand their plans for continued endorsement. This outreach has helped build a more streamlined, rigorous, and relevant measurement portfolio, keeping endorsed measures aligned with current clinical practice, policy priorities, and stakeholder needs across the health care system.

CBE is committed to burden reduction through portfolio consolidation and technical assistance to measure developers. These efforts help refine concepts, improve specifications, and ensure submitted measures are impactful and feasible to implement.

Battelle maintains portfolio integrity by verifying measure record accuracy and confirming continued interest in measures last endorsed over 5 years ago. These activities support gap analyses and inform committee discussions of emerging measurement needs, ensuring the portfolio evolves with the changing health care landscape.

2.3 Recommendations from Stakeholders

In 2025, Battelle convened stakeholders through the PRMR and MSR processes to build consensus on recommendations for CMS Medicare clinical quality measures. Over 5 days in January, Battelle led three PRMR committee meetings, bringing together CMS leadership, measure developers, and committee members to evaluate 41 proposed measures across 13 programs. In October, Battelle hosted a 2-day MSR meeting where committee members reviewed 21 measures active in CMS Medicare quality programs.

In measure-specific discussions, participants evaluated merits and challenges of measures under consideration (MUC) or measures in active use and identified opportunities to strengthen the quality measurement landscape.

Common themes across PRMR and MSR meetings included recommendations for CMS and measure developers to strengthen scientific rigor, reduce reporting burden, and better align measures sets with clinical practice and patient needs. The summary below highlights key takeaways from both review cycles.

Increase Stratified Reporting to Promote Meaningful Interpretation *PRMR*

Members recommended stratifying performance scores by patient- and provider-level factors such as rural/urban location, care type, and hospital trauma level to improve interpretability. They emphasized the need for stratification in rural and low-volume settings and for services such as behavioral health and maternity care.

Encourage CBE Endorsement *PRMR* *MSR*

Members urged measure developers to seek CBE endorsement before CMS consideration to ensure scientific rigor and to build stakeholder confidence.

Promote Representative and Rigorous Measure Testing *PRMR*

Members raised concerns about limited sample sizes and feasibility testing. They called for broader testing across a variety of EHR systems and greater transparency in how testing decisions are made.

Pair Cost and Quality Measures to Assess Value *PRMR*

Members recommended pairing cost measures with relevant quality indicators to ensure cost reductions do not compromise care quality—especially for high-cost conditions such as breast cancer and Parkinson's disease.

Support Data-Driven Improvement *PRMR*

Members encouraged CMS to provide regular performance feedback and to collaborate with providers during implementation, supporting continuous improvement.

Support Shared Decision-Making in End-of-Life Measures *PRMR* *MSR*

Members emphasized the importance of measures that reflect patient preferences and avoid penalizing providers for honoring individual care plans. They recommended incorporating flexibility into specifications to support freedom of choice.

Promote Harmonization and Alignment Across Programs *PRMR*

Members identified duplicative measures and called for standardized specifications and risk models across CMS programs to reduce reporting burden.

Adapt Measures to Shifts in Care Settings *PRMR*

Members noted the shift of procedures to outpatient settings and recommended revising risk adjustment models and developing parallel measures for ambulatory surgical centers.

Consider Phased Implementation of New Measures *PRMR*

Members proposed voluntary reporting periods or phased rollouts to ease adoption before full implementation in value-based programs.

Prioritize Measure Relevance and Lifecycle Management *MSR*

Members recommended retiring measures that are topped out, misaligned with guidelines, or lack actionability. They also called for proactive stewardship transitions to maintain continuity and data integrity.

Promote Scientific Rigor and Evidence-Based Design *MSR*

Members stressed the importance of aligning measures with current clinical guidelines and maintaining endorsement. They recommended updating exclusions and specifications based on evolving evidence.

Advance Care Continuity and Cross-Setting Coordination *MSR*

Members supported measures that incentivize coordination across inpatient, outpatient, and home health settings. They identified interoperability and attribution challenges—especially for measures reliant on community resources—as barriers to effective implementation.

Resolve Data Capture Challenges and EHR Limitations *MSR*

Members recommended transitioning to electronic reporting formats and exploring technologies such as artificial intelligence (AI) to reduce burden and improve data accuracy, particularly in resource-constrained settings.

Recognize and Mitigate Structural Barriers to Implementation *MSR*

Members called for adjustments to account for socioeconomic and clinical risk factors and for flexible reporting pathways to avoid penalizing providers serving vulnerable populations.

Integrate Public Health and Preventive Care *MSR*

Members prioritized preventive measures for their clinical and cost-saving benefits. They recommended streamlining reporting and enhancing digital infrastructure to support implementation.

Emphasize Patient-Centeredness and Shared Decision-Making *MSR*

Members strongly supported measures that reflect patient goals, particularly in oncology and end-of-life care. They recommended preserving low-burden, meaningful measures that support individualized care planning.

3.0 Implementation of Quality and Efficiency Measurement Initiatives

Pursuant to §1890(b)(2) of the SSA, the CBE shall "provide for the endorsement of standardized health care performance measures. The endorsement process under the preceding sentence shall consider whether a measure is (A) evidence-based, reliable, valid, verifiable, relevant to enhanced health outcomes, actionable at the caregiver level, feasible to collect and report, and responsive to variations in patient characteristics, such as health status, language capabilities, race or ethnicity, and income level; and (B) is consistent across types of health care providers, including hospitals and physicians." Section 1890 (b)(3) notes "the entity shall establish and implement a process to ensure that measures endorsed under paragraph (2) are updated (or retired if obsolete) as new evidence is developed." The CBE must describe results of these processes pursuant to §1890(b)(5)(i)(I) of the SSA.

3.1 E&M Overview

Battelle's E&M process evaluates the safety, effectiveness, and continued value of measures in the CBE measure portfolio. E&M measures are evaluated across five key domains:

- Importance
- Closing Care Gaps
- Feasibility
- Scientific Acceptability
- Use and Usability

Using these criteria, the committee reviews and provides a recommendation to Battelle on endorsement status.

The E&M cycles in this report cover October 2024–September 2025. During this period, Battelle reviewed and updated 110 clinical quality measures either as part of the endorsement process or maintenance of the E&M portfolio.

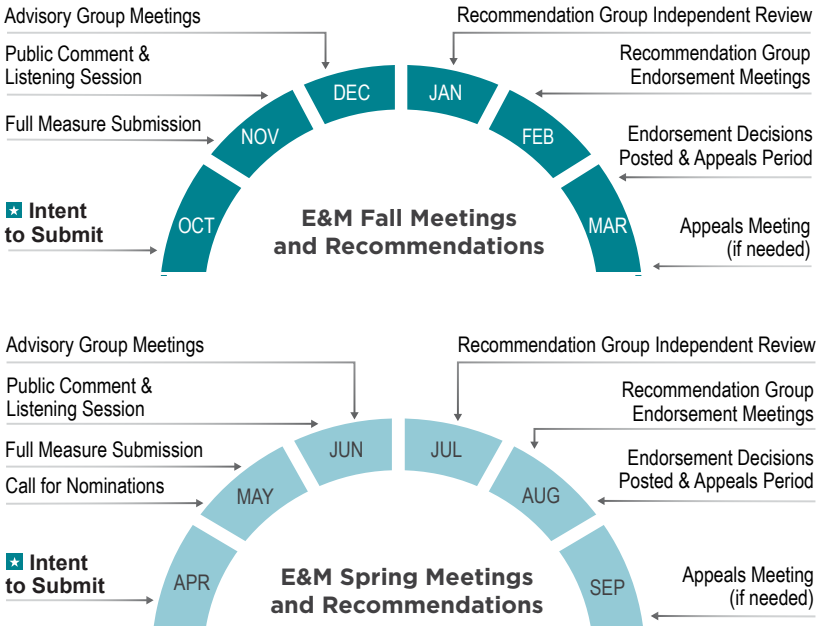

Figure 11. E&M Fall and Spring Timelines

Across two E&M cycles, Fall 2024 and Spring 2025, measure developers and stewards submitted 92 measures; E&M committees reviewed 59. Of those measures:

- 21 were endorsed
- 33 were conditionally endorsed
- 5 were not endorsed or endorsement removed

3.2 E&M Educational Guidance Documents

The following list outlines 2025 E&M Educational Guidance Documents.

E&M Policies

- Endorsement and Maintenance (E&M) Guidebook

2024 Fall Project Reports

- Primary Prevention
- Initial Recognition and Management
- Management of Acute Events and Chronic Disease
- Cost and Efficiency
- Advanced Illness and Post-Acute Care

2025 Spring Project Reports

- Primary Prevention
- Initial Recognition and Management
- Management of Acute Events and Chronic Disease
- Cost and Efficiency
- Advanced Illness and Post-Acute Care

E&M Educational Guidance Documents

- Reliability
- Pediatric Clinical Quality Measures
- Logic Models
- Closing Care Gaps

3.3 E&M Annual Results

This year, Battelle convened committees to review measures submitted during the Fall 2024 and Spring 2025 E&M cycles. The Fall 2025 cycle is ongoing and will be incorporated into next year's report.

Measure developers and stewards submitted a total of 92 measures: 39 in Fall 2024 and 53 in Spring 2025. Of these, committees reviewed 59. Developers/stewards withdrew the remaining 33 due to deferral review requests, combined submissions, or discontinued endorsement maintenance (Tables 3 and 4).

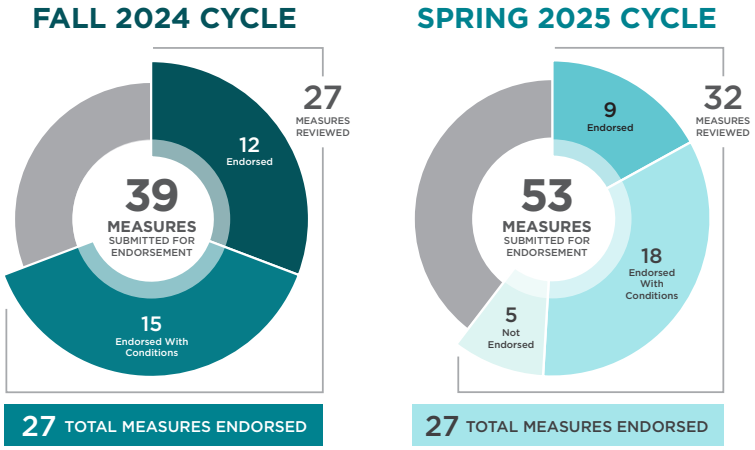

Figure 12. E&M Outcomes and Topics for Fall 2024 and Spring 2025

Fall 2024 Cycle Measures

For the Fall 2024 cycle, developers/stewards submitted 39 measures, including 24 new measures and 15 maintenance measures. Developers/stewards withdrew 12 measures due to deferral requests to a future cycle or combining with another measure submission. Table 3 details committee endorsement and maintenance recommendations for the Fall 2024 cycle.

Spring 2025 Cycle Measures

For the Spring 2025 cycle, developers/stewards submitted 53 measures, including 23 new measures and 30 maintenance measures. Developers/stewards withdrew 21 measures due to deferral requests to a future cycle. Table 4 details committee endorsement and maintenance recommendations for the Spring 2025 cycle.

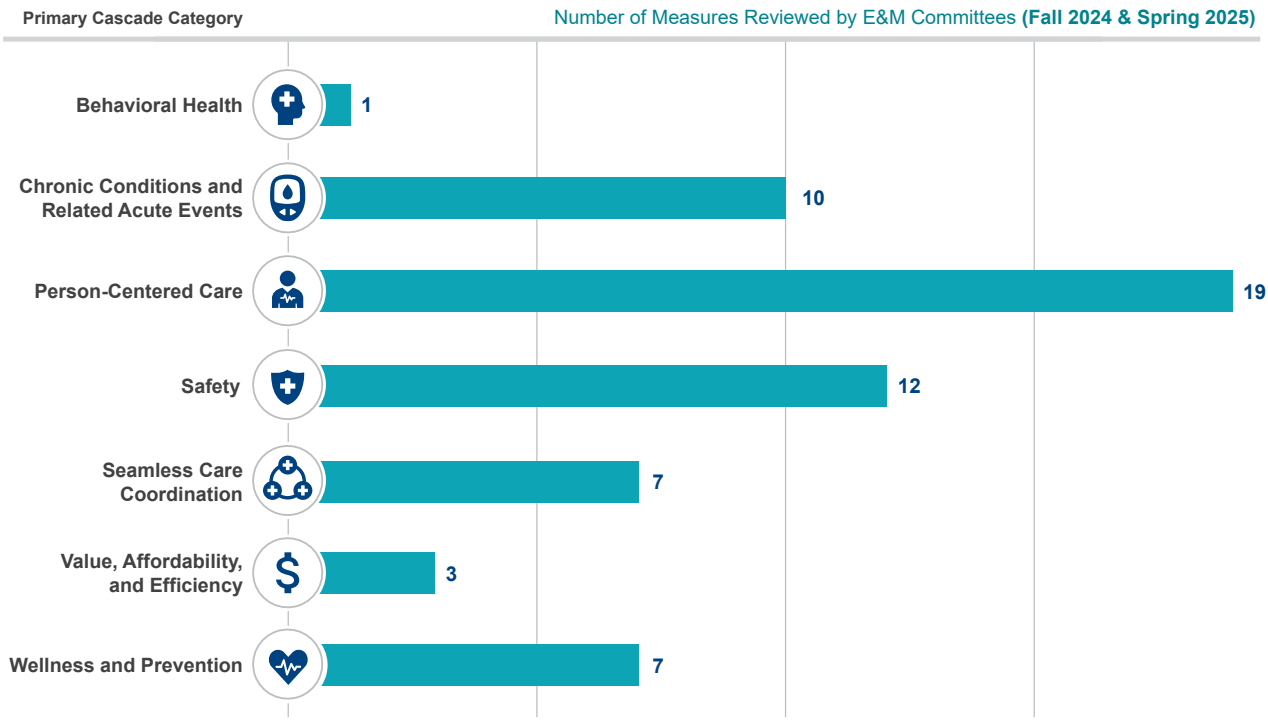

Figure 13. Cascade of Meaningful Measures Priority Areas in E&M

3.4 E&M Committee Membership

Battelle organizes E&M committee members into five topical areas: Primary Prevention, Initial Recognition and Management, Management of Acute Events and Chronic Disease, Cost and Efficiency, or Advanced Illness and Post-Acute Care, and assigns members to either the Advisory or Recommendation Group.

In total, the Fall 2024-Spring 2025 E&M committees convened 254 committee members across the five topical areas,

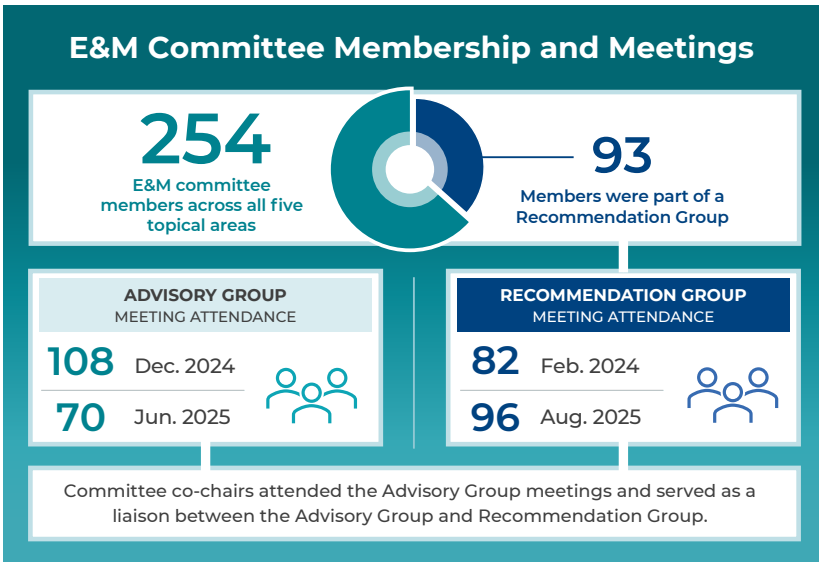

Figure 14. E&M Committee Membership and Meetings

93 of whom were part of a Recommendation Group, which provides the final vote and recommendation to CMS.

In December 2024 (Fall 2024 cycle) and June 2025 (Spring 2025 cycle), Battelle convened 108 and 70 Advisory Group members, respectively, alongside measure developers and stewards across five committee meetings facilitated by Battelle staff. Members provided feedback and asked questions regarding the measures under review. These inputs come from a larger number of voices that contribute to the consensus-building process. Project co-chairs attended the Advisory Group meetings and served as a liaison between the Advisory Group and Recommendation Group.

Recommendation Group members submitted written feedback on assigned measures through committee independent review on the PQM website, and Battelle synthesized those inputs with public comments, listening session feedback, and staff preliminary assessments to support Recommendation Group deliberations and to identify topics for focused discussion.

In February 2025 (Fall 2024 cycle) and August 2025 (Spring 2025 cycle), Battelle convened 82 and 96 Recommendation Group members, respectively, alongside measure developers to discuss and evaluate measures. Members voted to endorse, endorse with conditions, not endorse, or remove endorsement.

3.5 E&M Stakeholder Engagement

Battelle posts full measure submission materials for a 30-day public comment period, during which the health care community and public may submit feedback about the measures under review.

Battelle engaged stakeholders through:

- A written public comment period
  - » Fall 2024 Cycle: November 15-December 16, 2024
  - » Spring 2025 Cycle: May 14-June 13, 2025
- Public Comment Listening Sessions for spoken feedback
  - » Fall 2024 Cycle: November 21, 2024
  - » Spring 2025 Cycle: May 28, 2025

Across the Fall 2024 and Spring 2025 cycles, interested parties representing professional organizations/societies and patients or patient organizations submitted 147 written comments and four spoken comments.

This engagement process plays a critical role in shaping future clinical quality measures by incorporating perspectives from clinicians, professional societies, and patients.

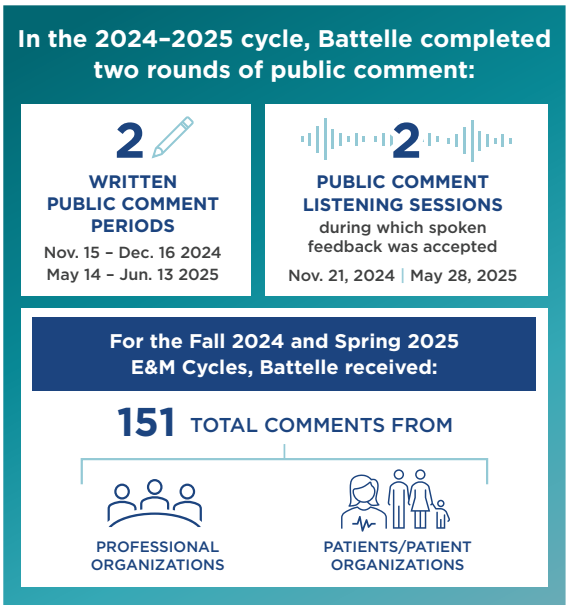

Figure 15. E&M Public Comment Outcomes

Table 3. Overview of Fall 2024 CBE Endorsement Decisions by E&M Cycle and Project

E&M Project	Submitted	Withdrawn	Endorsement Decision Counts				
			Reviewed	*Endorsed*	*Endorsed with Conditions*	*Not Endorsed/ Endorsement Removed*	*Details*
Fall 2024	**39**	**12**	**27**	**12**	**15**	**0**	
Primary Prevention	1	0	1	1	0	0	1 new measure endorsed
Initial Recognition and Management	8	3	5	0	5	0	0 new measures
Management of Acute Events and Chronic Disease	11	1	10	6	4	0	3 new measures endorsed
Advanced Illness and Post-Acute Care	15	7	8	5	3	0	4 new measures endorsed
Cost and Efficiency	4	1	3	0	3	0[1]	1 new measure endorsed with conditions

1 *The Cost and Efficiency Committee voted not to endorse one new measure and to remove endorsement for two maintenance measures. However, the developer submitted appeals for all three measures, and the Appeals Committee upheld the appeals, resulting in the measures being endorsed with conditions.*

Table 4. Overview of Spring 2025 CBE Endorsement Decisions by E&M Cycle and Project

E&M Project	Submitted	Withdrawn	Reviewed	Endorsement Decision Counts			
				Endorsed	*Endorsed with Conditions*	*Not Endorsed/ Endorsement Removed*	*Details*
Spring 2025	**53**	**21**	**32**	**9**	**18**	**5**	
Primary Prevention	7	0	7	5	1	1	2 new measures endorsed 1 new measure not endorsed
Initial Recognition and Management	4	3	1	0	1	0	1 new measure endorsed with conditions
Management of Acute Events and Chronic Disease	11	2	9	4	5	0	0 new measures
Advanced Illness and Post-Acute Care	29	16	13	0	9	4	4 new measures endorsed
Cost and Efficiency	2	0	2	0	2	0	0 new measures

3.6 Enhanced E&M Process

In 2025, E&M committee members, measure developers/stewards, and public commenters expressed concern about lengthy endorsement meetings, the impact of "Consensus Not Reached" voting outcomes on previously endorsed measures, the need for clearer integration of Advisory Group input, more precise endorsement decisions for instrument-derived measures (IDMs), and the need to adjust the consensus threshold for smaller voting groups.

In response, Battelle implemented targeted enhancements for the 2025 E&M cycles to improve efficiency, engagement, and consensus-building. Stakeholders responded positively, recognizing Battelle's commitment to refining the process and its responsiveness to technical and procedural feedback.

Enhancing E&M Meetings with More Meaningful Engagement

Battelle implemented three enhancements to increase engagement and collaboration, facilitate robust measure reviews, and better support patient participants.

- **Improving Endorsement Meeting Structure.** In prior E&M cycles, Battelle held single day endorsement meetings for each project, even when multiple measures were under review. Meetings often lasted up to 7 hours, leading to discussion fatigue and challenges maintaining a quorum. Starting in Spring 2025, Battelle scheduled projects with five or more measures over 2 days to sustain discussion, maintain attendance, and enable deeper review.
- **Elevating Patient Voices in Discussions.** Patient participants play a critical role in the consensus-building process by bringing unique lived experiences that highlight how a measure impacts and matters to patients. To increase patient engagement in discussions, Battelle facilitators now open E&M committee discussions by inviting patient participants to speak first. This structured opening ensures time for patient perspectives, supports their contributions, and reduces the risk that technical discussion will overshadow their voices.

- **Integrating Advisory Group Input.** The Advisory Group reviews measures and provides feedback 1 to 2 months before the Recommendation Group meeting. Some members were uncertain how their input affected endorsement decisions. To improve communication between the two committees, E&M co-chairs now attend Advisory Group meetings and carry patient and technical feedback forward to the Recommendation Group. This ensures Advisory Group insights are clearly presented and considered during endorsement deliberations.

Strengthening Rigor and Transparency of Measure Reviews

Battelle continuously refines the endorsement process to reinforce rigor, increase transparency, and safeguard the integrity of endorsed measures. In response to feedback and lessons learned, Battelle implemented four enhancements to strengthen E&M decision making.

- **Capturing Reasons to Not Endorse a Measure.** Beginning in spring 2025, committee members who vote "Do Not Endorse/Remove Endorsement" must provide a rationale. This change results in clearer insight into concerns, helps identify any measure evidence gaps, and supports actionable recommendations for improvement.

- **Refining Instrument-Derived Measure (IDM) Endorsement Decisions.** An IDM set is a group of related measures (for example, by condition, procedure, or specialty) derived from the same instrument or survey. Previously, endorsement decisions were made at the set level; as a result, measures with limitations (e.g., low reliability) could be endorsed with the set, or sets could be denied even when some measures met the criteria. As of the Spring 2025 E&M cycle, Battelle now evaluates and endorses measures within an IDM set individually. This change avoids bundled decisions, maintains the integrity of the process, and provides developers with targeted, measure specific feedback.
- **Implementing a Measure Reconsideration Process.** During maintenance reviews, a "Consensus Not Reached" outcome sometimes led to loss of endorsement for measures in use, even when a majority supported retaining endorsement but fell short of meeting the voting threshold. In Spring 2025, Battelle implemented a reconsideration process. Under this process, when a maintenance measure does not meet the consensus threshold but receives at least 60% support at an E&M endorsement meeting, the committee holds a focused discussion on outstanding concerns and then revotes at the end of the meeting. This step supports consensus based on the evidence and reduces the risk of losing endorsement due solely to procedural thresholds, without changing the standards for endorsement.
- **Adding 5-Year Data Recency Requirement for Measure Submission.** To maintain validity and relevance, measure submissions must now include testing data from within the past 5 years. Reliance on older data raised concerns about relevance due to changes in data standards, workflows, and care processes, particularly for maintenance measures. This requirement ensures that endorsement decisions are based on current evidence and that endorsed measures reflect contemporary practice.

Adjusting Consensus Thresholds to Group Size

To address concerns about the 75% consensus threshold being too high for smaller voting groups, Battelle now applies a 70% threshold for groups with fewer than 20 members. Larger groups retain the 75% standard. This adjustment maintains rigor and aligns with the Measure of Consensus target of 0.95000[2], ensuring meaningful agreement across all group sizes.

3.7 Quality Measurement Gap Areas and Evidence Needs

Over the past year, E&M committees and measure developers identified gaps in quality measurement and evidence needed to support development and endorsement.

Quality Measurement Gap Areas Identified

Through this process, Battelle identified gaps in quality measurement, evidence needs, and methods for standardizing measure endorsement.

Shift Toward Meaningful, Patient-Centered Outcomes

E&M committees emphasized the need to move beyond process measures to outcomes that matter most to patients, such as functional status, complications, and adherence. Patient participants reinforced this need, highlighting barriers that affect real-world outcomes, such as transportation and insurance coverage. Future measures should capture both clinical results and patient experience to ensure care improvements translate into better health.

Broader Applicability Across Populations and Settings

E&M committees called for expanding measures to include Medicare Advantage (MA) beneficiaries and

2 https://p4qm.org/sites/default/files/2025-08/Del-3-6-Endorsement-and-Maintenance-Guidebook-OP2-508.pdf#page=61

pediatric patients, reflecting demographic trends and population health priorities. They also stressed the importance of designing measures that apply across care settings, including outpatient and post-acute environments, to provide a comprehensive view of quality and avoid gaps in accountability.

Evidence Needs Identified and Addressed

Pediatric Quality Measure Evidence

Recognizing that limited available evidence can hinder developers' and stewards' ability to substantiate the importance, validity, and usability of pediatric CQMs, Battelle developed the CBE Policy on Pediatric Clinical Quality Measures in 2025. This policy provides guidance and considerations for when and how evidence from adult CQMs may be extrapolated to support pediatric measures.

Logic Model Guidance

In 2025, Battelle published Logic Model Guidance to support measure developers in creating comprehensive logic models that clearly articulate the pathway from measure inputs to desired outcomes.

Closing Care Gaps Guidance

In 2025, Battelle published Guidance for the Closing Care Gaps Domain for the Endorsement and Maintenance (E&M) of Clinical Quality Measures. The optional Closing Care Gaps domain encourages the collection of data across different subpopulations, allowing accountable entities to assess differences, explore underlying causes, and promote accountability among health care providers and systems, thereby building trust and credibility within the patient community.

Reliability Guidance

Endorsed measures must demonstrate scientific acceptability, including reliability. In 2025, Battelle released Reliability Guidance for the Endorsement and Maintenance (E&M) of Clinical Quality Measures to help developers select appropriate methods for assessing reliability at both the person/encounter and accountable entity levels, interpret statistical results, and address common challenges through recommended mitigation strategies. The goal is to ensure measures are methodologically sound and well-prepared for endorsement consideration.

Cost Measure Guidance

Cost measures can be challenging to review due to complex specifications, difficulty attributing costs to clinicians or groups, and the potential link between cost performance and quality of care. To address this knowledge gap, Battelle developed two guidance resources for measure developers and stewards:

- The CBE Guidance on Cost Measures outlines a standardized approach for reviewing cost measures, specifying key assertions and required evidence. It clarifies expectations, supports consistent evaluations, and helps ensure cost measures are reliable, safe, and effective for accountability use.
- The What Good Looks Like: Cost Measure Example walks through an example cost measure submission to show how each form item aligns with the five PQM Measure Evaluation Rubric domains. It serves as a practical guide to help committee members and measure developers understand what strong, well-supported submissions look like.

4.0 Multi-Stakeholder Engagement: Pre-Rulemaking Measure Review

Section 1890A(a) of the SSA states, "The Secretary shall establish a pre-rulemaking process under which the following steps occur with respect to the selection of quality and efficiency measures described in §1890(b)(7)(B)...Pursuant to §1890(b)(7), the entity with a contract under §1890 shall convene multi-stakeholder groups to provide input to the Secretary on the selection of quality and efficiency measures described in subparagraph (B)."

4.1 PRMR Overview

Each year, the PRMR process provides recommendations to HHS on which quality and efficiency measures should be considered for use in CMS quality reporting and value-based programs. Committees evaluate the measures on their relevance to specific programs and populations (e.g., skilled nursing facilities), and the measures must show clear value and alignment with program goals.

PRMR committee members evaluate each measure across three domains:

Meaningfulness: assesses if the measure meets criteria for importance, scientific soundness, feasibility, and usability for the intended population and program.

Appropriateness of Scale: examines if the measure is applied in a way that maximizes its value across different segments of the target population.

Time-to-Value Realization: determines if available evidence demonstrates a clear and feasible path from measurement to meaningful improvement in performance.

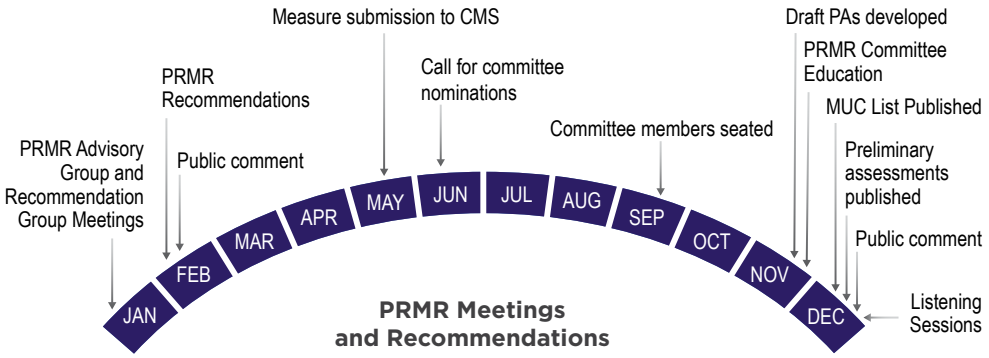

Figure 16. PRMR Timeline

In 2025, the PRMR committee provided recommendations on 52 measures:

- 27 measures were recommended; 17 of which were recommended with conditions.
- 5 measures were not recommended.
- 20 measures did not reach consensus.

4.2 PRMR Reports and Resources

The following list outlines the 2024-2025 PRMR Reports and Resources.

PRMR Policies and Processes

- Guidebook of Policies and Procedures for Pre-Rulemaking Measure Review and Measure Set Review

PRMR Report

- PRMR 2024-2025 MUC Recommendations Report

4.3 PRMR Annual Results

Three setting-specific committees reviewed 41 measures that spanned 13 CMS programs and all eight Cascade of Meaningful Measures 2.0 Health care Priority Areas, resulting in 52 measure-to-program combinations that were voted on separately.

Of the 52 measure-to-program votes:

- 10 measures were recommended.
- 17 measures were recommended with conditions.
- 5 measures were not recommended.
- 20 measures did not reach consensus.

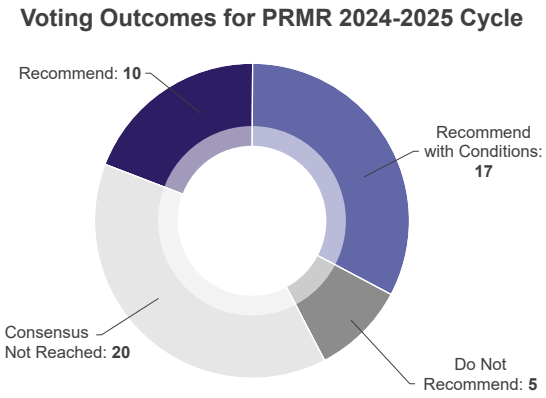

Figure 17. PRMR 2024-2025 Voting Outcomes

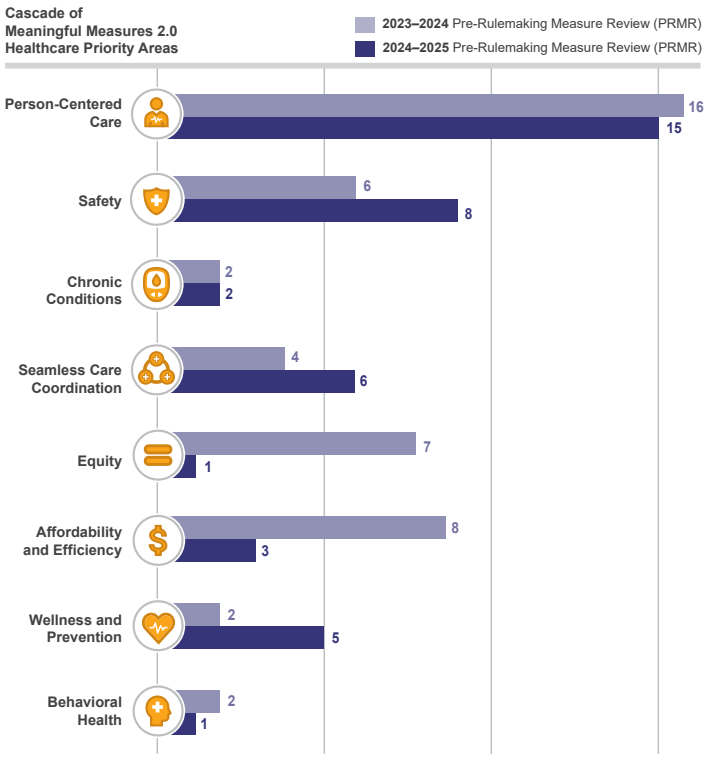

Figure 18. Cascade of Meaningful Measures Priority Areas in PRMR

4.4 PRMR Committee Membership

Battelle organizes PRMR members into three setting-specific committees: Hospital, Clinician, and Post-Acute Care/Long-Term Care (PAC/LTC), and assigns members to either the Advisory or Recommendation Group.

In total, the 2024-2025 PRMR committees had 179 committee members, In January 2025, Battelle convened 87 Advisory Group members across three committee-specific meetings facilitated by Batelle staff in collaboration with Recommendation Group co-chairs. Members provided feedback on the MUC measures based on their review of measure submission materials and preliminary analyses (PAs), as well as their professional and lived experience.

Advisory and Recommendation Group members submitted written feedback on assigned measures through Pre-Meeting Initial Evaluation (PIE) Forms, and Battelle synthesized those inputs with public comments and listening session feedback to support Recommendation Group deliberations and to identify non-consensus issues for focused discussion.

Between January 13 and 22, 2025, Battelle convened 75 Recommendation Group members, alongside CMS leadership and measure developers, to evaluate 41 measures across 13 CMS programs. Members voted to recommend, recommend with conditions (identifying actions required before implementation), or not recommend.

FEEDBACK FROM PRMR COMMITTEE MEMBERS

"I really appreciated how [Battelle] made everything easy for us patients, considering what some of us go through daily. It made me feel very welcome and it will encourage me to participate in many more measures in the future."

"I thought there was a very high level of engagement throughout the 2 days, and I enjoyed hearing everyone's point of view—so much learning there! The staff who facilitated the discussions and voting did an awesome job. IT support was great as well. I was honored to be part of this process. Really appreciate that CMS staff was there to listen and provide information during discussions."

"It was a great to connect and to meet such amazing experts in the field of measurement. I believe I learned much more than I was able to contribute."

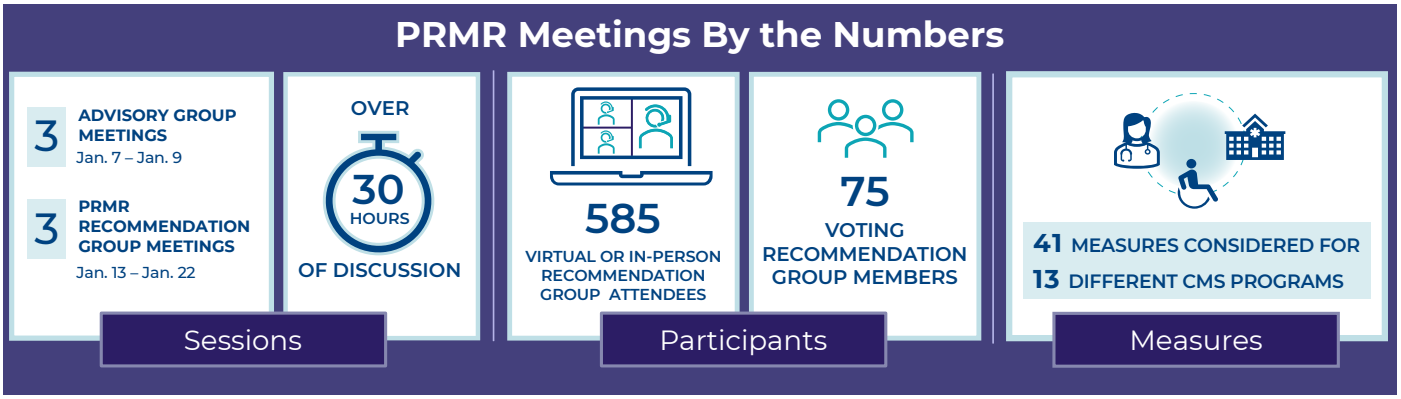

Figure 19. 2024–2025 PRMR Meetings by the Numbers

4.5 PRMR Stakeholder Engagement

Each PRMR cycle starts with the release of the MUC List, and Battelle actively invites broad stakeholder written and spoken feedback. This input plays a critical role in shaping future clinical quality measures by incorporating perspectives from clinicians, professional societies, and patients.

Battelle engaged stakeholders through:

- A written public comment period (November 25-December 30, 2024)
- Setting-specific listening sessions for spoken feedback (December 17-December 19, 2024)

Stakeholders submitted 239 written comments and 51 spoken comments, representing 234 professional organizations/societies and 56 patients or patient organizations. A compilation of public comments received on the 2024 MUC List and via PRMR listening sessions is available online.

During the final public comment period of the MUC committee recommendations (February 3-17, 2025), Battelle received five additional comments. While these comments did not change final recommendations, they offered additional context for CMS.

This engagement process ensures measure recommendations reflect real-world needs and priorities, enhancing their relevance and impact across care settings.

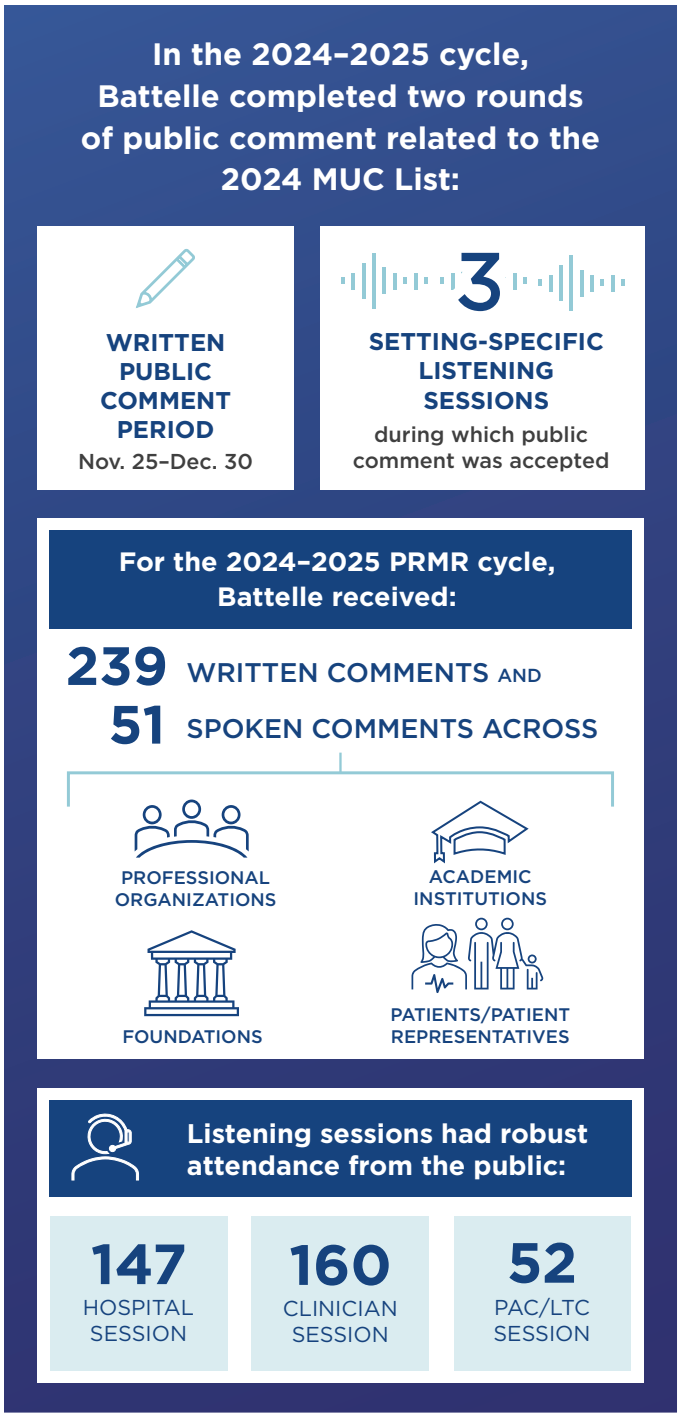

Figure 20. PRMR Public Comment Outcomes

Table 5. PRMR Recommendations for 2024 Measures Under Consideration[3]

Program*	MUC ID	Measure Title	Committee Final Recommendation	Conditions (if applicable)
Ambulatory Surgical Center Quality Reporting Program (ASCQR)	MUC2024-073	Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery, Patient Reported Outcome-Based Performance Measure (Information Transfer PRO-PM)	Consensus Not Reached	The conditions submitted included: • harmonizing the survey with the Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) survey to reduce redundancy in patient experience surveys, and • conducting additional testing in ambulatory surgical centers (ASCs) before the measure is implemented.
End-Stage Renal Disease Quality Incentive Program (ESRD QIP)	MUC2024-060	In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) Survey - Quality of Dialysis Center Care and Operations (QDCCO) measure	Recommend	The conditions submitted included: • continuing to assess ways to obtain data on topics originally covered by removed questions such as nephrologist performance, and • conducting additional testing on hard-to-reach populations.
Home Health Quality Reporting Program (HHQRP)	MUC2024-054a	CAHPS® Home Health Care Survey Care of Patients	Recommend	The conditions submitted included: • considering stratification by enrollment size for low-volume providers and geography for rural service areas.
	MUC2024-054b	CAHPS® Home Health Care Survey Communications Between Providers and Patients	Recommend	None provided.

3 *Due to rounding, percentages may not always add up to 100%*

**(measure may be considered for multiple CMS programs)*

Table 5. PRMR Recommendations for 2024 Measures Under Consideration *(continued)*

Program*	MUC ID	Measure Title	Committee Final Recommendation	Conditions (if applicable)
Home Health Quality Reporting Program (HHQRP) (cont.)	MUC2024-054c	CAHPS® Home Health Care Survey Talk About Home Safety	Recommend with Conditions	The conditions submitted included: • pairing the measure with a walkthrough or a safety assessment item to ensure comprehensive evaluation, • implementing a follow-up mechanism to ensure that patients fully understand the conversation about safety, and • using the collected data to identify and address patients' needs for safe equipment.
	MUC2024-054d	CAHPS® Home Health Care Survey Review Medicines	Recommend with Conditions	The conditions submitted included: • adding guidance to help survey administrators prompt patients on over-the-counter medications they may take, including supplements and other non-prescription medications, • capturing herbal medications including cannabis, vitamins, supplements, home remedies, etc., • adding indications for medications, and reviewing consistently, and • considering cultural sensitivities and language barriers during the medication review process.
	MUC2024-054e	CAHPS® Home Health Care Survey Talk About Medicine Side Effects	Recommend	The conditions submitted included: • considering a composite measure on medication for more actionable insights in the future.
Hospital Inpatient Quality Reporting Program (Hospital IQR Program)	MUC2024-027	Patient Safety Structural Measure	Do Not Recommend	The conditions submitted included: • reducing repetitive language and adjusting the language to align with the intent of the broader scope.

Table 5. PRMR Recommendations for 2024 Measures Under Consideration *(continued)*

Program*	MUC ID	Measure Title	Committee Final Recommendation	Conditions (if applicable)
Hospital Inpatient Quality Reporting Program (Hospital IQR Program) (cont.)	MUC2024-042	Hospital-Level, Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	Recommend with Conditions	The conditions submitted included: • stratified reporting, • providing hospitals with feedback on outcome variations between MA and Medicare Shared Savings Program (MSSP) populations, • breaking down performance data by payer, • re-evaluating the risk model as the measure matures to identify any adjustments needed for variation at the patient level across plans, and • considering if the reporting period is sufficient to avoid time lags that may hinder data usefulness and measure improvement.
	MUC2024-043	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Ischemic Stroke Hospitalization with Claims-Based Risk Adjustment for Stroke Severity	Recommend with Conditions	The conditions submitted included: • undergoing CBE endorsement, • reconsidering the measure structure to reduce the time lag to allow for timely information and useful data, and • adding risk stratification for pre-existing do-not-resuscitate orders.
	MUC2024-067	Proportion of patients who died from cancer admitted to the ICU in the last 30 days of life	Consensus Not Reached	The conditions submitted included: • adding data on the type of treatment received in the intensive care unit (ICU), • defining attribution more clearly, • adding patient preference for treatment, • stratifying for ICU capabilities based on geographic variability and resource capability, and • considering inclusion of MA data.

Table 5. PRMR Recommendations for 2024 Measures Under Consideration *(continued)*

Program*	MUC ID	Measure Title	Committee Final Recommendation	Conditions (if applicable)
Hospital Inpatient Quality Reporting Program (Hospital IQR Program) (cont.)	MUC2024-069	Addressing Social Needs Assessment & Intervention	Consensus Not Reached	The conditions submitted included: • accounting for rural facilities, critical access hospitals, and facilities with limited community resources that may not have as many interventions available for referral, • adding a voluntary option to give time for additional testing and allow hospitals to meet technical requirements, and • adding domestic violence as a domain to better align with prior measures.
	MUC2024-078	Proportion of patients who died from cancer admitted to hospice for less than 3 days	Consensus Not Reached	The conditions submitted included: • addressing hospital attribution and defining as hospital inpatient visits only, • excluding hospitals or regions without access to hospice, • adjusting for geographical service availability, • excluding programs without available services in the region, and • requiring physicians to initiate conversations with patients about preferences earlier.
	MUC2024-085	Hospital Harm – Anticoagulant-Related Major Bleeding	Consensus Not Reached	The conditions submitted included: • re-evaluating Criterion B, an absolute decrease in hemoglobin results of 2 g/dL within a 48-hour period excluding the first 24 hours of arrival, because there are a range of reasons for a 2 g/dL drop in hemoglobin that are unrelated to anticoagulants, • removing thrombolytics from the denominator, and • making reporting voluntary for the first 2 years.

Table 5. PRMR Recommendations for 2024 Measures Under Consideration *(continued)*

Program*	MUC ID	Measure Title	Committee Final Recommendation	Conditions (if applicable)
Hospital Outpatient Quality Reporting Program (Hospital OQR Program)	MUC2024-068	Proportion of patients who died from cancer receiving chemotherapy in the last 14 days of life	Consensus Not Reached	The conditions submitted included: • adding the ability to account for patient preference, • distinguishing between curative vs palliative chemotherapy, • excluding other therapies that do not affect quality of life, • providing training and resources in implementation guides so that hospitals are best able to have difficult end-of-life conversations, and • creating an attribution model that is limited to inpatient care/visits only.
	MUC2024-074	Median Time to Pain Medication for Patients with a Diagnosis of Sickle Cell Disease (SCD) with Vaso-Occlusive Episode (VOE)	Recommend with Conditions	The conditions submitted included: • providing case minimum exclusions, • stratifying by case volume or rural status, • establishing a threshold appropriate for rural or low-volume facilities, • adopting annual reporting to improve actionability of the measure for providers, • exploring ways to include a patient's individualized care plan, • considering an optional 2-year reporting of this measure before full implementation, and • exploring ways this or other future measures could incentivize rather than penalize time to pain medication administration.

Table 5. PRMR Recommendations for 2024 Measures Under Consideration *(continued)*

Program*	MUC ID	Measure Title	Committee Final Recommendation	Conditions (if applicable)
Hospital Outpatient Quality Reporting Program (Hospital OQR Program) (cont.)	MUC2024-075	Emergency Care Capacity and Quality (ECCQ)	Consensus Not Reached	The conditions submitted included: • revising the measure title to better match the measure focus, • stratifying by factors such as care type (i.e., maternity, behavioral health, etc.) as well as region and hospital/trauma-level designation, • reconsidering specification to separate measure components 1 and 2 from 3 and 4 with encouragement to explore additional measures for components 3 and 4 to reduce complexity, and • refraining from including the measure in STAR ratings.
	MUC2024-078	Proportion of patients who died from cancer admitted to hospice for less than 3 days	Consensus Not Reached	The conditions submitted included: • addressing hospital attribution and defining as hospital inpatient visits only, • excluding hospitals or regions without access to hospice, • adjusting for geographical service availability, • excluding programs without available services in the region, and • requiring physicians to initiate conversations with patients about preferences earlier.
Hospital Readmissions Reduction Program (HRRP)	MUC2024-030	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Acute Myocardial Infarction (AMI) Hospitalization	Recommend with Conditions	*The Hospital Recommendation Group discussed the risk-standardized readmission rate measures together. Their recommendations spanned across measures.* The conditions submitted included: • revising the inclusion criteria to include care provided in ambulatory settings, • considering a shorter inclusion window of 7 to 14 days, • stratifying the measure by MA vs. fee-for-service, and • conducting additional testing to evaluate whether the measure is topped out for all subgroups reporting.

Table 5. PRMR Recommendations for 2024 Measures Under Consideration *(continued)*

Program*	MUC ID	Measure Title	Committee Final Recommendation	Conditions (if applicable)
Hospital Readmissions Reduction Program (HRRP) (cont.)	MUC2024-032	Hospital 30-day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Heart Failure (HF) Hospitalization	Recommend with Conditions	*The Hospital Recommendation Group discussed the risk-standardized readmission rate measures together. Their recommendations spanned across measures.* The conditions submitted included: • revising the inclusion criteria to include care provided in ambulatory settings, • considering a shorter inclusion window of 7 to 14 days, • stratifying the measure by MA vs. fee-for-service, and • conducting additional testing to evaluate whether the measure is topped out for all subgroups reporting.
	MUC2024-040	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	Recommend with Conditions	*The Hospital Recommendation Group discussed the risk-standardized readmission rate measures together. Their recommendations spanned across measures.* The conditions submitted included: • revising the inclusion criteria to include care provided in ambulatory settings, • considering a shorter inclusion window of 7 to 14 days, • stratifying the measure by MA vs. fee-for-service, and • conducting additional testing to evaluate whether the measure is topped out for all subgroups reporting.

Table 5. PRMR Recommendations for 2024 Measures Under Consideration *(continued)*

Program*	MUC ID	Measure Title	Committee Final Recommendation	Conditions (if applicable)
Hospital Readmissions Reduction Program (HRRP) (cont.)	MUC2024-041	Hospital-Level, 30-Day, Risk-Standardized Readmission Rate (RSRR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	Recommend with Conditions	*The Hospital Recommendation Group discussed the risk-standardized readmission rate measures together. Their recommendations spanned across measures.* The conditions submitted included: • revising the inclusion criteria to include care provided in ambulatory settings, • considering a shorter inclusion window of 7 to 14 days, • stratifying the measure by MA vs. fee-for-service, and • conducting additional testing to evaluate whether the measure is topped out for all subgroups reporting.
	MUC2024-045	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Pneumonia Hospitalization	Recommend with Conditions	*The Hospital Recommendation Group discussed the risk-standardized readmission rate measures together. Their recommendations spanned across measures.* The conditions submitted included: • revising the inclusion criteria to include care provided in ambulatory settings, • considering a shorter inclusion window of 7 to 14 days, • stratifying the measure by MA vs. fee-for-service, and • conducting additional testing to evaluate whether the measure is topped out for all subgroups reporting.

Table 5. PRMR Recommendations for 2024 Measures Under Consideration *(continued)*

Program*	MUC ID	Measure Title	Committee Final Recommendation	Conditions (if applicable)
Hospital Readmissions Reduction Program (HRRP) (cont.)	MUC2024-046	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Coronary Artery Bypass Graft (CABG) Surgery	Recommend with Conditions	*The Hospital Recommendation Group discussed the risk-standardized readmission rate measures together. Their recommendations spanned across measures.* The conditions submitted included: • revising the inclusion criteria to include care provided in ambulatory settings, • considering a shorter inclusion window of 7 to 14 days, • stratifying the measure by MA vs. fee-for-service, and • conducting additional testing to evaluate whether the measure is topped out for all subgroups reporting.
Hospital Value-Based Purchasing Program (HVBP)	MUC2024-043	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Ischemic Stroke Hospitalization with Claims-Based Risk Adjustment for Stroke Severity	Recommend with Conditions	The conditions submitted included: • undergoing CBE endorsement, • reconsidering the measure structure to reduce the time lag to allow for timely information and useful data, and • adding risk stratification for pre-existing do-not-resuscitate orders.
	MUC2024-027	Patient Safety Structural Measure	Do Not Recommend	The conditions submitted included: • reducing repetitive language and adjusting the language to align with the intent of the broader scope.
	MUC2024-042	Hospital-Level, Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	Recommend with Conditions	The conditions submitted included: • stratified reporting, • providing hospitals with feedback on outcome variations between MA and MSSP populations, • breaking down performance data by payer, • re-evaluating the risk model as the measure matures to identify any adjustments needed for variation at the patient level across plans, and • considering if the reporting period is sufficient to avoid time lags that may hinder data usefulness and measure improvement.

Table 5. PRMR Recommendations for 2024 Measures Under Consideration *(continued)*

Program*	MUC ID	Measure Title	Committee Final Recommendation	Conditions (if applicable)
Hospital-Acquired Condition Reduction Program (HAC Reduction Program)	MUC2024-042	Hospital-Level, Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	Recommend with Conditions	The conditions submitted included: • stratified reporting, • providing hospitals with feedback on outcome variations between Medicare Advantage (MA) and Medicare Shared Savings Program (MSSP) populations, • breaking down performance data by payer, • re-evaluating the risk model as the measure matures to identify any adjustments needed for variation at the patient level across plans, and • considering if the reporting period is sufficient to avoid time lags that may hinder data usefulness and measure improvement.
	MUC2024-085	Hospital Harm – Anticoagulant-Related Major Bleeding	Consensus Not Reached	The conditions submitted included: • re-evaluating Criterion B, an absolute decrease in hemoglobin results of 2 g/dL within a 48-hour period excluding the first 24 hours of arrival, because there are a range of reasons for a 2 g/dL drop in hemoglobin that are unrelated to anticoagulants, • removing thrombolytics from the denominator, and • making reporting voluntary for the first 2 years.
Medicare Promoting Interoperability Program (PI)	MUC2024-069	Addressing Social Needs Assessment & Intervention	Consensus Not Reached	The conditions submitted included: • accounting for rural facilities, critical access hospitals, and facilities with limited community resources that may not have as many interventions available for referral, • adding a voluntary option to give time for additional testing and allow hospitals to meet technical requirements, and • adding domestic violence as a domain to better align with prior measures.

Table 5. PRMR Recommendations for 2024 Measures Under Consideration *(continued)*

Program*	MUC ID	Measure Title	Committee Final Recommendation	Conditions (if applicable)
Medicare Promoting Interoperability Program (PI) (cont.)	MUC2024-085	Hospital Harm – Anticoagulant-Related Major Bleeding	Consensus Not Reached	The conditions submitted included: • re-evaluating Criterion B, an absolute decrease in hemoglobin results of 2 g/dL within a 48-hour period excluding the first 24 hours of arrival, because there are a range of reasons for a 2 g/dL drop in hemoglobin that are unrelated to anticoagulants, • removing thrombolytics from the denominator, and • making reporting voluntary for the first 2 years.
Merit-based Incentive Payment System (MIPS)	MUC2024-025	Diagnostic Delay of Venous Thromboembolism (DOVE) in Primary Care	Recommend with Conditions	The conditions submitted included: • addressing implementation burdens for facilities with "less sophisticated EHRs."
	MUC2024-026	Person-Centered Outcome Measures: Goal-Identification, Follow-Up, and Goal Achievement	Recommend with Conditions	The conditions submitted included • undergoing CBE endorsement, • stratification by group type, and • further assessment of reporting burden.
	MUC2024-028	Screening for Abnormal Glucose Metabolism in Patients at Risk of Developing Diabetes	Recommend	None provided.
	MUC2024-031	Hepatitis C Virus (HCV): Sustained Virological Response (SVR)	Recommend	None provided.
	MUC2024-049	Breast Cancer Screening	Do Not Recommend	The conditions submitted included: • reconsidering the benchmark methodology.
	MUC2024-051	Prevalent Standardized Waitlist Ratio (PSWR)	Consensus Not Reached	None provided.

Table 5. PRMR Recommendations for 2024 Measures Under Consideration *(continued)*

Program*	MUC ID	Measure Title	Committee Final Recommendation	Conditions (if applicable)
Merit-based Incentive Payment System (MIPS) (cont.)	MUC2024-072	Addressing Social Needs Assessment & Intervention	Consensus Not Reached	The conditions submitted included: • adding a denominator exclusion for patients who refuse screening, • conducting additional testing with non-hospital-based data, and • conducting implementation testing within additional EHR systems.
	MUC2024-079	Assessment of autonomic dysfunction and follow-up	Recommend with Conditions	The conditions submitted included: • reviewing current clinical guidelines to ensure alignment with the latest recommendations and clinical evidence, and • expanding referral options (e.g., to occupational therapy) allowed by measure.
	MUC2024-080	Patient reported falls and plan of care	Recommend	None provided.
	MUC2024-082	Cancer Screening and Counseling Patient-Reported Outcome-Based Measure (PRO-PM)	Consensus Not Reached	None provided.
	MUC2024-084	Quality of life outcome for patients with neurologic conditions	Recommend	The conditions submitted included: • modifying the specifications so that lack of follow-up survey is not a denominator exclusion.
	MUC2024-100	Non-Pressure Ulcers	Consensus Not Reached	None provided.
	MUC2024-101	Parkinson's Syndromes, Multiple Sclerosis (MS), and Amyotrophic Lateral Sclerosis (ALS)	Do Not Recommend	The conditions submitted included: • separating the three conditions and reporting separately, and • pairing the measure with an appropriate quality measure.

Program*	MUC ID	Measure Title	Committee Final Recommendation	Conditions (if applicable)
Part C Star Ratings (Part C)	MUC2024-052	Social Need Screening and Intervention	Consensus Not Reached	The conditions submitted included: • undergoing CBE endorsement, and • providing more rigorous testing data in alignment with the proposed level of use in CMS programs.
	MUC2024-081	Adult Immunization Status (AIS-E)	Recommend	None provided.
	MUC2024-08	Depression Screening and Follow-Up for Adolescents and Adults (DSF)	Consensus Not Reached	The conditions submitted included: • aligning this measure with depression-focused measures currently in use within MIPS, • considering replacing the MIPS measure with this one, and • reporting of screening and follow-up rates separately.
Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program (PCHQRP)	MUC2024-027	Patient Safety Structural Measure	Do Not Recommend	The conditions submitted included: • reducing repetitive language and adjusting the language to align with the intent of the broader scope.
	MUC2024-069	Addressing Social Needs Assessment & Intervention	Consensus Not Reached	The conditions submitted included: • accounting for rural facilities, critical access hospitals, and facilities with limited community resources that may not have as many interventions available for referral, • adding a voluntary option to give time for additional testing and allow hospitals to meet technical requirements, and • adding domestic violence as a domain to better align with prior measures.

Program*	MUC ID	Measure Title	Committee Final Recommendation	Conditions (if applicable)
Rural Emergency Hospital Quality Reporting Program (REHQRP)	MUC2024-034	Influenza Vaccination Coverage Among Healthcare Personnel	Recommend	None provided.
	MUC2024-074	Median Time to Pain Medication for Patients with a Diagnosis of Sickle Cell Disease (SCD) with Vaso-Occlusive Episode (VOE)	Consensus Not Reached	The conditions submitted included: providing case minimum exclusions, • stratifying by case volume or rural status, • establishing a threshold appropriate for rural or low-volume facilities, • adopting annual reporting to improve actionability of the measure for providers, • •exploring ways to include a patient's individualized care plan, • considering an optional 2-year reporting of this measure before full implementation, and • exploring ways this or other future measures could incentivize rather than penalize time to pain medication administration.
	MUC2024-095	Emergency Care Capacity and Quality (ECCQ)	Consensus Not Reached	None provided.

4.6 Enhanced PRMR Process

On April 29 and May 1, PQM leadership discussed process enhancements with PRMR/MSR committees. These meetings provided an opportunity for committee members to give feedback on these changes, share thoughts on MSR measure-selection priorities, and learn how to maximize their input in measure reviews.

During the meeting, Battelle announced process changes for the 2025-2026 cycle that aim to increase efficiency, transparency, and scientific rigor in CMS's quality measurement strategy:

- **Revised PRMR Voting Structure:** Battelle clarified the voting options to improve consistency and reduce confusion.
- **Enhanced MSR Selection Framework:** Battelle incorporated public feedback and strategic criteria (e.g., impact, actionability, burden, thematic alignment).
- **Phased AI Integration:** Battelle introduced its Claim Argument Evidence System (CAES) to support evidence synthesis and reduce bias.
- **Updated Conflict of Interest Policy:** Committee members who have a conflict of interest can participate in discussions but cannot vote.
- **Strengthened Patient Representation:** Battelle has instituted intentional assignments to ensure the patient voice is reflected.

4.7 Stakeholder Recommendations and Considerations

During the PRMR meetings in January 2025, Recommendation Group members identified several recurring themes for improving measures. These themes highlight areas where committee members would like to see measure developers and CMS to focus resources in the future (Figure 21).

Details related to each consideration can be found below.

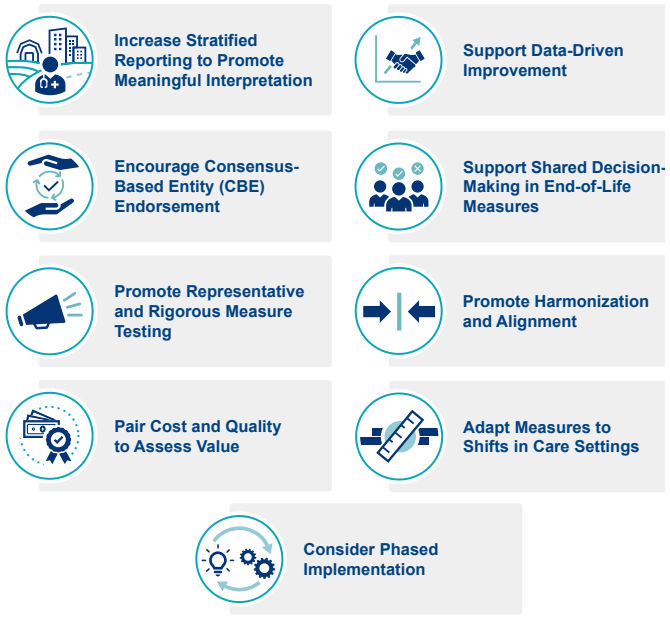

Figure 21. Areas for Future Consideration

Increase Stratified Reporting to Promote Meaningful Interpretation

Committees urged CMS and measure developers to complement patient-level risk adjustment with stratified reporting to improve interpretability and fairness by revealing performance differences within measured entities and targeting improvements.

Encourage CBE Endorsement

Committees urged developers to seek CBE endorsement before submitting measures to the MUC List to enhance measure credibility and program outcomes. They also noted that CBE endorsement review requires experts and other stakeholders to assess reliability and validity, ensuring scientific rigor

By encouraging developers to seek CBE endorsement before submitting measures to the MUC List, CMS can enhance measure credibility and program outcomes.

Promote Representative and Rigorous Measure Testing

Committee members advised CMS and developers to address concerns about measure testing quality by ensuring robust sample sizes, comprehensive feasibility testing, and representative populations. Additionally, committee members urged developers to use testing data to assess attribution accuracy in cost measures. They emphasized that misattributed outcomes could undermine clinician support and recommended mapping attribution to provider roles to better reflect real-world care delivery.

Pair Cost and Quality to Assess Value

Committee members noted CMS should consider pairing cost measures with relevant clinical quality measures to ensure meaningful improvement and prevent care gaps.

Support Data-Driven Improvement

Committee members noted CMS should provide regular, timely feedback (e.g., quarterly reporting) to support meaningful quality improvement.

Committee members also expressed interest in collaborating with a desire for CMS to refine measures during implementation, especially when incorporating Medicare Advantage data. They highlighted the need for CMS and developers to update risk adjustment models and exclusion criteria to avoid unintended consequences.

Support Shared Decision-Making in End-of-Life Measures

Committee members urged CMS to ensure end-of-life clinical quality measures incorporate shared decision-making and respect patient choice without penalizing providers. They also cautioned against relying solely on patient-reported outcome measures (PROMs), which may lead to survey fatigue. Instead, they recommended incorporating shared decision-making into measure specifications through exclusions, adjustments, or other mechanisms to support patient-centered care.

Promote Harmonization and Alignment

Committee members asked CMS and measure developers to standardize specifications and risk-adjustment methods for similar measures across programs to reduce reporting burdens and ensure alignment across federal efforts.

Adapt Measures to Shifts in Care Settings

Committees recommended that CMS and measure developers update risk adjustment models to reflect the migration of procedures to outpatient and ASC settings and create parallel measures for ASC and outpatient programs to ensure accurate, comparable performance evaluation across care settings.

Consider Phased Implementation

Committee members asked CMS to utilize phased implementation strategies such as voluntary reporting or soft-launch approaches such as those used in the Part C and D Star Ratings display page to ensure measures are fully validated before penalizing providers.

5.0 Multi-Stakeholder Engagement: Measure Set Review

Pursuant to 42 U.S. Code §1395aaa-1(c)(1) "The Secretary shall periodically (but in no case less often than once every 3 years) review quality and efficiency measures described in section 1395aaa(b)(7)(B) of this title; and with respect to each such measure, determine whether to (i) maintain the use of each measure; or (ii) phase out such measure."

5.1 MSR Overview

The MSR provides an annual opportunity to assess measures for potential removal from CMS quality programs. Battelle convenes PRMR committee members and other stakeholders to review measures and recommend their continued use, helping CMS maintain a meaningful, streamlined portfolio. The MSR process incorporates input from researchers, providers, and patients—the groups most affected by quality measurement—and informs CMS strategic priorities, measure refinement, and future development.

The **PRMR process** makes consensus recommendations about measures on the MUC List.

The **MSR process** builds consensus around measure continuation to optimize the CMS measure portfolio in the value-based programs.

MSR measure evaluations are based on the following three domains:

- **Meaningfulness:** assesses whether the measure continues to meet criteria for importance, feasibility, scientific acceptability, and usability and use, considering its use across programs and populations.
- **Data Stream Parsimony:** identifies and reduces redundancy in data collection.
- **Patient Journey:** evaluates alignment with the intended impact model, which illustrates how a measure "works" to have the greatest impact on patient outcomes.

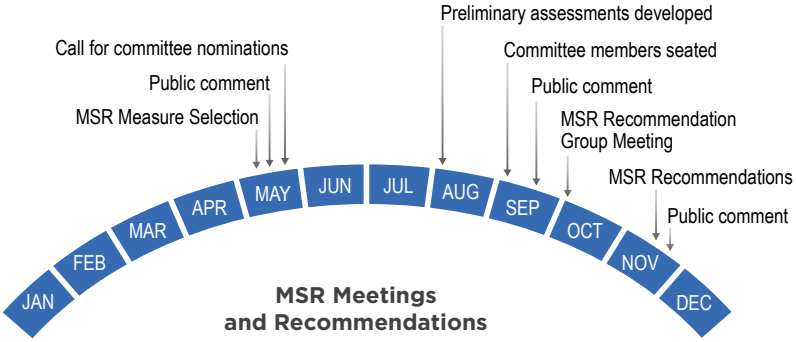

Figure 22. MSR Timeline

In consultation with CMS, Battelle identified 50 candidate measures for the 2025 MSR cycle. For each measure, Battelle developed a measure information sheet that provides an overview of the measure, its specifications and program use data, and endorsement status. Battelle invited the public to review these information sheets and provide feedback on the candidate measures. After reviewing public comments and consulting with CMS program and measure leads, Battelle selected 21 measures for committee review. For committee consideration, the MSR Recommendation Group meeting materials included public comment summaries.

Battelle aims to review all CMS quality program measures over a 5-year period, using the Cascade of Meaningful Measures framework to guide a phased, comprehensive approach.

For the 2025 MSR cycle, the review focused on measures that fall within the following Cascade of Meaningful Measures priority areas:

- Chronic Conditions and Related Acute Events (8)
- Person-Centered Care (7)
- Wellness and Prevention (5)
- Safety (1)

View comments on MSR candidate measures on the PQM website.

The 2025 MSR cycle measures span six Medicare programs:

- Merit-based Incentive Payment System (MIPS) *(11)*
- Hospital Inpatient Quality Reporting (IQR) *(3)*
- Medicare Promoting Interoperability Program (PI) *(3)*
- Inpatient Psychiatric Facility Quality Reporting (IPFQR) *(2)*
- Home Health Quality Reporting (HHQR) *(1)*
- Hospital Outpatient Quality Reporting (OQR) *(2)*

5.2 MSR Reports and Resources

The following list outlines the 2025 MSR Reports and Resources.

MSR Policies and Processes

- Guidebook of Policies and Procedures for Pre-Rulemaking Measure Review and Measure Set Review

2025 MSR Report

- 2025 Final MSR Recommendations Report

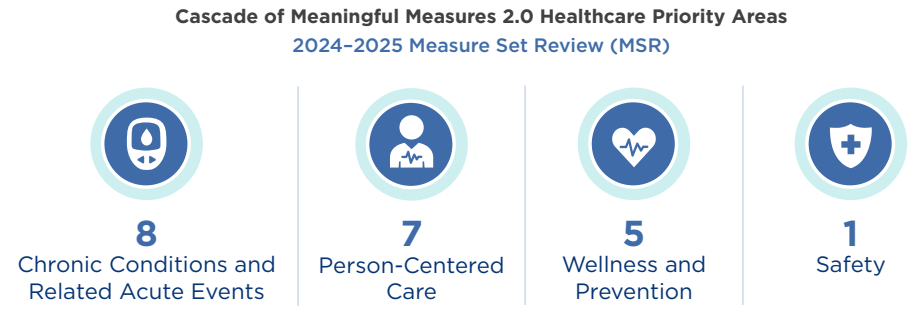

Figure 23. Cascade of Meaningful Measures 2.0 Health Care Priority Areas for MSR

5.3 MSR Annual Results

Battelle convened the MSR Recommendation Group virtually, for the 2025 MSR Meeting on October 6-7, 2025, to review 21 measures across the CMS measure portfolio. The goal of this meeting was to discuss the measures under review and make recommendations to CMS about their continued use. Twenty-two MSR Recommendation Group members attended on Day 1, and 21 members attended on Day 2.

Of the 21 votes:

- 15 measures were recommended for continued use.
- 6 measures were not recommended for continued use.

Table 6 outlines the Recommendation Group's final program-specific votes for continued use in each CMS program.

Table 6. MSR Recommendation Group Vote Counts per Measure

Program	CMS Measures Inventory Tool (CMIT) ID	Measure Title	Recommend Continued Use
Home Health Quality Reporting	00389-01-C-HHQR	Influenza Immunization Received for Current Flu Season	Recommend
	00410-01-C-HOQR	Left Without Being Seen	Do not Recommend
	00427-01-C-HOQR	Median Time from ED Arrival to ED Departure for Discharged ED Patients	Do not Recommend
Hospital Inpatient Quality Reporting	00062-04-E-HIQR	Anticoagulation Therapy for Atrial Fibrillation/Flutter	Recommend
	00064-03-E-HIQR	Antithrombotic Therapy by the End of Hospital Day Two	Recommend
	00211-02-E-HIQR	Discharged on Antithrombotic Therapy	Do not Recommend
Inpatient Psychiatric Facility Quality Reporting	00673-01-C-IPFQR	Screening for Metabolic Disorders	Recommend
	00386-03-C-IPFQR	Influenza Immunization	Recommend
Merit-based Incentive Payment System	00474-01-C-MIPS	Oncology: Medical and Radiation - Pain Intensity Quantified	Recommend
	00474-02-E-MIPS	Oncology: Medical and Radiation - Pain Intensity Quantified	Recommend
	00473-01-C-MIPS	Oncology: Medical and Radiation - Plan of Care for Pain	Recommend
	00676-01-C-MIPS	Sentinel Lymph Node Biopsy for Invasive Breast Cancer	Do not Recommend
	00178-01-C-MIPS	Coronary Artery Disease (CAD): Antiplatelet Therapy	Recommend
	00282-05-E-MIPS	Functional Status Assessments for Heart Failure	Recommend

Table 6. MSR Recommendation Group Vote Counts per Measure *(continued)*

Program	CMS Measures Inventory Tool (CMIT) ID	Measure Title	Recommend Continued Use
Merit-based Incentive Payment System (cont.)	00555-03-C-MIPS	Perioperative Temperature Management	Recommend
	00053-01-C-MIPS	Amyotrophic Lateral Sclerosis (ALS) Patient Care Preferences	Recommend
	00741-01-E-MIPS	Urinary Symptoms Score Change 6-12 Months After Diagnosis of Benign Prostatic Hyperplasia	Recommend
	00126-02-E-MIPS	Children Who Have Dental Decay or Cavities	Do not Recommend
Promoting Interoperability	00062-04-E-PI	Anticoagulation Therapy for Atrial Fibrillation/Flutter	Recommend
	00064-03-E-PI	Antithrombotic Therapy by the End of Hospital Day Two	Recommend
	00211-02-E-PI	Discharged on Antithrombotic Therapy	Do not Recommend

5.4 MSR Committee Membership

Battelle selects MSR Recommendation Group members from the setting-specific PRMR committees (i.e., Clinician, Hospital, PAC/LTC). Table 7 summarizes the 24 interested parties comprising the 2025 MSR Recommendation Group.

Figure 24. MSR Recommendation Group Interested Parties

Table 7. MSR Recommendation Group Interested Parties

Roster Category	Number of Committee Members
Clinician	3
Clinician Association	3
Facility Association	3
Facility/Institution	2
Other Interested Party	3
Patient Participant	3
Population Health	4
Purchasers and Plans	2
Researcher	1

5.5 MSR Stakeholder Engagement

Battelle engaged stakeholders through two 15-day public comment periods—first on the preliminary measure set and measure information sheets and then following publication of MSR recommendations—and developed preliminary assessments (PAs) for 21 measures using CMIT, PQM's Submission Tool and Repository (STAR) Measure Database, recent CMS program performance data (most recent 3 years), and relevant external sources. Each PA included performance data, any supplemental analyses from CBE endorsement submissions, importance tables (mean scores by decile), and a list of active program measures for context. Committee members used the PAs to complete PIE Forms; Battelle synthesized themes from public comments and PIE inputs, crafted discussion prompts to guide voting and provided the MSR Recommendation Group with brief measure descriptions, public comment summaries, and consolidated committee feedback to inform deliberations.

5.6 Stakeholder Recommendations

Key themes related to improving and revising measures emerged during the MSR Recommendation Group meeting. Figure 25 highlights MSR committee members' recommended areas for future investment by CMS and other stewards.

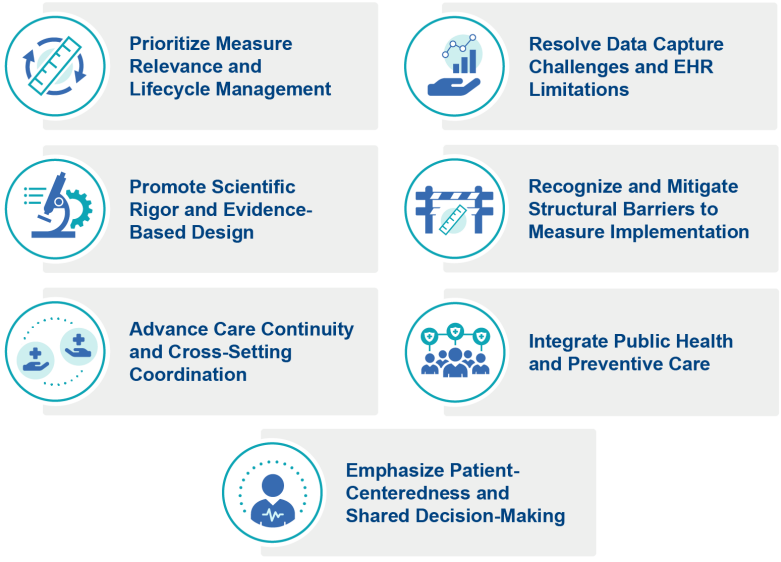

Figure 25. Areas for Future Consideration

Prioritize Measure Relevance and Lifecycle Management

Key Takeaway: Retire measures that are topped out, out, misaligned with current guidelines, lack actionability by providers, or no longer drive improvement. This action reduces reporting burden and focuses resources on measures with meaningful performance variation.

The committee did not recommend the following measures for continued use:

- **Discharged on Antithrombotic Therapy (00211-02-E-HIQR/PI)**
- **Sentinel Lymph Node Biopsy for Invasive Breast Cancer (00676-01-C-MIPS)**
- **Children Who Have Dental Decay or Cavities (00126-02-E-MIPS)**

Members cautioned against labeling voluntary measures as topped out and urged CMS to increase participation to better assess performance gaps. They also flagged stewardship concerns, recommending CMS proactively manage transitions to maintain continuity and data integrity.

Promote Scientific Rigor and Evidence-Based Design

Key Takeaway: Promote measures grounded in current clinical evidence and aligned with best practices. The committee also emphasized the importance of CBE endorsement in strengthening scientific credibility and policy relevance.

The committee recommended the following measures for continued use:

- **Anticoagulation Therapy for Atrial Fibrillation/Flutter (00062-04-E-HIQR/PI):** The committee recognized its

importance in stroke care and transitions of care, despite complexities in attribution and prescribing decisions. However, they also emphasized the importance of CBE endorsement, citing that such endorsement strengthens scientific credibility, supports alignment with national priorities, and promotes broader adoption and stakeholder confidence.

- **Coronary Artery Disease: Antiplatelet Therapy (00178-01-C-MIPS):** The committee ultimately recommended continued use of this measure. During their discussion, members addressed recent evidence from published literature indicating a need to update measure exclusions to ensure alignment with current guidelines. Concerns were also raised regarding the absence of a measure steward, which may hinder timely updates, as well as the importance of obtaining CBE endorsement.

The committee did not recommend the following measures for continued use:

- **Sentinel Lymph Node Biopsy (00676-01-C-MIPS):** The committee discussed the measure's misalignment with updated breast cancer treatment guidelines.

Advance Care Continuity and Cross-Setting Coordination

Key Takeaway: Promote measures that support care continuity across inpatient, outpatient, and home health settings.

The committee recommended the following measures for continued use:

- **Screening for Metabolic Disorders (00673-01-C-IPFQR)**
- **Influenza Immunization (00386-03-C-IPFQR, 00389-01-C-HHQR)**

The committee emphasized that measures promoting early intervention and better coordination—particularly within home health and inpatient psychiatric facilities—can lead to significant cost savings and improved health outcomes for populations. They also emphasized the importance of preventive care in settings where patients may have limited outpatient engagement, while noting barriers in attribution and record-sharing.

Resolve Data Capture Challenges and EHR Limitations

Key Takeaway: Improve data accuracy and reduce burden by clarifying care settings, adopting eCQMs, and exploring AI solutions.

The committee recommended the following measure for continued use:

- **Functional Status Assessments for Heart Failure (00282-05-E-MIPS)**

The committee recommended continued use of this measure due to its patient-centered focus. Manual data extraction remains a challenge for several measures, prompting calls for electronic formats and better integration of patient-reported outcomes.

Recognize and Mitigate Structural Barriers to Measure Implementation

Key Takeaway: Address workforce shortages, resource constraints, and fragmented systems by adjusting for risk factors and minimizing reporting gaps.

The committee did not recommend the following measures for continued use:

- **Left Without Being Seen (00410-01-C-HOQR)**
- **Median Time from ED Arrival to ED Departure for Discharged ED Patients (00427-01-C-HOQR)**
- **Children Who Have Dental Decay or Cavities (00126-02-E-MIPS)**

Committee members indicated that these measures underscore significant concerns regarding health care quality. They observed, however, that in the absence of actionable steps or sufficient resources, such measures could disproportionately impact providers who care for populations vulnerable to poor health outcomes. While these measures highlight critical issues, members cautioned against removing measures without suitable replacements.

Integrate Public Health and Preventive Care

Key Takeaway: Prioritize preventive measures that offer clinical benefits, cost savings, and support their implementation with streamlined reporting and digital infrastructure. CMS should design measures that reflect patient preferences, address timing and interoperability issues, and explore electronic reporting to reduce administrative burdens and enhance implementation.

The committee recommended the following measures for continued use:

- **Influenza Immunization (00386-03-C-IPFQR, 00389-01-C-HHQR)**
- **Screening for Metabolic Disorders (00673-01-C-IPFQR)**

Committee members recommended these measures for continued use, emphasizing their role in protecting vulnerable populations. Preventive care measures can lower long-term health care costs and improve population outcomes. Discussions emphasized the need to consider patient refusal, vaccine hesitancy, and access barriers, especially in home health and inpatient psychiatric settings. Preventive interventions, particularly where primary care access is limited, can minimize hospitalizations and emergency visits, aligning with CMS's value-based care goals. Integrating preventive care into inpatient and home health workflows enhances efficiency by using existing encounters to deliver impactful services.

Emphasize Patient-Centeredness and Shared Decision-Making

Key Takeaway: Prioritize measures that align treatment plans with patient goals, reduce unnecessary interventions, enhance patient experience, and support individualized care. The committee strongly supported measures that reflect patient goals and facilitate shared decision-making.

The committee recommended the following measures for continued use:

- **Amyotrophic Lateral Sclerosis (ALS) Patient Care Preferences (00053-01-C-MIPS)**
- **Oncology: Medical and Radiation - Pain Intensity Quantified (00474-01-C/02-E-MIPS)**
- **Oncology: Medical and Radiation - Plan of Care for Pain (00473-01-C-MIPS)**

These measures are particularly valuable for vulnerable populations and in settings where pain management and end-of-life planning are critical. Removing them would diminish visibility of patient priorities. Future considerations for CMS include maintaining low-burden, technically feasible measures that reflect patient goals, preserving paired pain measures for feasibility and meaningfulness, and ensuring Medicare program reporting captures the complexity of care planning across a range of settings.

FEEDBACK FROM MSR RECOMMENDATION GROUP MEMBERS

"I am honored to be a part of this meeting for the first time and really enjoyed this process."

"Love seeing the continuous improvement in the [committee feedback] process over the past few years. You've done a great job incorporating feedback and making the [committee feedback] process more meaningful and user friendly."

6.0 Core Quality Measures Collaborative

CQMC is a public-private partnership founded in 2015 by CMS and AHIP to promote alignment of CQMs across payers. Battelle convenes the CQMC, which includes more than 70 member organizations, ranging from insurers and provider groups to consumer and employer representatives.

6.1 CQMC Overview

The CQMC develops core measure sets organized by clinical condition or topic to assess health care quality. Members of the "Full Collaborative" populate various workgroups based on medical or health care condition and/or care setting. Workgroups prepare initial recommendations, which then move forward to a meeting of the Full Collaborative. The CQMC aims to:

- Identify high-value, high-impact, evidence-based measures promoting better health outcomes, and providing useful information for improvement, decision-making, and payment
- Align measures across public and private payers to achieve congruence in the use of measures for quality improvement, transparency, and payment purposes
- Reduce the burden of measurement by eliminating low-value metrics, redundancies, and inconsistencies in measure specifications and quality measure reporting requirements across payers.

Ongoing Maintenance and Enhancement

Annual Process for Full/Light Maintenance: In 2025, the CQMC continued its maintenance of core measure sets. Half of the core sets went through full maintenance whereby the workgroups reviewed potential new measures to address high-priority areas and measures in the existing sets and remove measures if necessary. The other half of the core sets underwent light maintenance during which the workgroup only looked at measures for potential removal. The purpose of these alternating reviews is to encourage consistency in the sets while ensuring that measures remain clinically relevant, evidence-based, and aligned with current best practices.

Key Themes from Core Set Workgroup Meetings: During these reviews, workgroups emphasized closing measurement gaps, particularly for patient-reported outcomes and prevention-focused metrics. They also prioritized improving measure accessibility by providing clearer implementation guidance and ensuring digital code availability, meaning that measure specifications are published in standardized, machine-readable formats to support seamless integration into electronic health record systems and other health IT platforms.

These efforts reflect CQMC's dual focus; refining measure sets through evidence-informed decisions and addressing adoption challenges by expanding transparency and streamlining implementation across payers to improve U.S. health care quality.

2025 Highlights

- As of November 2025, the following seven workgroups met to discuss core set updates: Cardiology, Gastroenterology, HIV & Hepatitis C, Medical Oncology, Obstetrics & Gynecology, Pediatrics, and Behavioral Health.
- Battelle convened the CQMC Full Annual Strategic Meeting to discuss and set priorities for core set implementation and adoption, partnerships with state-level entities, and digital readiness.
- The CQMC explored strategies to overcome measure adoption barriers, such as challenges with proprietary measures, and began shaping the next phase of CQMC's vision.

6.2 CQMC Proprietary Measures for Payers Toolkit

The CQMC Proprietary Measures for Payers Toolkit supports health care payers in adopting core measure sets by providing implementation guidance and practical tools. In 2025, Battelle:

- Developed the toolkit based on a series of key informant interviews
- Organized a feedback meeting with the CQMC Steering Committee to gather insights and refine the toolkit based on interested party input
- Conducted a roll-out meeting with the CQMC Steering Committee to promote awareness and adoption

The toolkit serves as both an educational resource and a practical guide, addressing a common barrier to core set use: proprietary registry-based measures. By offering clear, actionable content and free access, the toolkit aims to streamline implementation, promote consistency, and empower payers in quality measurement efforts.

7.0 Initiatives to Advance Measurement

Pursuant to 1890 (42 U.S.C. 1395aaa) 1(b) (1) (A) (B), the CBE must include 1) Priority setting process.—The entity shall synthesize evidence and convene key stakeholders to make recommendations, with respect to activities conducted under this Act, on an integrated national strategy and priorities for health care performance measurement in all applicable settings.

Battelle led several initiatives in 2025 to advance quality measurement, supporting federal priorities in prevention, wellness, digital measurement, and AI.

Figure 26. Project Goals to Advance Quality Measurement

Integrating AI into Measure Review

Battelle employs AI to streamline the measure endorsement process, making it more efficient and impactful. For example, Battelle developed the CAES, an AI framework, to enhance the evaluation of the safety, effectiveness, and trustworthiness of CQMs. CAES analyzes literature, empirical data, and simulation modeling to provide evidence-based assessments of measures submitted to Battelle. CAES also estimates real-world impact, such as lives saved or improved diagnostics, by analyzing performance data and simulating adoption scenarios. It evaluates measure developers' claims using evidence from studies, expert panels, and implementation data. Battelle is phasing AI adoption into E&M and PRMR processes, with progress based on milestones.

> Battelle's CAES system helps the CBE and PQM committee members make confident, data-driven assessments about which measures to endorse and recommend to CMS.

Deployment of AI Tool and Toolkit (CMS CAES)

As part of an agency-wide effort to build capacity around AI, Battelle and CMS agreed to pilot CAES in the CMS environment. CMS CAES uses AI to ensure CQMs considered for endorsement, use in CMS quality programs, or removal from those programs are well supported by published evidence. Specifically, CMS CAES seeks to ensure all claims by measure developers about measure properties (e.g., importance, reliability, validity, and usability) are explicit, and to evaluate all the evidence submitted by measure developers in support of those claims.

Prioritizing Digital Quality Measurement

Digital quality measurement is evolving rapidly with interoperability advances such as Fast Healthcare Interoperability Resources (FHIR) and related terminology standards like United States Core Data for Interoperability (USCDI) and USCDI+, promising more efficient data exchange, reduced reporting burden, and more person-centered care. Persistent barriers—data quality, semantic consistency, and system interoperability—complicate development and implementation. To address these, Battelle is developing a Digital Measure Evaluation Roadmap that clarifies the interoperability and infrastructure needed for dQM development and implementation and identifies how evolving standards should inform updates to CBE evaluation criteria and measure review processes.

In 2025, Battelle reviewed literature on FHIR and USCDI/USCDI+; hosted a public comment period to assess the impact of dQMs on the health care community, including potential changes to the E&M process and ways the CBE can support dQM development and implementation; and conducted key informant interviews to better understand early challenges in developing FHIR-based quality measures.

Charting Outcomes of Measure Feedback

In response to PQM member requests for greater transparency on measure disposition after CBE review, Battelle created a systematic tracking and timeline that links E&M, PRMR, and MSR committee recommendations to final outcomes (endorsement, adoption, or removal). The approach also monitors endorsement decisions before and after measures appear on the MUC List, with date-stamped recommendations and actions to clearly show how CMS and other stakeholders used committee input to advance health care quality and efficiency.

8.0 Financial Information for Fiscal Year 2025

Pursuant to §1890(b)(5)(A)(ii)(I) and (II), the CBE must present "an itemization of financial information for the fiscal year ending September 30 of the preceding year, including—(I) annual revenues of the entity (including any Government funding, private sector contributions, grants, membership revenues, and investment revenue) and (II) annual expenses of the entity (including grants paid, benefits paid, salaries or other compensation, fundraising expenses, and overhead costs)."

8.1 Battelle Finances

As shown in Table 8, Battelle's revenues for fiscal year (FY) 2025 were $13,485,995,836 including federal funds or government revenue authorized under §1890(d) of the SSA, private-sector contributions, and investment revenue. Battelle does not charge participants for PQM membership.

Battelle's expenses for FY 2025 were $13,385,439,355. These expenses include grants and benefits paid, salaries and other compensations, purchased services such as subcontracting, fundraising expenses, and overhead costs.

Table 8. Battelle's Unaudited Financial Statement of Revenues and Expenses, for FY2025

Financial Statement Fiscal Year 2025 (unaudited)

Account Type	Amount ($)
Government Revenue	$13,361,306,875
Commercial Revenue	$118,331,365
Other Revenue	$6,357,596
Total Revenue	**$13,485,995,836**
Investment Income	$81,453,363
Salaries and Benefits	$8,063,452,900
Purchased Services and Materials	$5,043,629,579
Other Expense	$278,356,876
Total Expense	**$13,385,439,355**

8.2 NCDC Finances

Pursuant to §1890(b)(5)(A)(ii)(III), the CBE must provide "a breakdown of the amount awarded per contracted task order and the specific projects funded in each task order assigned to the entity." Table 9 lists the tasks with award amounts and funded amounts in option year 2 of the contract.

Table 9. Federally Funded Tasks Awarded and Funded in FY 2025 Under Indefinite Delivery Indefinite Quality IDIQ Contract 75FCMC23C0010

ID # (SLIN)	Description	Awarded, $	Funded, $
CLIN0004			
0004AA	Measures Reviewed: Endorsement and Maintenance	$3,962,340	$3,962,340
0004AB	(OPTIONAL) Measures Reviewed: Endorsement and Maintenance	$552,380	$552,380
0004AC	Measures Reviewed: Pre-Rulemaking	$1,207,740	$1,207,740
0004AD	(OPTIONAL) Measures Reviewed: Pre-Rulemaking	$373,065	$373,065
0004AE	(OPTIONAL) Measures Reviewed: Pre-Rulemaking	$373,065	$373,065
0004AF	Measures Reviewed: Measure Set Review	$365,610	$365,610
0004AG	(OPTIONAL) Measures Reviewed: Measure Set Review	$160,725	$160,725
0004AH	(Deliverable 2-3) Final Project Management Plan	$1,091,556	$1,091,556
0004AJ	(Deliverable 2-13) Final Annual Report	$553,299	$553,299
0004AK	(Deliverable 2-17) Health Care Ad Hoc Tasks: Level of Effort Units	$2,805, 000	$2,805,000
0004AL	(Deliverable 4-27) Measure Selection and Removal-Related Ad Hoc Tasks	$449,883	$449,883
0004AM	(Deliverable 5-1) Core Quality Measures Collaborative (CQMC) Activities Implementation Proposal	$500,078	$500,078
0004AN	(Deliverable 6-1) Transition Plan	$75,656	$75,656
0004AP	Final Artificial Intelligence (AI) Implementation Guide and Toolkit	$1,049,929	$1,049,929
0004AQ	Payer Alignment Roll-Out Meeting	$183,599	$183,599
TOTAL		**$13,703,925**	**$13,703,925**

9.0 Updates to Policies and Procedures

Pursuant to §1890(b)(5)(A)(iii), the consensus-based entity must report updates to internal policies and procedures, including any changes to disclosure of interests and conflicts for committees, work groups, task forces, and advisory panels; disclose relevant interests and any conflicts for all members; and report the total percentage by health care sector of all convened bodies.

Since 2023, Battelle has developed and posted nomination and conflict-of-interest (COI) forms and made no policy or procedure changes in 2025. Policies are in the E&M Guidebook and the PRMR/MSR Guidebook.

Under the PQM Conflict of Interest Policy, nominees must complete a general disclosure of interests (DOI) per committee before seating and annually thereafter. For E&M standing committees, seated members must also complete a measure-specific DOI at the start of each evaluation cycle for all measures under review (and related or competing measures), which Battelle uses to determine recusals; members who do not submit this form before evaluation meetings may not participate in discussions or vote.

At the beginning of each committee meeting, committee members were asked to disclose any potential conflicts of interest, including prior affiliation or collaboration related to the measures under review. In instances where a potential conflict was identified, the affected participant (s) were recused from the relevant portions of the discussion and voting. This approach ensured transparency and maintained the integrity of the reviews.

10.0 Conclusion

The CMS consensus-based entity (CBE) serves as a trusted, neutral mechanism for evaluating the scientific rigor, relevance, and usability of health care performance measures. Battelle is committed to partnering with CMS and PQM members to ensure that measures used across payer programs remain meaningful, scientifically sound, and focused on outcomes that matter to patients. Looking ahead, Battelle is prepared to support emerging needs in measurement science, including digital quality measurement and responsible AI utilization, so federal programs can continue to drive improvements in care while reducing unnecessary burden.

11.0 Abbreviations

ACA	Affordable Care Act
ACC	American College of Cardiology
ACO	Accountable Care Organization
AGC	After Government Contract
AHIP	Formerly known as American Health Insurance Partnership
AHRQ	Agency for Healthcare Research and Quality
AI Pilot	Artificial Intelligence Pilot
AIPAC	Advanced Illness and Post-Acute Care
AIR	American Institutes for Research
ANOVA	Analysis of Variance
ASCO	American Society of Clinical Oncology
ASCQR	Ambulatory Surgical Center Quality Reporting Program
ASCs	Ambulatory Surgical Centers
C&E	Cost and Efficiency
CAH	Critical Access Hospital
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CBE	Consensus-Based Entity
CBE ID	Consensus-Based Entity Identification
CDC	Centers for Disease Control and Prevention
CDS	Clinical Decision Support
CDSS	Clinical Decision Support System
CIS	Clinical Information Systems
CMIT	CMS Measures Inventory Tool
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
CO	Contracting Officer
COIs	Conflicts of Interest
COR	Contracting Officer's Representative
CPG	Clinical Practice Guidelines
CQL	Clinical Quality Language
CQM	Clinical Quality Measure
CQMC	Core Quality Measures Collaborative
CSAC	Consensus Standards Approval Committee
DEL	CMS Data Element Library
Del.	Deliverable
DOI	Disclosure of Interest
dQMs	Digital Quality Measures
DRC	Direct Reference Code
E&M	Endorsement and Maintenance
EC	Electronic Copy
eCQI	Electronic Clinical Quality Improvement
eCQM	Electronic Clinical Quality Measures
ED	Emergency Department
EHR	Electronic Health Record
EPC	Evidence-Based Practice Center
ESRD QIP	End-Stage Renal Disease Quality Improvement Program
EVI	Expected Value of Information
FAQs	Frequently Asked Questions
FFS	Fee-For-Service

Abbreviations *(continued)*

FHIR	Fast Healthcare Interoperability Resources
FMS	Full Measure Submission
FY	Fiscal Year
HACRP	Hospital-Acquired Conditions Reduction Program
HCBS	Home and Community-Based Services
HCD	Human-Centered Design
HEDIS	Healthcare Effectiveness Data and Information Set
HH QRP	Home Health Quality Reporting Program
HH VBP	Home Health Value-Based Purchasing
HHS	Department of Health and Human Services
HIQR	Hospital Inpatient Quality Reporting
HOPD	Hospital Outpatient Department
HOPE	Hospice Outcomes and Patient Evaluation
HOQR	Hospital Outpatient Quality Reporting
HQMF	Health Quality Measurement Format
HQR	Hospice Quality Reporting
HQRP	Hospice Quality Reporting Program
HRRP	Hospital Readmission Reduction Program
HSAG	Health Services Advisory Group
HTML	Hypertext Markup Language
HVBP	Hospital Value-Based Purchasing
IAW	In Accordance With
ICD	International Classification of Diseases (International Statistical Classification of Diseases and Related Health Problems)
IHI	Institute for Healthcare Improvement
IMPACT Act	Improving Medicare Post-Acute Care Transformation Act
IPF	Inpatient Psychiatric Facilities
IPF QRP	Inpatient Psychiatric Facility Quality Reporting Program
IPPS	Inpatient Prospective Payment System
IQR	Inpatient Quality Reporting
IR	Initial Recognition
IRF	Inpatient Rehabilitation Facilities
IRF QRP	Inpatient Rehabilitation Facility Quality Reporting Program
IT	Information Technology
ITS	Intent to Submit
LLMs	Large Language Models
LTACH	Long-Term Acute Care Hospitals
LTCH	Long-Term Care Hospital
LTCH QRP	Long-Term Care Hospital Quality Reporting Program
MA	Medicare Advantage
MACRA	Medicare Access and CHIP Reauthorization Act
MACS	Medicaid: Adult Core Set
MAQIP	Medicare Advantage Quality Improvement Program
MAT	Measure Authoring Tool
MCCS	Medicaid: Child Core Set
MCO	Managed Care Organization
MERIT	Measures Under Consideration Entry/Review Tool

Abbreviations *(continued)*

MIPPA	Medicare Improvement for Patients and Providers Act of 2008
MIPS	Merit-based Incentive Payment System
MLTSS	Managed Long-Term Service and Support
MMS	Measures Management System
MS-DOI	Measure-Specific Disclosure of Interest
MSR	Measure Set Review
MSSP	Medicare Shared Savings Program
MUC	Measures Under Consideration
n	Sample Size
NCDC	National Consensus Development and Strategic Planning for Health Care Quality Measurement Contract
NCQA	National Committee for Quality Assurance
NHDNG	Novel Hybrid Delphi and Nominal Groups
NHQI	Nursing Home Quality Initiative
NLP	Natural Language Processing
NQF	National Quality Forum
NQS	CMS National Quality Strategy
NTTAA	National Technology Transfer and Advancement Act
OMB	Office of Management and Budget
OP	Option Period
OY	Option Year
PA	Preliminary Assessment
PAC/LTC	Post-Acute Care/Long-Term Care
PaLS	Patient Life Goals Survey
PAM	Patient Activation Measure
PCHQR	PPS-Exempt Cancer Hospital Quality Reporting
PDF	Portable Document Format
PIE Form	Pre-Meeting Initial Evaluation Form
PL	Project Leader
PM	Project Manager
PMP	Project Management Plan
POC	Point of Contact
PPS	Prospective Payment System
PQA	Pharmacy Quality Alliance
PQM	Partnership for Quality Measurement
PRA	Paperwork Reduction Act
PRMR	Pre-Rulemaking Measure Review
PRO	Patient-Reported Outcome
PROM	Patient-Reported Outcome Measure
PRO-PMs	Patient-Reported Outcome Performance Measures
Q&A	Question & Answer
QC	Quality Control
QCDR	Qualified Clinical Data Registries
QDM	Quality Data Model
QI	Quality Improvement
QMDSA	Quality Measure Developer and Steward Agreement
QPP	Quality Payment Program
REHQR	Rural Emergency Hospital Quality Reporting (Program)
SDOH	Social Determinants of Health

Abbreviations *(continued)*

SES	Socioeconomic Status
SLIN	Subline Item Number
SMEs	Subject Matter Experts
SMP	Scientific Measures Panel
SNF	Skilled Nursing Facilities
SNF QRP	Skilled Nursing Facility Quality Reporting Program
SNF VBP	Skilled Nursing Facility Value-Based Purchasing
SOP	Standard Operating Procedure
SOW	Statement of Work
SSA	Social Security Administration
STAR	Submission Tool and Repository
SUD	Substance Use Disorder
TBD	To Be Determined
TEP	Technical Expert Panel
TL	Task Lead
UMLS	Unified Medical Language System
USCDI	United States Core Data for Interoperability
VSAC	Value Set Authority Center
Yale CORE	Yale Center for Outcomes Research and Evaluation

Appendix

Pursuant to 1890(b(5)(A)(iii)(II) , the CBE must include information on external stakeholder participation in the duties of the entity under this section (including complete rosters for all committees, work groups, task forces, and advisory panels funded through government contracts, descriptions of relevant interest and any conflicts of interest for members of all committees, work groups, task forces and advisory panels, and the total percentage by health care sector of all convened committees, work groups, tasks forces and advisory panels.

Battelle convenes committees and workgroups with a broad representation of health care sector members. As the consensus-based entity for this contract, Battelle requires all participating members to complete a disclosure of interest process before appointment, ensuring transparency. This year, Battelle did not identify any conflicts of interest that could undermine the objectivity of work performed under this contract. Table 10 outlines the number of health care sectors represented.

Table 10. Proportional Representation of Health Care Sectors in PQM Committees in 2025

Health Care Sector	Percentage
Patient, Caregiver, Advocate, Partner	17%
Clinician	18%
Facility/Institution	12%
Other Interested Party	12%
Purchaser and Plan	5%
Clinician Association	4%
Health Services Researcher	9%
Population Health Expert	17%
Facility Association	3%

E&M Cost and Efficiency Committee Roster

COMMITTEE MEMBER	RELEVANT INTEREST
Alikhaani, Jacqueline	*Patient Participant*
Anand, Nishant	*Clinician*
Andronaco, Sopida	*Clinician*
Beaty, Melody	*Clinician*
Bell, Alice	*Clinician*
Borah, Bijan	*Researcher*
Chen, Jason	*Population Health*
Chen, Melissa	*Facility/Institution*
Chin, Amy	*Researcher*
Clark, Mary Ann	*Population Health*
Crum, Erin	*Other Interested Party*
Das, Sandeep	*Population Health*
Deutsch, Anne	*Researcher*
Ekholm, Rebecca	*Population Health*
Elliott, Marisa	*Facility/Institution*
Fernandez, Maria	*Population Health*
Fitzgerald, Stephanie	*Clinician*
Freeman-Wright, Carrie I.	*Patient Participant*
Garrett, Nancy	*Purchaser/Plan*
Gross-Balzano, Olga	*Facility/Institution*
Guinn, Megan	*Facility/Institution*
Hannan, Kelci	*Purchaser/Plan*
Hansen, Stephanie	*Clinician*
Hawley, Charles	*Other Interested Party*
Hibay, Sharon	*Researcher*
Higgins, Kristal	*Patient Participant*
Hill, Corey	*Researcher*

COMMITTEE MEMBER	RELEVANT INTEREST
Hughes, Allyson	*Population Health*
Hurst, Christina	*Patient Participant*
James, Veronica	*Other Interested Party*
Jhamnani, Sunny	*Clinician*
Jones, Robert	*Clinician*
Kanter, Michael	*Facility/Institution*
Lu, Amy	*Facility/Institution*
Mahan, Charles	*Facility/Institution*
Morris, Laura	*Facility/Institution*
Morrison, Seth	*Patient Participant*
Needleman, Jack	*Researcher*
Pease, Sonya	*Population Health*
Peterson, Jessica	*Other Interested Party*
Roberts, Pamela	*Other Interested Party*
Roberts, Susan	*Patient Participant*
Schramke, Mary	*Patient Participant*
Schuyler, Lynden	*Population Health*
Selvarajah, Shalini	*Researcher*
Smith, Mary	*Population Health*
Smith, Trisha Jean	*Patient Participant*
Spivack, Steven	*Other Interested Party*
Staloff, Jonathan	*Researcher*
Stanton, Dorothy	*Other Interested Party*
Thomas-Hemak, Linda	*Population Health*
Tran, Jackie	*Population Health*
Tyree, Kim	*Population Health*

E&M Primary Prevention Committee Roster

COMMITTEE MEMBER	RELEVANT INTEREST
Angove, Rebekah	Patient Participant
Babiuch, Christopher	Facility/Institution
Bailey, Robert D.	Population Health
Bailly, Edward	Other Interested Party
Bal, Poonam	Researcher
Berryhill, Willie	Patient Participant
Bi, Jingzhu	Population Health
Booker, Kissley	Clinician
Brady, Jeff	Purchaser/Plan
Burdick, Jon	Clinician
Campa, David	Clinician
Casey, Don	Clinician
Cockrell, Tina	Population Health
Davidoff, Bahar	Researcher
Davis, Melissa	Clinician
Dickinson, Megan	Population Health
Engebrecht, Kerri	Patient Participant
Farrell, Paula	Clinician
Green, Beverly	Clinician
Ho, Michael	Researcher
Hudson, Thoma	Other Interested Party
Kelley, Daniel	Population Health
Kothari, Pooja	Patient Participant
Kredit, Sheila	Clinician
Krueger, John	Population Health
Lacoy, Roger	Patient Participant
Lansang, Jenel	Clinician

COMMITTEE MEMBER	RELEVANT INTEREST
Lee, Emily	Patient Participant
Levy, Shoshana	Purchaser/Plan
Lin, Zhenqui	Other Interested Party
Lovec-Theobald, Rhonda	Clinician
Lowry, Ayanna	Researcher
Martin, John	Researcher
McKiernan, Colleen	Other Interested Party
Moreno, Amy	Patient Participant
Mumford, Quinyatta	Patient Participant
O'Rourke, Erin	Purchaser/Plan
Phillips, Kami	Population Health
Pryor, David	Facility/Institution
Qaseem, Amir	Other Interested Party
Raposo, Nicholas	Researcher
Rodgers, Kimberly	Patient Participant
Rozenich, Jennifer	Population Health
Shea, Suellen	Other Interested Party
Snyder, Alexis	Patient Participant
Surreira, Celeste	Population Health
Tait-Dinger, Ashley	Patient Participant
Thompson-Byrd, Alana	Facility/Institution
Tong, Elisa	Clinician
Warren, Jeffrey	Researcher
West, Milli	Facility/Institution
Williams, Danielle	Patient Participant
Williams-Bader, Jenna	Other Interested Party
Wiltz, Jennifer	Other Interested Party

E&M Advanced Illness and Post-Acute Care Committee Roster

COMMITTEE MEMBER	RELEVANT INTEREST
Austin, James	Patient Participant
Beckwith, Samira	Facility/Institution
Calliste, Joshua	Purchaser/Plan
Campos, Karen	Other Interested Party
Chuzi, Sarah	Clinician
Clayman, David	Clinician
Coleman, Elizabeth	Population Health
Di Palo, Katherine	Clinician
Dwyer, Kathleen	Clinician
El Zein, Lama	Purchaser/Plan
Fugate, Karie	Patient Participant
Galantowicz, Sara	Other Interested Party
Calchutt, Paul	Patient Participant
Geoffrey, Kimberly	Patient Participant
Gettel, Cameron	Clinician
Godfrey, Sarah	Clinician
Green, Laura	Population Health
Goves, Brenda	Patient Participant
Hamilton, Morris	Other Interested Party
Hiersteiner, Dorothy	Other Interested Party
Jaramillo, Maria Catalina	Population Health
Jersey, Andrea	Clinician
Johnson, Victoria	Population Health
Jones, Raymond	Researcher
Jones, Warren	Population Health
Jun, Soojin	Patient Participant
Kitko, Lisa	Researcher
Lamb, Gerri	Clinician
Marfeo, Elizabeth	Clinician; Health Services Researcher
Martin, Emily	Clinician
Matthews, Kyle	Patient Participant
Miller Temple, Kay	Population Health
Pease, Amy	Clinician
Perez-Protto, Silvia	Clinician
Piltz, Lori	Patient Participant
Puri, Tipu	Clinician
Raygoza, Heather	Clinician
Redus, Lauri	Facility/Institution
Rosenberg, Eric	Clinician
Rowan, Patricia	Researcher
Sanchez, Anthony	Patient Participant
Sandin, Karl	Clinician
Schweiger, Andrea	Other Interested Party
Seidl, Kristin	Clinician
Siebert, Carol	Population Health
Spoto, Marcia	Facility/Institution
Stolpe, Samuel	Researcher
Stuercke, Michelle	Clinician
Swain-Eng, Rebecca	Other Interested Party
Thirlwell, Sarah	Clinician
Thompson, Heather	Facility/Institution
Tufte, Janice	Patient Participant
Walters, Ronald	Clinician
Weed, Stephan	Patient Participant
Wladkowski, Stephanie	Researcher

E&M Management of Acute Care Committee Roster

COMMITTEE MEMBER	RELEVANT INTEREST
Agoratus, Lauren	Patient Participant
Ayers, Sharon	Patient Participant
Barham, Jeni	Clinician
Bartel, Rosie	Patient Participant
Bolden, Nakia	Population Health
Bowman-Zatzkin, Whitney	Patient Participant
Bramlee, Carrie	Patient Participant
Catalfumo, Frankie	Other Interested Party
Cobabe, Maurine	Facility/Institution
Farquhar, Marybeth	Researcher
Flanagan, Angela	Clinician
Fondahn, Emily	Clinician
Gans, Mika	Purchaser/Plan
Geoffrey, Byron	Patient Participant
Glance, Laurent	Researcher
Gupta, Pankaj	Purchaser/Plan
Herring, Shawn-Marie	Other Interested Party
Hultz, Kyle	Facility/Institution
Hunt, Jennifer	Patient Participant
Jenkins, Wiley	Population Health
Johnson, Sarah	Patient Participant
Jospeh, Vilma	Clinician
Koufalis, Sachie	Population Health
Mammo, Abate	Other Interested Party
Mattingly, Kristen	Facility/Institution
Nosamiefan, Chisa	Patient Participant

COMMITTEE MEMBER	RELEVANT INTEREST
Ojeda, Tamaire	Clinician
Perez-Hudgins, Adelisa	Clinician
Plathe, Jennifer	Population Health
Porter, Heidi	Facility/Institution
Poznyak, Dmitriy	Researcher
Ray, Monika	Researcher
Sackett, Rena	Facility/Institution
Sarabu, Nagaraju	Clinician
Schoenthaler, Antoinette	Population Health
Seckel, Maureen	Clinician
Shah, Vikram	Purchaser/Plan
Shahian, David	Clinician
Shirley, Benjamin	Other Interested Party
Shitara, Kenneth	Population Health
Sinyagovskiy, Pavel	Clinician
Slocum, Chloe	Clinician
Slye, Annie	Population Health
Streur, Megan	Researcher
Stump, Terra	Other Interested Party
Susman, Jeff	Clinician
Suter, Lisa	Clinician
Theodoropoulos, Eleni	Other Interested Party
Thicklin, Florence	Patient Participant
Tierney, Samantha	Other Interested Party
Toomey, Sara	Clinician
Trangle, Michael	Clinician

E&M Management of Acute Care Committee Roster (continued)

COMMITTEE MEMBER	RELEVANT INTEREST
van den Berk-Clark, Carissa	Researcher
Wagner, John	Facility/Institution
Ward, Sharronne	Population Health
Ying, Wei	Purchaser/Plan

COMMITTEE MEMBER	RELEVANT INTEREST
Young, Bianca	Patient Participant
Yuce, Tarik	Researcher
Zima, Bonnie	Researcher

E&M Initial Recognition Committee Roster

COMMITTEE MEMBER	RELEVANT INTEREST
Abbott, Stephanie	Patient Participant
Abshire Saylor, Martha	Researcher
Ajayi, Kobi	Patient Participant
Alkhairw, Hadeel	Other Interested Party
Alycon, Hillary	Facility/Institution
Anderson, Kory	Facility Institution
Austin, Matt	Researcher
Bailit, Jennifer	Other Interested Party
Banks, Tom	Population Health
Bartles, Rebecca	Other Interested Party
Blauvelt, Jacqueline	Facility/Institution
Blazier, Jill	Population Health
Bradley Sr., Darius	Patient Participant
Cable, Nicole	Patient Participant
Caceres, Billy	Population Health
Calvert, Emily	Other Interested Party
Chand, David	Purchaser/Plan
Comiskey, Ashley	Clinician
Dantes, Raymund	Clinician

COMMITTEE MEMBER	RELEVANT INTEREST
Davis, Carrie	Clinician
Donovan, Carl	Patient Participant
Fernandes, Karen	Patient Participant
Hampton, Ryan	Facility/Institution
Harris, April	Patient Participant
Hayes, Joseph	Population Health
Hemmelgarn, Carole	Patient Participant
Holden, Erin	Facility/Institution
Hurley, Janet	Facility/Institution
Ingber, Hannah	Researcher
Irelan, Lindsey	Other Interested Party
Iyer, Sonali	Clinician
Jacob, Abraham	Clinician
Jones, Rebecca	Other Interested Party
Kalantar-Zadeh, Kamyar	Clinician
Kivowitz, Barbara	Patient Participant
Love, Tammy	Other Interested Party
Madarász, Laura	Researcher
McCowan, Precious	Patient Participant

E&M Initial Recognition Committee Roster *(continued)*

COMMITTEE MEMBER	RELEVANT INTEREST
McElhaney, Cindi	Researcher
McFadden, Rhelinda	Population Health
Merryweather-Arges, Patricia	Patient Participant
Milam, Adam	Population Health
Morehead, Carmen	Population Health
Morse, Denise	Other Interested Party
Pindolia, Vanita	Purchaser/Plan
Powell, Sharon	Patient Participant
Ramanan, Harshitha	Population Health
Roberts, Darryl	Researcher
Romano, Patrick	Researcher
Saseen, Joseph	Clinician
Sasson, Talia	Clinician
Scott, Lisa	Population Health
Seidenwurm, David	Facility/Institution
Spiegel, Thomas	Facility/Institution
Subramani, Aarthi	Clinician
Thriffiley, Phoebe	Other Interested Party
Tilly, Jean-Luc	Purchaser/Plan
Venugopal, Usha	Population Health
Weinhandl, Eric	Researcher
Young, Janice	Facility/Institution

CBE Strategy Work Group

WORK GROUP MEMBER	RELEVANT INTEREST
Bringham-Gray, Erin	CareSource
Burstin, Helen	Council of Medical Specialty Societies
Danforth, Missy	The Leapfrog Group
Demehin, Akin	American Hospital Association
Fleisher, Lee	Rubrum Advising
Hemmelgarn, Carole	Patients for Patient Safety US
McGaffigan, Patricia	Institute for Healthcare Improvement
Nguyen, Viet	HL7 International
Regenhold, Kevin	Humana
Robertson, Peter	Purchaser Business Group on Health
Schrieber, Michelle	Centers for Medicare & Medicaid Services

Wellness and Nutrition Framework Work Group

WORK GROUP MEMBER	RELEVANT INTEREST
Abbott, Stephanie	Patient Participant
Coltman, Anne	Measure Developer/Steward
Katz, David	Researcher
Little, Jessica	Health Improvement Network
Vogt, Dawne	Clinician

Wellness and Nutrition Framework Key Informant Interviewees

KEY INFORMANT INTERVIEWEES	RELEVANT INTEREST
Brigham, Erin	Health Plan/Providers
Buslovich, Steven	Clinician/Researcher
Daniels, Tania	Health Improvement Network
Demehin, Akinluwa	Facility Association
DuBard, Annette	Health Improvement Network
Fowler, Terri	Clinician/Researcher
Kligler, Benjamin	Veterans Affairs
Landon, Bruce	Clinician/Researcher
Nash, David	Clinician
Norcross, Michelle	Health Improvement Network
Oglesby, Billy	Population Health and/or Researcher
Ornish, Dean	Clinician
Pandya, Naushira	Clinician
Phillips, Cheryl	Population Health
Regenhold, Kevin	Health Plan/Providers
Wachter, Robert	Clinician/Researcher

Pre-Rulemaking Measure Review Hospital Committee Roster

COMMITTEE MEMBER	RELEVANT INTEREST
Adirim, Terry	Other Interested Party
Bartel, Rosie	Patient Participant
Basel, David	Population Health
Bott, John	Purchaser/Plan
Buck, Jeffrey	Researcher
Butt, Zahid	Other Interested Party
Carvalho, Marissa	Clinician Association
Ciesielski, Thomas	Clinician
Danforth, Missy	Purchaser/Plan
Dardis, Michelle	Other Interested Party
Devkaran, Subashnie	Clinician
Doll, Michelle	Researcher
Dougherty, Geoff	Population Health
Fitterman, Nick	Clinician Association
Fitts, Wendy	Clinician
Frederickson, Thomas	Population Health
Gandhi, Tejal	Population Health
Ghiorso, Angela	Facility/Institution
Gillooley, Caitlin	Facility Association
Hatlie, Martin	Patient Participant
Healy, Sara	Patient Participant
Hyde, Sandi	Population Health
Irwin-Scott, Virginia	Clinician Association
Khan, Abigail	Population Health
Kim, Christopher	Clinician
Krizay, Mary	Facility Association

COMMITTEE MEMBER	RELEVANT INTEREST
Kroll, David	Clinician
Lane, Michael	Other Interested Party
Ledbetter, Stefanie	Facility/Institution
Levine, David	Facility/Institution
Logan, Merranda	Facility/Institution
Lundblad, Jennifer	Population Health
Lynch, Michael	Purchaser/Plan
Marcinek, Julie	Clinician Association
Matthes, Nikolas	Other Interested Party
McBride, Tilithia	Facility Association
McCard, Hal	Population Health
McDonald, Ann Marie	Other Interested Party
McGaugh, Ben	Patient Participant
McMullan, Somaieh	Purchaser/Plan
Michl, Shari	Patient Participant
Minnich, Amy	Purchaser/Plan
Moore, James	Facility/Institution
Nair, Devika	Researcher
Nguyen, Hien	Facility/Institution
Ortiz, Glorimar	Facility/Institution
Orton, Jan	Facility/Institution
Parker, Mark	Clinician
Pollak, Ed	Facility/Institution
Pollock, Benjamin	Researcher
Ramsey, Phoebe	Clinician Association
Rauch, Kathleen	Facility Association

Pre-Rulemaking Measure Review Hospital Committee Roster (continued)

COMMITTEE MEMBER	RELEVANT INTEREST
Roshon, Michael	Facility Association
Runyan, Susan	Population Health
Schumacher, Jessica	Researcher
Shapiro, Lauren	Clinician Association
Shelton, Darlene	Patient Participant
Shelton, Kristin	Patient Participant
Silberzweig, Jeffrey	Clinician
Varnell, Holly	Population Health
Wilson, Christopher	Population Health
Wilson, Kathy	Other Interested Party
Zambrana, Isis	Population Health
Zimmerman, Beth	Facility/Institution

Pre-Rulemaking Measure Review Clinician Committee Roster

COMMITTEE MEMBER	RELEVANT INTEREST
Abdallah, Ramsey	Facility/Institution
Anand, Nishant	Clinician
Andre, Paulo	Other Interested Party
Baez, Rose	Purchaser/Plan
Baliker, Mary	Patient Participant
Barnes, Reginald	Patient Participant
Bitterman, Jennifer	Patient Participant
Boffa, Anne	Purchaser/Plan
Braxton, Stephanie	Other Interested Party
Butt, Zeeshan	Researcher
Cerasale, Matthew	Clinician Association
Clements, Kari	Purchaser/Plan
Crum, Erin	Facility Association
Davila, Victor	Researcher
Davis, Kristina	Clinician
DiMarco, Christopher	Other Interested Party
Drummond, Jean	Population Health
Eakin, Sarah	Clinician
Ferranti, Erin	Population Health
French, Jonathan	Other Interested Party
Friedland, Richard	Clinician
Goodman, Barbara	Facility/Institution
Gopal, Deepak	Clinician Association
Griffin, Shawn	Population Health
Gruner, Marc	Clinician
Guidone, Heather	Patient Participant
Hammond, Gmerice	Population Health
Harahsheh, Ashraf	Clinician Association
Heller, Richard	Researcher
Hitchens, John	Clinician
Jackson, Shalini S.	Researcher
Jhamnani, Sunny	Population Health
Kalantar-Zadeh, Kam	Population Health
Kertai, Miklos	Facility/Institution

Pre-Rulemaking Measure Review Clinician Committee Roster (continued)

COMMITTEE MEMBER	RELEVANT INTEREST
MacMillan, Carlene	Clinician Association
Macon, Vera	Other Interested Party
McGee, Corey	Clinician Association
Murphy, Daniel	Facility/Institution
Mylod, Deirdre	Population Health
Norris, Joseph	Patient Participant
Novikoff, Ethan	Population Health
O'Connor, Diane	Facility/Institution
O'Rourke, Erin	Purchaser/Plan
Parker, Matthew	Purchaser/Plan
Parsons, Darla	Facility/Institution
Pearlmutter, Lori	Facility Association
Petrino, Traci	Facility/Institution
Puri, Tipu	Facility/Institution
Qaseem, Amir	Clinician Association

COMMITTEE MEMBER	RELEVANT INTEREST
Reyna, Megan	Facility Association
Roeger, Kristyne	Other Interested Party
Roman, Sheila	Clinician
Rose, Geoffrey	Clinician
Rubin, Koryn	Clinician Association
Seidenwurm, David	Clinician Association
Sheares, Karen	Researcher
Shuemaker, Jill	Researcher
Starkey, Christa	Patient Participant
Susman, Jeff	Population Health
Tinloy, Bradford	Clinician
Toedt, Michael	Population Health
Waldron, Kayla	Facility/Institution
Woodward, Jennifer	Clinician Association
Ying, Wei	Purchaser/Plan

Pre-Rulemaking Measure Review Post-Acute Care/Long-Term Care Committee Roster

COMMITTEE MEMBER	RELEVANT INTEREST
Aaron, Leslie	Patient Participant
Accetta, Robert	Clinician
Albertson, Maureen	Facility/Institution
Bednarski, Donna	Clinician Association
Behnke, Lyn	Population Health
Benton, Jeremy	Researcher
Blackburn, Katie	Clinician Association
Blair, Rachel	Other Interested Party

COMMITTEE MEMBER	RELEVANT INTEREST
Bolden, Michelle	Patient Participant
Brockman, Jennifer	Population Health
Brogdon, Jack	Facility/Institution
Burrows, Lara	Purchaser/Plan
Butler, Melissa	Patient Participant
Campbell, Brandy	Population Health
Cannady, Jolene	Clinician
Charbonneau, Elissa	Population Health

Pre-Rulemaking Measure Review Post-Acute Care/Long-Term Care Committee Roster *(continued)*

COMMITTEE MEMBER	RELEVANT INTEREST
Charles, Karen	Population Health
Coomes, J.	Purchaser/Plan
Coxon, April	Facility Association
Das, Rohit	Other Interested Party
Davenport, Claire	Facility/Institution
DeBardeleben, Mary Ellen	Facility/Institution
Doherty, Mary	Population Health
Eyigor, Jodi	Other Interested Party
Grotzky, Danielle	Population Health
Henwood, Patricia	Facility/Institution
Hillman, Troy	Facility Association
Hofmann, Laura	Clinician
Hufnagel, Heleena	Purchaser/Plan
Huling, Sarah	Population Health
Jakubik, Andrew	Facility/Institution
Khan, Shabina	Patient Participant
Kiser, Annette	Facility/Institution
Klusch, Leah	Clinician Association
Lally, Kate	Clinician Association
Leffler, Robert	Clinician
Lerza, Cathy	Purchaser/Plan
Lillard-Green, Arion	Population Health

COMMITTEE MEMBER	RELEVANT INTEREST
Littlehale, Steven	Researcher
Mahajan, Dheeraj	Clinician
Luger Motyka, Tana	Facility Association
Palat, Sing	Facility/Institution
Parikh, Vicky	Population Health
Phillips, Cheryl	Other Interested Party
Plasencia, Rosa	Other Interested Party
Pue, Janet	Facility Association
Rask, Kimberly	Population Health
Roberts, Pamela	Facility Association
Sanchez, Anthony	Patient Participant
Schmidt, Theresa	Researcher
Schweon, Steven	Clinician
Siebert, Carol	Population Health
Sreenivas, Kiran	Researcher
Syed, Quratulain	Clinician
Thomas, James	Patient Participant
Tufte, Janice	Patient Participant
Von Raesfeld, Christine	Patient Participant
Wagner, Jennifer	Population Health
Wascom, Melanie	Clinician
Worz, Chad	Clinician Association

Measure Set Review Committee Member Roster

COMMITTEE MEMBER	RELEVANT INTEREST
Albertson, Maureen	Facility/Institution
Barnes, Reginald	Patient Participant
Basel, David	Population Health
Behnke, Lyn	Population Health
Butt, Zahid	Other Interested Party
Coxon, April	Facility Association
Danforth, Missy	Purchaser/Plan
Gandhi, Tejal	Population Health
Gillooley, Caitlin	Facility Association
Hatlie, Martin	Patient Participant
Jhamnani, Sunny	Population Health
Macon, Vera	Other Interested Party

COMMITTEE MEMBER	RELEVANT INTEREST
Marcinek, Julie	Clinician Association
Meth, Steve	Facility/Institution
O'Rourke, Erin	Purchaser/Plan
Pearlmutter, Lori	Facility Association
Phillips, Cheryl	Other Interested Party
Pollak, Ed	Facility/Institution
Qaseem, Amir	Clinician Association
Roman, Sheila	Clinician
Rubin, Koryn	Clinician Association
Shuemaker, Jill	Researcher
Silberzweig, Jeffrey	Clinician
Tufte, Janice	Patient Participant
Wascom, Melanie	Clinician

CQMC

CQMC Full Collaborative Voting Member Organizations

- Aetna
- American Academy of Family Physicians (AAFP)
- American Academy of Pediatrics (AAP)
- American Association on Health and Disability (AAHD)
- American Benefits Council
- American Board of Family Medicine Foundation (ABFM Foundation)
- American College of Cardiology (ACC)
- American College of Emergency Physicians (ACEP)
- American College of Obstetricians and Gynecologists (ACOG)
- American College of Physicians (ACP)
- American Gastroenterological Association (AGA)
- American Geriatrics Society (AGS)
- American Heart Association
- American Medical Association (AMA)
- American Occupational Therapy Association
- American Psychiatric Association
- American Society of Clinical Oncology (ASCO)
- American Specialty Health (ASH)
- America's Health Insurance Plans (AHIP)
- AmeriHealth Caritas
- Blue Cross Blue Shield of Michigan
- Bone Health and Osteoporosis Foundation
- Centene
- Centers For Medicare & Medicaid Services (CMS)
- Cigna Healthcare
- Consumers' Checkbook/Center for the Study of Services
- Council of Medical Specialty Societies (CMSS)
- Defense Health Agency (DHA)
- Elevance Health
- Health Resources and Services Administration (HRSA)
- HealthCareTN
- HIV Medicine Association of the Infectious Diseases Society of America
- Humana
- Kaiser Permanente
- Minnesota Community Measurement
- Molina
- National Association of ACOs (NAACOS)
- National Patient Advocate Foundation (NPAF)
- Shatterproof
- Society for Maternal-Fetal Medicine (SMFM)
- U.S. Department of Veterans Affairs (VA)
- Wisconsin Collaborative for Healthcare Quality (WCHQ)

CQMC Full Collaborative Non-Voting Member Organizations

- American College of Lifestyle Medicine
- American Hospital Association (AHA)
- Civitas Network for Health
- Contexture
- Hematology Oncology Pharmacy Association (HOPA)
- National Committee for Quality Assurance (NCQA)
- Oracle Cerner
- Pharmacy Quality Alliance (PQA)
- Solventum
- Texas Medical Association (TMA)
- Vizient