799 9th Street NW
Suite 210
Washington, DC 20001

T (202) 354-2600
vizientinc.com

January 6, 2026

Submitted electronically via PRMR Measures | Partnership for Quality Measurement

Re: Vizient comments to the Partnership for Quality Management (P4QM) on the 2025 Measures Under Consideration (MUC) List

Background

Vizient, Inc. appreciates the opportunity to comment on the Partnership for Quality Measurement (P4QM) measure development process, particularly the Pre-Rulemaking Measure Review (PRMR) process. Vizient applauds P4QM, specifically the hospital committee, for working with stakeholders and the public on developing these important measures, as they significantly impact healthcare providers and the patients they serve.

Vizient, Inc., the nation's largest provider-driven healthcare performance improvement company, serves more than 65% of the nation's acute care providers, including 97% of the nation's academic medical centers, and more than 35% of the non-acute market. The Vizient contract portfolio represents $140 billion in annual purchasing volume enabling the delivery of cost-effective, high-value care. With its acquisition of Kaufman Hall in 2024, Vizient expanded its advisory services to help providers achieve financial, strategic, clinical and operational excellence. Headquartered in Irving, Texas, Vizient has offices throughout the United States.

Inclusion of Medicare Advantage Data in Certain Measures[1]

Vizient appreciates efforts to update several measures by adding Medicare Advantage (MA) population data as more than half of Medicare patients are covered through MA plans. While Vizient recognizes the importance of updating quality measures to reflect a broader range of Medicare beneficiaries, we continue to believe that additional steps are needed to ensure that MA data can be used reliably alongside fee-for-service (FFS) data. For example, as noted in Vizient's FY 2026 IPPS Proposed Rule comments, there may be differences in how FFS claims and MA encounter data are recorded, yet it does not appear that an analysis to identify the impact of these types of differences has been completed. Vizient encourages P4QM to consider our recommendation that CMS analyze the data to ensure encounter data is accurate and comparable between FFS and MA before including MA beneficiaries in these measures.

In addition, another important consideration is that MA populations can vary significantly across plans, and in some cases may be selectively healthier. Without careful attention to appropriate risk adjustment, these differences could unintentionally bias performance results. Ensuring that

[1] MUC2025-030: Excess Days in Acute Care (EDAC) after Hospitalization for Acute Myocardial Infarction (AMI); MUC2025-031: Excess Days in Acute Care (EDAC) after Hospitalization for Heart Failure (HF); MUC2025-036: Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction (AMI) Hospitalization; MUC2025-037: Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Heart Failure (HF) Hospitalization; and MUC2025-039: Excess Days in Acute Care (EDAC) after Hospitalization for Pneumonia; MUC2025-040: Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Chronic Obstructive Pulmonary Disease (COPD) HospitalizationMUC2025-044: Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Pneumonia (PN) Hospitalization; MUC2025-046: Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) Surgery

MA data are risk-adjusted correctly is essential for fair and meaningful comparisons across hospitals.

Increasing Counts for Emergency Department and Observation Stays in Excess Days in Acute Care (EDAC) Measures[2]

CMS is also considering changing the EDAC measure specifications to increase the count for Emergency Department (ED) visits from 0.5 days to one full day, and to calculate observation stays (OBSs), based on the total hours spent in observation, by rounding that time up to one full day. Vizient agrees with this change of counting ED visits and OBSs to one day and plans to use this timeframe for future benchmarking work. This update will also help improve consistency among measures.

Measures to Improve Sepsis Care[3]

Vizient supports the agency's efforts to identify measures to help improve sepsis care. However, the measures under consideration explicitly related to sepsis and those related to pneumonia, which include patients with a sepsis diagnosis, may be unnecessary. For example, several of the contemplated measures introduce new requirements which appear to overlap with existing measures that hospitals report, such as the Severe Sepsis and Septic Shock: Management Bundle (SEP-1). Vizient is concerned that introducing multiple new sepsis-related measures, especially if existing measures are retained, risks increasing burden without clear evidence regarding which measurement approach, if any, will be most beneficial in the context of patient care.

We are also concerned that the measures under consideration suggest that CMS is seeking to add several measures to different quality programs, which runs counter to the agency's aims to reduce the overall number of measures, decrease burden and streamline program requirements. Given the overlap with SEP-1 and the significant burden associated with SEP-1, we suggest retiring SEP-1 and replacing it with significantly fewer measures.

Vizient also notes that the considered sepsis measures would benefit from undergoing additional review, as these measures have not been used in CMS programs or thoroughly vetted or tested by hospitals. Vizient cautions against advancing measures that have not been rigorously evaluated by experts and tested, as such measures may not achieve their desired outcome, create unintended consequences or prove unworkable in real-world settings. Vizient believes additional analysis and testing would help to better understand the impacts of these measures, including whether similar benefits can be achieved with fewer measures.

Finally, several of these measures rely on complex algorithms, require precise clinical documentation or depend on data elements that may not be consistently captured across hospitals. For example, MUC2025-016 and MUC2025-019 are electronic clinical quality measures (eCQMs), which tend to be less burdensome to report than chart-abstracted

[2] MUC2025-030: Excess Days in Acute Care (EDAC) after Hospitalization for Acute Myocardial Infarction (AMI); MUC2025-031: Excess Days in Acute Care (EDAC) after Hospitalization for Heart Failure (HF); MUC2025-039: - Excess Days in Acute Care (EDAC) after Hospitalization for Pneumonia

[3] MUC2025-016: Excess Antibiotic Duration for Adult Hospitalized Patients with Uncomplicated Community-Acquired Pneumonia; MUC2025-019: Inappropriately Broad Empiric Antibiotic Selection for Adult Hospitalized Patients with Uncomplicated Community-Acquired Pneumonia; MUC2025-045: Adult Community-Onset (CO) Sepsis Standardized Mortality Ratio (SMR); MUC2025-047: Hospital Sepsis Program Core Elements Score; and MUC2025-055: Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Sepsis Hospitalization

measures but can still pose challenges for providers. Vizient suggests that additional information be provided related to potential challenges associated with reporting these eCQMs.

Shared Decision-Making[4]

According to the measure description, this measure assesses facility level compliance with administration of the CollaboRATE Shared Decision-Making tool to patients undergoing outpatient or ambulatory surgery. To be compliant, facilities must offer 95% of patients the option to complete the CollaboRATE survey within one week of the shared decision-making conversation. Vizient has several operational concerns with this measure as it will impose additional operational and financial burden on hospitals, particularly because hospitals often must hire vendors or additional staff, or revise their information technology systems, to administer existing patient surveys. Further, providers may need additional guidance and support regarding how to effectively utilize information from the surveys. While Vizient appreciates efforts to increase shared decision-making, we are concerned with the additional burden associated with this measure, particularly as hospitals have numerous other reporting requirements and are already operating on thin margins.

In addition, Vizient is concerned with the agency's interest in including this measure in the Hospital Outpatient Quality Program (OQR), as noted on the MUC List. Questions in the tool appear to be directed at whether the surgeon/proceduralist listened to the patient and helped the patient understand their health issues and choices. This type of communication during the preoperative process more commonly occurs in clinics, particularly for independent practitioners. Therefore, this measure is not best suited for the Hospital OQR and may be better suited to physician-oriented quality measure programs like the Merit-based Incentive Payment System (MIPS).

Also, Vizient is concerned about introducing this new measure without considering alternative approaches to support shared decision-making or carefully reviewing the necessity of this measure in the context of other quality measures (e.g., Information Transfer PRO PM survey, OAS CAHPS survey) and overall burden on hospitals.

In addition, while the measure previously received consensus-based entity endorsement in 2019, there is limited evidence to support expanding the measure to other quality programs. As provided in the materials associated with the measure, there is a lack of information regarding the measure's validity and provider burden, particularly for those providers with limited resources. Since Vizient suggests adopting measures that are grounded in peer-reviewed research to avoid excessive, unnecessary burden, given the need for additional evidence and analysis related to this measure, we caution broadening its use at this time.

Diabetes Care[5]

Related to the MUC List, CMS outlines several new measures that align with Make America Health Again (MAHA) priorities, including MUC2025-053: Excess Days in Acute Care (EDAC) After Hospitalization for Diabetes. Vizient appreciates CMS's interest in identifying measures that can help address quality issues related to diabetes.

[4] MUC2025-023: CollaboRATE Shared Decision-Making Tool for Ambulatory or Outpatient Surgery Patients (Surgical CollaboRATE OAS-PM)
[5] MUC2025-053: Excess Days in Acute Care (EDAC) After Hospitalization for Diabetes

In addition, Vizient recognizes the value of identifying opportunities to reduce avoidable acute care utilization for patients with diabetes. However, as this is a newly developed measure, we have concerns regarding adoption of the measure and believe additional testing, validation and stakeholder review are needed before the measure is considered for use in the Hospital Inpatient Quality Reporting (IQR) program.

In 2024, a Technical Expert Panel (TEP) released a summary of its meetings on the development of a similar 30-day risk-standardized EDAC Following Hospitalization for Diabetes Measure, where TEP members raised concerns regarding the reliability of diagnosis coding for diabetes, the complexity of risk adjustment and the feasibility of accurately capturing the full range of acute care encounters for patients with diabetes, among other concerns.[6] The TEP suggested additional refinement and indicated additional testing would be necessary to ensure the measure's validity and reliability. Considering the concerns raised by the TEP and the limited testing information currently available, Vizient recommends that CMS continue to refine and evaluate this measure before it is included in the Hospital IQR program.

Vizient also encourages sharing additional information regarding how the measure aligns with existing diabetes-related quality initiatives and whether it has been evaluated for overlap or redundancy with existing measures. Understanding how this measure fits within the broader diabetes quality measurement landscape is essential to avoiding unnecessary burden and ensuring that new measures add meaningful value.

Postoperative Venous Thromboembolism (VTE) Measure

CMS is considering including the MUC2025-067: Hospital Harm – Postoperative Venous Thromboembolism (VTE) in the Hospital IQR Program; Hospital-Acquired Condition Reduction Program and Medicare Promoting Interoperability Program. While Vizient supports development of a VTE measure, we encourage additional validation and testing before broad implementation, especially since the measure has never been included in a CMS quality program.

In addition, Vizient recommends the measure undergo further refinement, particularly related to risk adjustment given the measure relies heavily on denominator exclusions to remove certain clinical scenarios. Vizient anticipates that a more thorough review and measure refinement, particularly considering differences in patient risk, would improve the measure and should be completed before this measure is endorsed.

Emergency Care Access & Timeliness (ECAT) Measure

CMS is considering expanding use of MUC2025-072: ECAT to include the Hospital IQR Program, Medicare Promoting Interoperability Program and Hospital Value-Based Purchasing (VBP) Program. Currently, this measure will be used in the Hospital Outpatient Quality Reporting Program on a voluntary basis for calendar year 2027. Given the limited experience hospitals have had with this measure, Vizient discourages CMS from broadening application of the measure at this time.

In addition, key experts have raised concerns with the measure, which also align with Vizient's concerns. For example, the Measure Emergency Care Capacity and Quality Electronic Clinical

[6] TEP Meetings Summary Report for 30-Day Risk-Standardized Excess Days in Acute Care (EDAC) following Hospitalization for Diabetes

Quality Measure (eCQM) TEP[7] raised persistent implementation concerns around accurately capturing time to place a patient in a private treatment space, which Vizient agrees creates practical challenges and could make the measure less actionable.

Related to actionability, Vizient anticipates that the outcomes from the measure will not be sufficiently clinically useful. For example, the measure only captures wait times and does not account for patient acuity, severity or other clinical factors that meaningfully influence emergency department operations and patient outcomes.

In addition, without careful attention to stratification for acuity or severity, the measure risks drawing misleading comparisons between hospitals that treat fundamentally different patient populations. High-acuity emergency departments may appear to perform worse simply because they care for sicker, more complex patients who require longer evaluation and stabilization times. These issues can also limit quality improvement opportunities, benchmarking and meaningful identification of variation in emergency care delivery.

Vizient is also concerned that the ECAT measure could create confusion, as key concepts such as “dedicated treatment area” and “boarding” could be interpreted differently. Clear and consistent definitions are essential to ensure hospitals interpret and report these elements uniformly. Without precise definitions, hospitals may classify treatment areas or boarding status differently, undermining the validity of the measure and limiting its usefulness for quality improvement. Standardization is also necessary to ensure that data collected across diverse emergency departments can be reliably used to assess capacity constraints and identify opportunities to improve patient flow and emergency care delivery. Given these concerns, Vizient recommends that P4QM and CMS work closely with stakeholders to better understand stakeholder experiences for those voluntarily reporting this measure under the Outpatient Quality Reporting Program. Such information will be critical to consider should this measure evolve or be included in other CMS programs.

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

Although not identified by CMS as a substantive change, the exclusion criteria in the MUC list for MUC2025-037: Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure Hospitalization no longer includes language to explicitly remove Left Ventricular Assist Device (LVAD) and heart transplant cases from the denominator.[8] Vizient requests clarification of this change to the exclusion criteria, including the rationale and an impact analysis, particularly if the goal of the revision is to modify which types of cases will be excluded from the measure

Conclusion

Vizient appreciates P4QM’s efforts to gain additional feedback regarding these topics. Vizient membership includes a variety of hospitals ranging from independent, community-based hospitals to large, integrated health care systems that serve acute and non-acute care needs. In

[7] https://mmshub.cms.gov/sites/default/files/ECCQ-TEP-2-Summary-Report.pdf
[8] The language associated with the measure on the MUC List is as follows: “For patients with more than one eligible HF admission in the reporting period, only one index admission per year is randomly selected for inclusion in the cohort. Additional admissions within that time period are excluded.” The current language from CMIT is as follows: “With a procedure code for left ventricular assist device implantation or heart transplantation either during the index admission or in the 12 months prior to the index admission. For patients with more than one eligible HF admission in one of the three split time periods, only one index admission is randomly selected for inclusion in the cohort. Additional admissions within that time period are excluded.”

closing, on behalf of Vizient, I would like to thank P4QM for providing the opportunity to comment on the measure development process. Please feel free to contact me, or Randi Gold at Randi.Gold@vizientinc.com, if you have any questions or if Vizient may provide any assistance as you consider these recommendations.

Respectfully submitted,

Shoshana Krilow
Senior Vice President of Public Policy and Government Relations
Vizient, Inc.