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National Consensus Development and Strategic Planning for Health Care Quality Measurement

Spring 2025 Cycle Endorsement Meeting Summary

Cost and Efficiency

SEPTEMBER 2025

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Spring 2025 Cost and Efficiency Endorsement Meeting Summary

Overview

Battelle, the consensus-based entity (CBE) for the Centers for Medicare & Medicaid Services (CMS), convened the Recommendation Group of the Cost and Efficiency committee on August 6, 2025, for discussion and voting on measures under endorsement consideration for the Spring 2025 cycle. Battelle, the consensus-based entity (CBE) for the Centers for Medicare & Medicaid Services (CMS), convened the Recommendation Group of the Cost and Efficiency committee on August 6, 2025, for discussion and voting on measures under endorsement consideration for the Spring 2025 cycle. Meeting participants joined virtually through a Zoom meeting platform. Measure stewards/developers and members of the public also attended.

The objectives of the meeting were to:

- Review and discuss measures submitted to the committee for the Spring 2025 cycle;
- Review staff preliminary assessments, Advisory and Recommendation Group feedback, public comments, and developer responses regarding the measures under endorsement review; and
- Render endorsement decisions using a virtual voting platform.

The Recommendation Group voted to endorse two measures with conditions (Table 1 below). This summary provides an overview of the meeting, the Recommendation Group deliberations, and the endorsement decision outcomes. Full measure information, including all public comments, staff preliminary assessments, Advisory Group feedback, and committee independent reviews can be found on the project committee's webpage on the Partnership for Quality Measurement (PQM) website.

After the endorsement meeting, measures and endorsement decisions enter an appeals period for 3 weeks, from August 27–September 16, 2025. Any interested party may submit an appeal, which Battelle will review for eligibility according to the criteria within the Endorsement and Maintenance (E&M) Guidebook. If eligible, the Appeals Committee, consisting of all co-chairs from the five E&M project committees, will convene to evaluate the appeal and determine whether to maintain or overturn an endorsement decision.

Welcome, Roll Call, and Disclosures of Interest

Brenna Rabel, PQM deputy director, welcomed the attendees to the meeting and introduced her co-facilitators, Matt Pickering, E&M task lead, and Anna Michie, E&M deputy task lead. Ms. Rabel also introduced the committee co-chairs, William Golden, the non-patient co-chair, and

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Seth Morrison, the patient co-chair. Mr. Morrison and Dr. Golden provided welcoming remarks. The role of the co-chairs during the meeting is to summarize feedback from the Advisory Group to ensure the Recommendation Group takes it into account during their deliberations. Additionally, the co-chairs confirm the proposed conditions placed on measures. They also actively engage with and support patient representatives on the committee. Battelle facilitators summarize the deliberations of the Recommendation Group before proceeding to an endorsement vote.

Elena Hughes, social scientist, then conducted roll call, and members disclosed any perceived conflicts of interest regarding the measures under review. No members were recused from voting based on Battelle's conflict of interest policy.

After roll call, Battelle staff established whether quorum was met and outlined the procedures for discussing and voting on measures. The discussion quorum requires the attendance of at least 60% of the active Recommendation Group members (n=12). Voting quorum requires at least 80% of active Recommendation Group members who have not recused themselves from the vote (n=16). Both discussion quorum and voting quorum were established and maintained throughout the meeting.

Evaluation of Candidate Measures

Ms. Michie provided an overview of the two measures under review. For Spring 2025, the Cost and Efficiency committee received no new measures and two measures undergoing maintenance endorsement review (Figure 1). The measures focused on unplanned readmission for cancer patients and excess days in acute care.

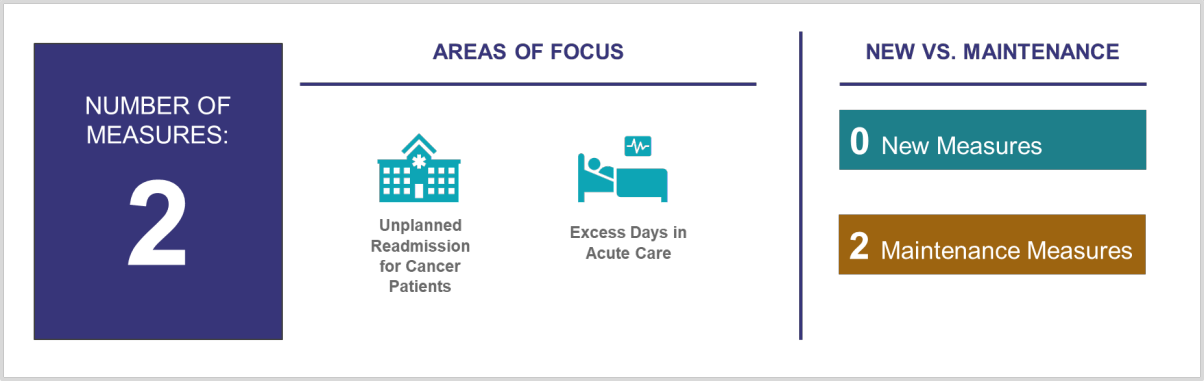

Figure 1. Cost and Efficiency measures for Spring 2025

Battelle convened a public Advisory Group meeting on June 2, 2025, to gather initial feedback and questions about the measures under endorsement review. Developers had the opportunity to provide additional clarifications following the Advisory Group meetings. Battelle then shared the Advisory Group feedback and questions, along with the developer/steward responses, with the Recommendation Group a week prior to the endorsement meeting.

On July 28, 2025 Battelle provided Recommendation Group members the full measure submission details for each measure up for review, including all attachments, the PQM Measure Evaluation Rubric, the public comments received for the measures under review, and the staff preliminary assessments.

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Recommendation Group members conducted independent reviews for each measure against the PQM Measure Evaluation Rubric. Recommendation Group members assigned a rating of "Met," "Not Met but Addressable," or "Not Met" for each domain of the PQM Measure Evaluation Rubric. In addition, Recommendation Group members provided associated rationales for each domain rating, which were based on the rating criteria listed for each domain. Battelle staff aggregated and summarized the results and distributed them back to the Recommendation Group, and to the respective measure developers/stewards, for review 1 week prior to the endorsement meeting.

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Table 1. Spring 2025 Management of Acute Events and Chronic Conditions Measure Endorsement Decisions

CBE ID	Measure Title	New/ Maintenance	Endorsement Decision	Endorse | n (%)	Endorse with Conditions | n (%)	Not Endorse/ Remove Endorsement | n (%)	Recusals
3188	30-Day Unplanned Readmissions for Cancer Patients	Maintenance	Endorse with Conditions	2 (12%)	11 (65%)	4 (24%)	0
2881	Excess Days in Acute Care (EDAC) After Hospitalization for Acute Myocardial Infarction (AMI)	Maintenance	Endorse with Conditions	9 (50%)	7 (39%)	2 (11%)	0

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CBE #3188 – 30-Day Unplanned Readmissions for Cancer Patients [Alliance of Dedicated Cancer Centers]

Specifications | Comment Summary Guide

Description: 30-Day Unplanned Readmissions for Cancer Patients measure is a cancer-specific measure. It provides the rate at which all adult cancer patients covered as Fee-for-Service Medicare beneficiaries have an unplanned readmission within 30 days of discharge from an acute care hospital. The unplanned readmission is defined as a subsequent inpatient admission to a short-term acute care hospital, which occurs within 30 days of the discharge date of an eligible index admission and has an admission type of "emergency" or "urgent."

Committee Vote: Endorse with Conditions

Conditions: When the measure returns in 3 years for maintenance endorsement, the developer would have:

- Conducted an empirical exploration of the reasons for patients being readmitted, especially considering those unrelated to cancer, and the impact of those reasons on the measure's performance.

Vote Count: Endorse (2 votes; 12%), Endorse with Conditions (11 votes; 65%), Remove Endorsement (4 votes; 24%); Recusals (0).

Advisory Group Comments: The Advisory Group discussed the multifaceted nature of cancer care and expressed concerns about the current measure's applicability, given its limited provider population. They emphasized the need to distinguish between patients who undergo complex surgical procedures and those who receive chemotherapy, as these groups may have different risks for readmission. The Advisory Group also raised additional considerations, such as the impact of patients' functional status, do not resuscitate (DNR) orders, involvement in experimental therapies or clinical trials, and the presence of comorbidities. They noted that the complexity of different tumor types, such as solid versus hematologic tumors, should be taken into account.

Public Comments: Battelle received one comment prior to the meeting. The commenter expressed concern that the measure's focus on unplanned readmissions might lead to negative unintended consequences for patients and fail to accurately capture the appropriate patient population due to its current structure and timeframe. They also indicated that the measure specifications and definitions are not aligned with other readmission measures used in CMS programs.

Measure Discussion:

Discussion Topic/Theme	Recommendation Group Discussion
Importance	• A few Recommendation Group members expressed concerns about the measure's ability to meaningfully differentiate performance across facilities. They noted that the risk adjustment seemed to have eliminated most of the variation between facilities, calling into question the

Discussion Topic/Theme	Recommendation Group Discussion
	continued need for the measure as there may no longer be room for improvement. • The developer indicated that they added all the variables that their technical expert panel thought were critical to the risk adjust and acknowledged that this did reduce variation. They noted the challenge of balancing risk model variables and indicated that there is no clear answer as to what is meaningful variation for cancer patients.
Validity and Risk Adjustment	• A Recommendation Group member raised concerns about the complexity of care coordination and access, especially in rural settings. They noted the measure is related to how a complication happens to be treated as opposed to whether a patient has experienced a complication that compromises the measure's validity. • A few Recommendation Group members expressed concerns with the risk adjustment using claims data, which is limited, as key aspects about the characteristics of a cancer patient are not recorded in claims data. A Recommendation Group member questioned the reliability of the "admission type" variable, indicating that it is not always accurately reported by providers. • The developer indicated that the use claims data because they are readily available but acknowledged their limitations. They stated they used validated methods to mitigate the challenges associated with using claims data.
Measure Misalignment	• A few Recommendation Group members expressed concerns about the measure's alignment with other readmission measures. • A Recommendation Group member indicated that the measure is problematic because it only captures formal readmissions, not emergency department (ED) visits or observation stays. They stated that a hospital can potentially manipulate the measure depending on whether or not they decide to admit a patient. • The developer explained that the measure follows the trend of other hospital readmission measures and does not include ED or observation stays to avoid overlap with existing measures. • Another Recommendation Group member commented about the potential for patients to be readmitted for unrelated conditions. They expressed the way the principal and secondary diagnoses are counted for a readmission seems complicated, particularly if a patient's cancer worsens. This may lead to hospitals being unfairly penalized for factors outside of their control or unrelated to cancer care. • The developer noted that since the measure focuses on specific cancer hospitals, it is highly unusual for patients to come in for anything other than cancer-related care. They further noted that it would be unusual to code the primary or secondary diagnosis at readmission as a cancer-

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Discussion Topic/Theme	Recommendation Group Discussion
	related diagnosis if a patient came in for services unrelated to cancer care.
Measure Scope and Utility	• A few Recommendation Group members questioned the measure's scope and utility outside of the 11 cancer hospitals the measure focuses on and whether the results would extend to other institutions. • The developer indicated that CMS adopted the measure for those 11 cancer hospitals; however, testing was done using all Medicare fee-for-service claims. • Another Recommendation Group member inquired about the scope of what is being measured and why, asking what the driving cause of readmissions is for this measure. • The developer indicated that they have not looked at the different measures for an index admission, though there were variables related to the index admission that were included in the risk-adjustment model. • A Recommendation Group member inquired what actions hospitals have taken based on the measure's data. • The developer described several quality improvement initiatives informed by the measure including enhanced goals of care discussions, care coordination, symptom management, and post-discharge follow-up.
Additional Recommendations	• The developer may want to consider looking at including emergency department (ED) visits and/or observation stays due to Recommendation Group concerns of potential gaming and alignment with other readmissions measures.

Committee members who voted to remove endorsement cited the following key concerns:

- The measure does not adequately capture the true nature of cancer care, especially for patients with complex cancer care needs.
- Claims data used in the measure fail to capture key clinical characteristics of the disease itself.
- The measure isn't appropriate for assessing outcomes of care for cancer patients.
- It is limited to cancer-specific hospitals and does not reflect the broader needs of patients and communities, particularly in terms of access and characteristics.

CBE #2881 – Excess Days in Acute Care (EDAC) After Hospitalization for Acute Myocardial Infarction (AMI) [Centers for Medicare & Medicaid Services (CMS)]

Specifications | Comment Summary Guide

Description: This measure assesses days spent in acute care within 30 days of discharge from an inpatient hospitalization for acute myocardial infarction (AMI) to provide a patient-centered assessment of the post-discharge period. This measure is intended to capture the quality of

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care transitions provided to discharged patients hospitalized with AMI by collectively measuring a set of adverse acute care outcomes that can occur post-discharge: emergency department (ED) visits, observation stays, and unplanned readmissions at any time during the 30 days post-discharge. In order to aggregate all three events, we measure each in terms of days. The Centers for Medicare & Medicaid Services (CMS) annually reports the measure for patients who are 65 years or older, are enrolled in Medicare Fee-For-Service (FFS) or Medicare Advantage (MA) and are hospitalized in non-federal short-term acute care hospitals (including Indian Health Service hospitals) and critical access hospitals.

Committee Vote: Endorse with Conditions

Conditions: When the measure returns in 5 years for maintenance endorsement, the developer would have:

- Empirically explored the differences with outpatient visits and post-hospitalizations for MA patients compared to fee-for-service patients

Vote Count: Endorse (9 votes; 50%), Endorse with Conditions (7 votes; 39%), Remove Endorsement (2 votes; 11%); Recusals (0).

Advisory Group Comments: The Advisory Group, including patient representatives, were generally supportive of the measure, highlighting the importance of including Medicare Advantage (MA). Advisory Group members posed several technical questions about inclusion of MA related to the continuous enrollment requirement and the risk adjustment approach. The Advisory Group also raised concerns about measure overlap and the inclusion of observation stays.

Public Comments: Battelle received one comment prior to the meeting. The commenter expressed concern that the measure's focus on unplanned readmissions might lead to negative unintended consequences for patients and fail to accurately capture the appropriate patient population due to its current structure and timeframe.

Measure Discussion:

Discussion Topic/Theme	Recommendation Group Discussion
Measure Scope	• A Recommendation Group member expressed their appreciation that the measure includes ED visits and observation stays; however, they were concerned that the measure counts any ED visit or observation stay, not just those related to AMI care. They indicated that this may lead to hospitals being penalized for unrelated acute care events, especially in communities with poor outpatient care. Additionally, the measure does not count mortality, so hospitals with worse outcomes (i.e., deaths) may appear to have better performance since these cases would not be captured as readmissions. • The developer indicated that mortality and readmission are kept as separate measures because their risk adjustment and quality improvement implications differ. They provided support for the use of an all-cause approach, citing empirical evidence (figure 4 and table 7) showing that most post-discharge acute care events are cardiac-related. • The developer cited evidence they provided which shows that most readmissions were cardiac-related.
Reliability and Other Acceptability Criteria	• A Recommendation Group member expressed concerns about the reliability threshold of 0.6, indicating that it is not adequate for endorsing a measure. • Another Recommendation Group member echoed this concern. They suggested that the committee should not rely on the C-statistics of other performance measures to determine if the current measure's risk adjustment model C-statistic is acceptable. • *The Battelle facilitator appreciated the comments and reminded the committee that a 0.6 reliability estimate is considered sufficient under the current endorsement rubric. Battelle is developing further guidance for developers on addressing low reliability estimates. Understanding the characteristics of entities and individuals with low and high reliability scores can help identify factors contributing to reliability issues and inform strategies to mitigate them. Regarding the C-statistic concern, the facilitator noted that there is currently no standard for what constitutes an acceptable C-statistic for endorsement. As a result, developers have used C-statistics from similar endorsed measures to support the claim that their risk adjustment model performance is sufficient. Battelle is planning to work with the Scientific Methods Panel to develop risk adjustment guidance, which will include C-statistic considerations.*

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Discussion Topic/Theme	Recommendation Group Discussion
Risk Adjustment	• A few Recommendation Group members expressed concerns about the risk-adjustment variable for Medicare Advantage (MA), questioning its appropriateness and noting that the findings are contrary to the prediction about why the MA estimate was included. • A Recommendation Group member asked for clarification on MA coding. Another Recommendation Group member explained that MA plans encourage aggressive coding, which can inflate risk scores. • The developer explained that the decision to include MA in risk adjustment was carefully considered, noting that overcoding is more common in outpatient claims, but both inpatient and outpatient data are used. They noted that unadjusted rates for MA patients are higher than those for fee-for-service patients and asked for feedback on handling this issue. • The developer discussed the challenge of adjusting for access issues (e.g., MA, dual-eligibility, income), noting that applying different standards to different variables is problematic. Currently, the measure does not adjust for dual eligibility or income but tracks these factors and has developed methods to stratify outcomes by special populations. • A Recommendation Group member proposed that the developer empirically explore differences in outpatient follow-up visits post-hospitalization between MA and Medicare fee-for-service patients, using available claims data, to better understand the drivers of acute care use. • A Recommendation Group member inquired about trends in the mean level of excess days, which were not provided.
Measure Specifications	• A Recommendation Group member asked how different types of acute care days (ED, inpatient, observation) were weighted and if the measure can distinguish between them. • The developer indicated that inpatient admissions are counted in straight days. For example, if you stay in the hospital for 20 days, that will count as 20 days. ED visits are counted as one day, and observations are counted to the nearest integer of days. • The developer indicated that better performance on an EDAC or readmission measure correlates with better performance on mortality. • A Recommendation Group member sought clarification as to whether there is a minimum case requirement for this measure. • The developer indicated that for public reporting, the minimum is 50 cases; however, they do calculate measure scores for all hospitals for quality improvement purposes.

Committee members who voted to remove endorsement cited the following key concern:

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- While measuring the quality of care for patients treated for AMI is highly desirable, the measure isn't appropriate for assessing the quality of care.

Next Steps

Battelle staff shared that they would publish a meeting summary by September 4, 2025. The appeals period will run from August 27–September 16, 2025. If an eligible appeal is received, the Appeals Committee will meet on September 30, 2025, to evaluate the appeal and determine whether to maintain or overturn an endorsement decision.

Appendix A: Acronyms

Please note: The following list encompasses acronyms that Battelle commonly encounters and uses in its work as a CBE. Not all the acronyms will appear in this document.

Acronym	Definition
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

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Acronym	Definition
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
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

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Acronym	Definition
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

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Acronym	Definition
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
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

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Acronym	Definition
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
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

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Acronym	Definition
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

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