Eligible Clinician Electronic Clinical Quality Measure (EC eCQM) Development, Evaluation, and Implementation

Deliverable 4-3: Base Year Technical Expert Panel (TEP) Meeting 2 Summary Report

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Contents

Technical Expert Panel Overview

The Centers for Medicare and Medicaid Services (CMS) has contracted with the American Institutes for Research® (AIR®) and its collaborators (University of California, Davis; Smile Digital Health; Clinician-Driven Quality [CDQ] Solutions; and Lazy Labs, LLC), henceforth the "project team," to support CMS in advancing quality measurement in health care.

Key Definitions

- **Clinical Quality Measures (CQMs)** are mechanisms for assessing the degree to which a clinician competently and safely delivers clinical services appropriate for a patient in an optimal time frame. CQMs are a subset of the broader category of quality measures.
- **Electronic Clinical Quality Measures (eCQMs)** are measures specified in a standard electronic format that use data that are electronically extracted from electronic health records (EHRs) and/or health information technology (IT) systems to measure the quality of the health care provided.

The objectives of the Eligible Clinician[1] Electronic Clinical Quality Measure (EC eCQM) Development, Evaluation, and Implementation project include the following:

- Identifying, developing, specifying, and testing new electronic clinical quality measures (eCQMs) for potential implementation in CMS quality programs that align with the CMS quality goals;
- Evaluating and preparing the measures for consideration and potential endorsement by the CMS Consensus-Based Entity; and
- Maintaining CMS-stewarded eCQMs, clinical quality measures (CQMs), and/or Medicare Part B Claims measures in the Merit-based Incentive Payment System (MIPS).

The purpose of the EC eCQM Technical Expert Panel (TEP) is to advise CMS and the project team in developing and maintaining eCQMs and CQMs for eligible clinicians for potential consideration and use in CMS quality programs. This TEP is a collaborative advisory body of 18 individuals who represent a broad range of technical expertise and perspectives. The TEP includes patients, caregivers, patient advisors and advocates, clinicians, electronic health record (EHR) vendor representatives, quality improvement experts, and health system representatives.

[1] The term *clinician* refers to a health care professional who is qualified in the clinical practice of medicine. Clinicians are those who provide principal care for a patient where there is no planned endpoint for the relationship; expertise needed for the ongoing management of a chronic disease or condition; care during a defined period and circumstance, such as hospitalization; or care as ordered by another clinician. Clinicians may be physicians, nurses, pharmacists, or other allied health professionals. Source: https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/mms/qmy-clinicians

The specific duties of the members of the TEP include the following:

- Reviewing, prioritizing, and evaluating eCQM and CQM measure concepts for development and maintenance; and
- Reviewing and providing guidance on the measures in response to feedback from expert workgroups, public comments, and testing results regarding eCQM and CQM feasibility, usability, validity, and reliability.

Considerations for Prioritizing Quality Measures

- Alignment of concept with quality program goals
- Technical feasibility
- Workflow feasibility: patient and clinician burden considerations
- Measurement gaps
- Quality of evidence regarding measure concept and clinical actions that can be taken to improve measured outcome
- Importance to clinicians
- Importance to patients
- Alignment with existing (competing) measures
- Potential for unintended consequences

The EC eCQM TEP will provide input to the AIR project team throughout the measure development life cycle. The project team will consider the TEP's recommendations and will convey those recommendations to CMS; however, CMS ultimately will make decisions regarding measure selection and development.

Report Purpose

The purpose of the EC eCQM TEP Meeting Report (Deliverable 4-3) is to summarize the TEP's key takeaways and suggestions for the project team's consideration. This report does not include the project team's final recommendations to CMS based on TEP input. The project team will formalize its recommendations based on TEP feedback through other deliverables, including Deliverable 4-5: Draft Documentation Set and Deliverable 4-6: Final Documentation Set.

Meeting Summary

The project team convened the second TEP meeting of the Base Year via Zoom teleconference on Monday, June 23, 2025. Seventeen of the 18 TEP members attended the meeting.

Appendix A. TEP Members presents a list of all TEP members and indicates those in attendance. Appendix B. EC eCQM Project Team Meeting Attendees includes a list of CMS staff and project team members in attendance. Appendix C. TEP Agenda includes a copy of the full meeting agenda. Appendix D. TEP Meeting 2 Handout includes specifications for measures discussed during this meeting.

The objectives of the June 23, 2025, EC eCQM TEP meeting were to

- Review key takeaways from the first TEP meeting held on April 7, 2025;
- Hear from TEP members with lived experience in managing chronic conditions and navigating the health care system; and
- Gather TEP insights and feedback on potential updates to four CMS-stewarded quality measures that are under maintenance. These measures are as follows:
  - Quality ID (QID) #134/CMS2: Preventive Care and Screening: Screening for Depression and Follow-Up Plan
  - QID #128/CMS69: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
  - QID #438/CMS347: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
  - QID #377/CMS90: Functional Status Assessments (FSA) for Heart Failure

Exhibit 1 summarizes the TEP member's discussion of potential measure updates and recommendations from the June 23, 2025, TEP meeting.

Exhibit 1. TEP Member Discussion Summary and Recommendations From the June 23, 2025, TEP Meeting

Topic/measure	Potential updates to this measure for TEP meeting discussion	Discussion summary and recommendations
QID #134/CMS2: Preventive Care and Screening: Screening for Depression and Follow-Up Plan	• Explore adding mental health disorders (e.g., major depressive disorder) to potentially expand the exclusion criteria. – The current specification excludes patients with bipolar disorder; additional mental health disorders are being considered due to: » Implementer feedback indicating that patients who do not need screening are being captured in the measure. These patients have a previous diagnosis and have a treatment plan in place. » Expert Workgroup feedback indicating that the measure should focus on screening and not treatment. • The bipolar disorder exclusion is not recommended for removal per implementer feedback.	• The TEP expressed concerns about the measure over-screening patients for depression who have either already been screened or do not need to be screened as patients with depression are not currently excluded. The TEP agreed with adding acute depression (e.g., a diagnosis of major depression or current active depression therapy or medication status) to the exclusion criteria so that the measure does not require screening for patients who are currently diagnosed and receiving treatment or therapy for depression. TEP members suggested changing the measure name to "Screening for Acute Depression" to align with this exclusion change. • TEP members noted that this exclusion recommendation may also decrease documentation and reduce burden in the provision of preventive care. • One TEP member cautioned that adding diagnoses to the exclusion list would make it harder to accurately trend the measure. • The TEP noted that the screening tool often used for this measure, the Patient Health Questionnaire-9 (PHQ-9), is overused and may be frustrating to patients. As a result, it may be losing its clinical impact. The TEP expressed a desire for future development of a more outcome-based and patient-centered measure, especially for use in non-context-specific settings.
QID #128/CMS69: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	• Add an exception for dental encounters. – Per implementer feedback, dentists often do not have the ability to reliably measure height and weight or to document follow-up plans. • Expand the follow-up plan time frame. The current measure specification requires a BMI follow-up plan to be documented on or before the date of the encounter.	• The TEP endorsed the proposed exception for dental encounters. • The TEP did not raise concerns about the current time frame for the follow-up plan to be documented. • One TEP member cautioned that the current language related to the follow-up plan does not clearly state whether a follow-up plan is required before a BMI screen is completed. The project team agreed to revisit the measure logic.

Topic/measure	Potential updates to this measure for TEP meeting discussion	Discussion summary and recommendations
	• Expert Workgroup feedback indicated that developing a follow-up plan on the day of the encounter is often not feasible. A follow-up plan requires additional time for aspects such as testing and relationship building with patients.	• The TEP raised several concerns about the use of BMI as a screener for obesity and health, and noted particularly that the BMI range specified in the measure is not appropriate for several populations including older adults, patients with fluid retention due to a medical condition or medications (e.g., those who have received transplants, patients with liver disease), and others for whom this measure is not an accurate indicator of health such as athletes. The TEP recommended using a BMI indicator of 30 or above as the trigger for a follow-up plan; however, the professional guidelines do not currently reflect this recommendation. Overall, the TEP strongly encouraged moving toward a measure that uses different indicators than BMI.
QID #438/CMS347: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	• Update the rhabdomyolysis exclusion from "diagnosed during the measurement period" to "diagnosed prior to the end of the measurement period." – Logic Reviewers and the Expert Workgroup recommended this change due to clinical relevance. • Add patients who are pregnant at any time during the measurement period as an exclusion. – This proposed change was identified in information-gathering activities because pregnancy is a contraindication to statins. • Limit Population 1 denominator to patients 18–75 years of age. • Implementer feedback indicated that pediatric patients who are not indicated for statin use are being captured in the measure.	• Overall, the TEP had no objections to the potential exclusions presented by the project team. • The TEP discussed the implementation challenges posed by the ascertainment period associated with a statin-precipitated diagnosis of rhabdomyolysis. The TEP proposed addressing this challenge by extending the ascertainment period backward so that a diagnosis of rhabdomyolysis at any point in patient history related to taking a statin could be indicated as the reason why a patient or clinician may decline statin therapy for the prevention or treatment of cardiovascular disease. • The TEP agreed that an opt-out choice related to adverse reactions or statin-intolerance could be included as part of an exclusion. They also emphasized the importance of capturing and excluding patients who decline treatment. • The TEP noted that alternative medications are used for the prevention and treatment of cardiovascular disease when patients experience side effects from statins and could also be considered an exclusion.

Topic/measure	Potential updates to this measure for TEP meeting discussion	Discussion summary and recommendations
QID #377/CMS90: Functional Status Assessments (FSA) for Heart Failure	• Remove the requirement for a follow-up assessment. – The current specification requires a follow-up FSA to be documented at least 30 days but no more than 180 days after the initial FSA. OR • Exclude patients with a New York Heart Association (NYHA) functional status of I or II. – The Expert Workgroup made this recommendation to avoid over-assessment of patients.	• TEP feedback was mixed regarding removing patients with an NYHA functional status of I or II from the inclusion criteria of the measure. Some clinician TEP members advocated for this change because it would decrease screening procedures for patients who are less likely to need it and decrease the documentation burden on clinicians. TEP members with lived experience reiterated the importance of regular follow-up and communication between clinicians and their patients who are at high risk of heart failure. These members advocated for keeping the requirement for a follow-up assessment for all patients. • Regarding potential removal of the requirement for a follow-up FSA, some TEP members cautioned that measures are not clinical support tools and that the FSA requirement in the measure should focus the intent of the quality measure. Revising the measure to require follow-up assessments at different times for different populations of patients with heart failure (e.g., patients with varying levels of severity) is an attempt at clinical decision support. The TEP noted that attempting to build a clinical support tool could result in over-screening patients who do not need to be screened so frequently. • A TEP member suggested alternatively rephrasing the first proposal (removing the follow-up FSA) to incorporate considerations from the second proposal (requiring a follow-up FSA only for patients with a NYHA functional status of III or IV). This could be accomplished by requiring follow-up to be documented within 30 to 180 days for patients with an NYHA functional status of III and IV but only requiring one assessment for patients with an NYHA functional status of I or II. This would ease concerns that assessment is unnecessary for patients with an NYHA functional status of I and II, as they would remain in the measure.

The following sections of this report provide details about the information that the project team shared with TEP members and TEP member feedback received during the meeting.

Welcome and Roll Call

The project team welcomed TEP members, acknowledged CMS staff, facilitated roll call and introductions of TEP members in attendance, and reviewed the meeting agenda.

TEP Roles and Responsibilities

The project team reviewed information about the purpose and structure of the TEP and member expectations for meeting attendance and participation, as outlined below:

- **TEP Purpose:** To advise CMS and the project team in developing and maintaining eCQMs for eligible clinicians for potential consideration and use in CMS quality programs.
- **TEP Meetings:** The TEP will meet up to four times per each 12-month contract period. The project team may periodically request TEP input via email. All meetings will be virtual and conducted via teleconference (e.g., Zoom). Meetings are expected to last up to 2 hours. Materials will be shared for review in advance of the meeting.
- **TEP Roles and Responsibilities:**
  - Offer expertise, share individual and organizational perspectives, and engage in constructive deliberation to create an open and productive environment.
  - Review and consider the information and questions provided.
  - Arrive at each meeting prepared to provide feedback and recommendations on distributed materials. If unable to attend, provide input to the TEP Coordinator prior to the meeting.
  - If unable to fulfill TEP duties on an ongoing basis, notify the TEP Coordinator immediately.
  - Adhere to the terms of the confidentiality and disclosure agreement in the signed TEP Nomination Form.
- **TEP Transparency and Commitment:** CMS and the project team are committed to providing opportunities for TEP feedback and to accurately documenting TEP recommendations and concerns. Although CMS and the project team may not be able to implement all TEP recommendations, the team will ensure that they are considered fully. The project team will also provide clear rationale for those situations in which CMS is unable to implement specific TEP recommendations.

TEP Meeting 1 Recap

The project team provided an overview of the first TEP meeting held on April 7, 2025. Project team members addressed the following topics with the TEP during the meeting:

- TEP member introductions and conflict of interest disclosures
- Project goals and tasks and the measure development process
- TEP member roles and responsibilities
- Comprehensive reevaluation of Quality ID (QID) #383, Adherence to Antipsychotic Medications for Individuals with Schizophrenia, including submission to the Partnership for Quality Measurement (PQM) for maintenance of endorsement
- One measure under development, Foot Assessment and Follow-Up for Patients with Diabetes

The project team also reviewed key takeaways regarding the two measures discussed at the first TEP meeting (Exhibit 2).

Exhibit 2. TEP Member Recommendations From the April 7, 2025, TEP Meeting

Topic/measure	Recommendations
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (QID #383)	• The TEP generally endorsed the measure but expressed concerns about the measure's ability to indicate whether good quality clinician care is provided. • The TEP noted that the measure relies on prescription refills rather than patient monitoring to assess good quality care. Prescription refills are not necessarily evidence of medication adherence, and keeping prescriptions active without monitoring can be deleterious, specifically in this patient population. In addition, clinicians who value monitoring and adjusting patient treatments to include electroconvulsive or drug holiday therapy over continuous days of coverage would fail this measure despite seeing better patient outcomes. Lastly, the TEP noted that adherence to prescription medication is a measure of patient compliance rather than clinician performance. • TEP members suggested future measure development activities that included identifying patient- or outcome-based mechanisms for assessing adherence to medications. Examples of technological approaches to monitoring adherence include video documentation of medication adherence, electronic pill counts, and systems that permit self-documentation of medication consumption. • The TEP also advised exploring why there are differences in performance on the measure between states.
Foot Assessment and Follow-Up for Patients with Diabetes	• The TEP largely endorsed the measure for its relevance and importance for improving patient outcomes. One TEP member positively considered the measure's requirement for a follow-up plan specifically to be a patient-centered activity. • TEP members recommended increasing clinician efforts to support patient education and health literacy about foot care and follow-up.

Topic/measure	Recommendations
	• TEP members cautioned that the measure carries a high documentation burden for clinicians due to the number of components in the measure that clinicians need to understand and track. The TEP recommended several ways to reduce this burden: – Clarifying that there is flexibility in the options for follow-up care. For example, if a referral was made in a previous year, an "encounter with a specialist" (to whom the patient has already been referred) should be sufficient to meet measure requirements. – Limiting or clearly defining the time window required for each type of follow-up (e.g., within 1 week or within 12 months. – Being less prescriptive with the type of foot exam required.

After this recap of the first TEP meeting, the project team provided an update on the PQM submission for QID #383: Adherence to Antipsychotic Medications for Individuals with Schizophrenia:

- This measure refers to the percentage of individuals at least 18 years of age as of the beginning of the performance period with schizophrenia or schizoaffective disorder who had at least two prescriptions filled for any antipsychotic medication and who had a Proportion of Days Covered (PDC) of at least 0.8 days for antipsychotic medications during the performance period.
- The AIR team submitted this measure to the PQM on April 30, 2025, for maintenance of endorsement.
- PQM endorsement process events included (1) a public comment period from May 14 through June 14, 2025; (2) a public comment listening session on May 28, 2025; and (3) the Management of Acute Events and Chronic Conditions Advisory Group meeting and endorsement meeting on June 9 and August 4–5, 2025, respectively.
- PQM staff provided a preliminary assessment of the measure submission, noting that all required domains were met.
  - Limitations included the absence of risk adjustment and limited patient input. PQM staff indicated that the application could be strengthened with expanded discussion on how the measure is meaningful to people with schizophrenia and schizoaffective disorder. PQM also noted that the absence of risk adjustment creates residual risk for confounders (e.g., substance use or comorbid conditions, medication cost or insurance coverage, pharmacy access, etc.).
- Next steps for this measure include preparing for the PQM endorsement meeting and following up on any items that may arise from the application or endorsement meeting.

The project team expressed gratitude for TEP feedback during and following the last meeting and discussed how TEP feedback on both measures was used in measure evaluation and development:

- TEP feedback informed face validity testing results that were included in the PQM submission for the Adherence to Antipsychotic Medications for Individuals with Schizophrenia measure.
- For measure development, the TEP endorsed the Foot Assessment and Follow-Up for Patients with Diabetes measure for its relevance and importance for improving patient outcomes, which confirmed that the development of the measure should continue. This feedback also helped to identify options for reducing clinician burden. The TEP also supported the measure as being patient-centered, given that the measure requires that a follow-up plan of care be completed to meet the measure's numerator.
- The TEP's comments on how clinicians' documentation of the data elements required for the measure (e.g., foot exams, results, patient education, follow-up plans) may be inconsistent reinforced the importance of feasibility assessments in the development process.

One TEP member asked about the next steps in the process for changes to measures that resulted from TEP feedback, whether the proposed changes would be tested, and whether and when the TEP would see this information. The project team explained that it depends on the measure. Some changes will not require testing, and other changes will not be tested immediately but rather as part of the maintenance process. As a result, the effect of the recommended changes on the measure will not be available to share for some time.

Patient and Caregiver Reflections: Lived Experience

The project team highlighted the importance of grounding TEP discussions about quality measurement in real-world experiences from individuals who bring primary perspectives as patients or caregivers. The project team reviewed patient and caregiver reflections from the first TEP meeting, which included discussions of the importance of quality of life and care coordination across settings; the need for more focus on ways to improve patients' medical conditions; challenges that people with chronic conditions face when accessing care due to having multiple providers and concurrent health issues; and the need for patients and caregivers to have a seat at the table to ensure the delivery of high-quality care.

The project team then shifted to the discussion topic for this meeting. Currently, information about a clinician's performance on clinical quality measures as well as care process and patient experience measures are shared on Medicare's Care Compare website. However, there may be other ways to share this information with patients and caregivers. Examples include making

publicly reported information more user-friendly or working with advocacy organizations and increasing recruitment efforts to get patients and caregivers involved in the measure development process. This may include participation in a TEP, focus or working group, or one-on-one interviews.

The project team asked each patient and caregiver TEP member in attendance to share brief reflections in response to the following question, which was shared in advance:

Questions Posed to Patient and Caregiver TEP Members:

Clinical quality measures assess the quality of patient care by evaluating processes, outcomes, and patient experiences. Patient awareness of these measures can improve patients' understanding of the health care system and promote better communication and shared decision-making between patients and providers.

How can we increase awareness and understanding of clinical quality measures among patients and caregivers?

Five TEP members with lived experience as a patient and/or caregiver attended the TEP meeting and shared their perspectives:

- One patient and caregiver TEP member shared via the meeting chat that information around quality measures could be more user-friendly and shared in a simpler way. The member suggested that making pamphlets or brochures available in waiting areas might pique interest, and that making the public aware of the goals of quality measures rather than the specifics of the individual measures may lead to greater interest among the younger generation in particular. This member also added that home health agencies provide onboarding information to new patients, which may be another avenue for sharing information about quality measures.
- A patient TEP member agreed with the initial suggestions from the project team regarding what may be helpful to increase awareness. They added that the opportunity to be on a TEP is important as it gives patients and caregivers a seat at the table to provide input to which the professionals are not privy unless they hear it from patient partners directly. This opportunity can help to ensure that policies and rules that are in development consider patients' experiences and needs. The TEP member noted that being transparent and educating, talking with, and involving patients and their care partners in these discussions and decisions is very valuable.
- A patient TEP member shared that the broader audience of patients and caregivers who could learn more about these measures is large but the pool of individuals who participate in measurement efforts is not so large. The TEP member shared that the best way to increase involvement and awareness would be to increase recruitment and messaging for efforts like this project and the TEP. The TEP member shared that they have been a national

advocate for many years and did not know about quality measures before getting involved in these efforts. They also discussed increasing awareness of public comment periods and integrating measure information into clinical care discussions, while also expressing doubt that many clinicians would have time to do this in practice. Alternatively, clinicians could share handouts or brochures with relevant information, particularly when public comment periods are available.

- A patient and caregiver TEP member agreed with the previous TEP members' suggestions. The TEP member added that the language used may not encourage participation because the language is at a level that is not accessible to those outside of these specific projects. They recommended ensuring that the language used to share this information is translated for lay audiences and inviting from the patient perspective.
- A patient and patient advisor TEP member noted that the TEP members on this project are not representative of all the health issues being discussed at this meeting. Therefore, it is important to contact advocacy groups for specific patient populations with registries to help reach a larger number of people who can share more direct experiences with these conditions. The TEP member shared that the main goal of quality measures should be to improve care at a population health level. The TEP member emphasized the importance of increasing awareness and understanding of clinical quality measures through webinars and public outreach. They shared past experiences hosting and participating in webinars on measurement and stakeholder engagement and noted the growing public interest and efforts to develop measures related to the science of engagement. They noted that many people find the topic of clinical quality measures intimidating but stressed the value of learning through participation. The TEP member also suggested using social media platforms like LinkedIn, Facebook, Instagram, and TikTok to promote involvement and awareness of measure development efforts, especially for measures that are relevant to population-level concerns.

A broader discussion between TEP members took place following these patient and/or caregiver TEP member reflections:

- One TEP member partially agreed with the previous TEP member's comments but disagreed with the idea of making patients more aware of clinical quality measures. They explained that such measures are complex, developed for specific clinical contexts, and often lack relevance at the patient level. Instead, they advocated for prioritizing measures that incorporate patient engagement and experience and emphasize goal-setting and wellness strategies that help patients understand and improve their health outcomes over time.

  - Another TEP member agreed with this idea and added that the measurement period and timeline for publishing clinical quality measure performance results often do not overlap.

- A patient TEP member reflected on a point made by an earlier patient and caregiver member about the importance of using patient-friendly language. As a patient advocate, they emphasized that clear communication is essential for patient understanding. They highlighted the effectiveness of the "teach-back" method used by nephrologists and other clinicians, where physicians explain medical information and then ask patients to repeat it back in their own words. This approach has proven to be especially helpful for individuals with chronic kidney disease.
- One TEP member reiterated the complexity of quality measurement and the importance of not overburdening patients with needing to understand its technical aspects. They agreed that the primary goal should be to assess and improve health care quality, not to educate patients on measurement terminology. Instead, they advocated for focusing efforts on enhancing patient engagement in the care process and improving interactions between patients and clinicians. Although they supported patient involvement in developing quality measures, they believed that the priority should be on making the care experience more meaningful rather than ensuring that patients understand the intricacies of quality metrics.
  - Another member added in the meeting chat that patients need to understand the "why" behind medications and interventions.
- One TEP member suggested that one way that patients could use quality measures is through public reporting when selecting health care providers. They noted that there is a discrepancy in how patients engage with these measures, and highlighting in particular that the Medicare Advantage star rating system is more commonly used by patients when choosing health plans. They proposed that CMS might explore why this difference exists, and noting that this may point to a broader issue in how patients interact with and use quality measurement systems.
  - A patient advocate TEP member acknowledged this point about the relevance of public reporting mechanisms but clarified that the core issue should be about patient participation in the development and implementation of quality measures. Without patient involvement, the resulting measures may not effectively support the desired outcomes of care. This member emphasized that engaging patients earlier in the process could lead to more meaningful and effective measures and ultimately improve the quality of care.
  - Another TEP member shared their experience with a study funded by the Patient-Centered Outcomes Research Institute (PCORI) that received a top clinical trial award

and emphasized the importance of involving patients at every stage of the research process. This member advocated for a similar approach in quality measure development and implementation and noted that even if only a select few patients are involved, having the patient voice represented is essential.

- One patient and caregiver TEP member shared that the CMS, Department of Health and Human Services committees, or departments of social and health services could consider posting a broader call for patients who may want to be involved further upstream in the process of improving health care, such as in the development of quality measures. The member suggested including the topic of conversation and a phone number for patients and caregivers to call to get involved.

Potential Future Updates to Measures Under Maintenance

As shown in Exhibit 3, the project team reviewed the measure maintenance activities conducted during the period between April 2025 and June 2025.

Exhibit 3. Measure Maintenance Activities

Measure maintenance activity	Applicable measures
Comprehensive information gathering	• QID #383: Adherence to Antipsychotic Medications for Individuals with Schizophrenia • QID #438/CMS347: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease • QID #182: Functional Outcome Assessment • QID #336: Maternity Care: Postpartum Follow-up and Care Coordination
Targeted literature and guideline reviews	All measures (excluding measures with Comprehensive Information Gathering reports)
Implementer feedback reviews	All measures
Professional society outreach	All measures
Expert workgroups	Behavioral Health: • QID #383: Adherence to Antipsychotic Medications for Individuals with Schizophrenia • QID #134/CMS2: Preventive Care and Screening: Screening for Depression and Follow-Up Plan BMI: • QID #128/CMS69: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan Cardiovascular Health: • QID #317/CMS22: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented • QID #377/CMS90: Functional Status Assessments for Heart Failure • QID #438/CMS347: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

The project team then introduced the four measures (Exhibit 4) that required TEP input during the meeting and then facilitated discussions of each measure.

Exhibit 4. Maintenance Measures for TEP Discussion

Category	Measure ID	Measure name	CQM or eCQM
Behavioral Health/Psychiatry	QID #134/ CMS2	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Both
Body Mass Index (BMI)	QID #128/ CMS69	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Both
Cardiovascular Health	QID #438/ CMS347	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	Both
Cardiovascular Health	QID #377/ CMS90	Functional Status Assessments (FSA) for Heart Failure	eCQM

QID #134/ CMS2: Preventive Care and Screening: Screening for Depression and Follow-Up Plan

The project team provided the following details on the measure:

- **Measure Description:** This is a measure of the percentage of patients 12 years of age and older who were screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, *and* if positive, a follow-up plan is documented on the date of or up to 2 days after the date of the qualifying encounter.
- **Potential Changes:**
  - Explore adding mental health disorders (e.g., major depressive disorder) to expand the exclusion criteria.
    - The current specification excludes patients with bipolar disorder; additional mental health disorders are being considered due to
      - Implementer feedback indicating that patients who do not need screening are being captured in the measure.
      - Expert Workgroup feedback indicating that the measure should focus on screening and not treatment.
  - The bipolar disorder exclusion is not recommended for removal based on workgroup feedback.

The project team posed the following questions to the TEP for discussion:

Questions Posed to the TEP:

Do you anticipate any questions or concerns about the proposed changes to this measure?

Do you have additional suggestions for proposed changes that we should consider as we reevaluate this measure?

The TEP held the following discussion on the potential changes to this measure:

- One TEP member raised two key points. First, they expressed concerns that adding clinical conditions to an exclusion list could significantly hinder the ability to assess trends in or reliably calculate the measure rate. Second, they recommended updating the eCQM terminology by replacing "attestation" with more specific reference codes to better accommodate different screening instruments and scoring methods, thereby improving the specificity and sensitivity of the measure for identifying individuals needing follow-up.
  - The project team responded that capturing the measure numerator more efficiently, possibly by transitioning to more Fast Healthcare Interoperability Resources (FHIR)-based specifications, would be a larger substantive change to the measure and something to undertake in the future.
- One patient and patient advisor TEP member raised the concern that, without specifying that this measure is limited to an initial visit or encounter, a patient could enter a loop where they are repeatedly administered a Patient Health Questionnaire (PHQ)-9 screener.
- Another TEP member expressed support for the project team's exclusion recommendation because it will decrease documentation and reduce burden in the provision of preventive care. They shared that, based on their experience in clinical practice, the measure captures more information than it should, such as all the patients who already have an established diagnosis and are engaged in care in their system. They raised a concern about the documentation required for meeting the follow-up plan component of the measure, asked what is considered a follow-up plan, and cautioned that the requirement for a follow-up plan could result in clinicians documenting something such as a referral as a follow-up plan for the sake of documentation.
- One TEP member cautioned that historically, this measure has included an exclusion for a current depression diagnosis, but it was removed in a previous iteration of measure maintenance.
  - The project team confirmed that the depression exclusion was removed previously to ensure that patients experiencing a recurrence of depression, or those who still require screening, are not overlooked—regardless of whether they are currently receiving

treatment. The intention behind this change was to better capture and support patients who may still have symptoms or need additional follow-up. While the intent was good, including all patients with active depression—even those on follow-up plans—has created implementation challenges. These challenges have prompted discussions about reinstating the exclusion or exploring alternative solutions based on implementer feedback. The challenge has been accurately distinguishing between patients who are actively receiving treatment for depression—such as those on medication, in therapy, or under clinical supervision—and those in long-term remission who may appropriately reenter screening after a period without treatment. However, recent improvements in structured EHR data make it more feasible to identify and operationalize this distinction.

  - Another TEP member added in the meeting chat that their practice created a SmartList in Epic that documents PHQ-9 and automatically selects the appropriate Healthcare Common Procedure Coding System (HCPCS) codes. They shared that this process has improved their performance as the HCPCS codes for the PHQ-9 are now captured for use in the measure and the screenings are no longer documented in text-only fields.

- One TEP member raised concerns about the definition of a "qualifying encounter" for a mandatory eCQM in the Accountable Care Organization (ACO) space. They noted a significant discrepancy between their practice's internal performance data and Medicare benchmarks, largely due to patients being attributed through specialty care. The member shared that this discrepancy results in specialists, such as ophthalmologists, being expected to conduct depression screenings despite lacking relevant workflows or expertise. They requested clarification on the measure's technical specifications, which appear to include a broad range of encounter types, including physical therapy and telephone visits.
  - Another TEP member agreed that they were experiencing this problem in their practice as well. They highlighted challenges with depression screening data quality, despite the use of FHIR and certified EHRs. They also emphasized that without adherence to proper workflows, data remain unreliable, and that a major issue is inconsistent documentation practices, with clinicians often entering information in notes rather than discrete fields. They called for a requirement to pass a quality score of some type to certify data, noting that current variability among EHR vendors creates significant complications for ACOs.
- One TEP member shared that quality measures are like "a paintbrush on a very complex canvas," meaning that some variability in results is inevitable and perfect scores should not be expected. They noted that this measure seems to focus on *acute* depression screening—where follow-up is expected—rather than general screening. To address the key concern, which is continuing to screen patients who are already receiving therapy, they advocated for excluding such patients and tying the exclusion to a diagnosis or current therapy status.

They raised the issue of how to determine whether a follow-up plan occurred, suggesting it may ultimately require attestation.

  - In the meeting chat, one member suggested changing the measure's name to "Screening for Acute Depression" and revising the exclusion criteria such that the measure would exclude patients currently receiving therapy. Three TEP members agreed with this recommendation in the chat.
  - One TEP member shared in the meeting chat that they advocate for a measure that uses direct Logical Observation Identifiers Names and Codes (LOINC) instead of attestation codes to ensure that the administration of the screener or monitoring instrument is captured in a useable space in the EHR.

- Another TEP member echoed a concern raised earlier about what qualifies as a follow-up plan, noting that current approaches often reduce complex clinical decisions to a checkbox. While acknowledging the need for documentation, they pointed out that in team-based care models, everyone is asking these questions, yet some patients may still be excluded from reporting. They questioned the practicality of identifying which patients to exclude from screening and expressed concerns about how patients feel when asked the same questions repeatedly.
- Another TEP member expressed a concern that repeated depression screenings—especially when done in non-context-specific settings like ophthalmology offices—can frustrate patients and reduce the tool's effectiveness. They emphasized the need to better define when and where the measure should apply, suggesting that while the PHQ-9 has value, its use has become overly routine and may lack clinical impact. This member advocated for a shift toward outcome-based measures in behavioral health, noting that current process measures may be "topping out" in utility.
  - The project team agreed and shared that, although PHQ-9-based screening plays a critical role, the measure must align with its clinical purpose. The team acknowledged ongoing discussions about refining the measure—potentially by incorporating data on medications, active diagnoses, and recent encounters.

QID #128/ CMS69: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

The project team provided the following details on the measure:

- **Measure Description:** This is a measure of the percentage of patients 18 years of age and older with a BMI documented during the current encounter or within the previous 12 months *and* who had a follow-up plan documented if the most recent BMI was outside of normal parameters.

- **Potential Changes:**
  - Add an exception for dental encounters.
    - » Per implementer feedback, dentists often do not have the ability to reliably measure height and weight or to document follow-up plans.
  - Expand the follow-up plan time frame. The current measure specification requires a BMI follow-up plan to be documented on or before the date of the encounter.
    - » Upon further review of the measure specifications, the project team found that this change is not required as the measure allows the follow-up to take place prior to the end of the measurement period.

The project team posed the following questions to the TEP for discussion:

Questions Posed to the TEP:

Do you anticipate any questions or concerns about the proposed changes to this measure?

Do you have additional suggestions for proposed changes that we should consider as we re-evaluate this measure?

The TEP held the following discussion on the potential changes to this measure:

- One patient member of the TEP raised a concern about the use of BMI as a tool for assessing obesity due to their lived experience with receiving a transplant. The TEP member shared that due to medications and a range of other factors, some patients may present as obese when in fact they retain water or fluid and experience swelling due to steroids such as prednisone and immune suppressants, and they noted that BMI does not accurately capture these effects. The patient cautioned against measures that rely on a BMI assessment to determine whether additional weight management follow-up is necessary.
  - Another TEP member added in the meeting chat that this misalignment affects patients with liver disease who may have sarcopenia as well.
  - Another TEP member asked if the measure had a different BMI cutoff for older adults given that the range of healthy BMI is different for older adults and counseling someone with an older adult profile and a BMI of 29 to lose weight would be inappropriate. Another TEP member agreed in the meeting chat that the BMI should not read as "<25" but reframed as "over 30." The concern was validated by two other TEP members in the meeting chat who did not think that BMI is a good tool for measuring health as it is not sensitive to therapies, medications, and other issues, and who noted that there are better tools available for managing health and obesity.
  - The project team responded that they share the TEP members' concern for using BMI in this way, particularly given the range of 25–30, which is specified in the measure. The

project team noted these concerns from the clinical perspective and added that the professional guidelines are prescriptive about a BMI of 25 being the appropriate threshold for intervention. However, this recommendation does not capture the nuances described by TEP members such as those for older adult patients. The project team agreed that many patients can be healthy within that BMI range and that increases in BMI can be a result of fluid, body-building practices, athletic participation, and other causes. The project team agreed that the goal is not to encourage practitioners to make decisions based on a single value, but rather on the temporal trend of values over time.

- A patient TEP member asked if there was guidance for health care providers who treat transplant patients, particularly those on long-term medications that can lead to weight gain and swelling. They asked whether there will be specific recommendations for physicians to consider BMI in such cases, and whether transplant patients could be eligible for exclusions from standard BMI assessments. They emphasized the importance of considering the unique challenges faced by patients like themselves and those they advocate for, especially in the context of ongoing efforts to improve immunosuppressant medications and overall quality of life among patients.
  - The project team agreed with these points and explained that MIPS measures in general are reported by clinicians who voluntarily choose which measures to report. The project team explained that specialists typically report measures they consider relevant to their own specialty. Although exceptions could occur when clinicians are part of multi-specialty groups, which may lead to their reporting on measures outside of their specific subspecialty, overall, clinicians' self-reporting addresses issues where a measure is not relevant to a specific patient.
  - A patient advocate member of the TEP added in the meeting chat that they would expect their primary care provider to know if they are on medications or therapies that might skew data, and that they would expect their primary care provider to provide the most patient-centered care for them, as opposed to their specialists.
  - Another TEP member added in the meeting chat that the measure seems to be expanding beyond quality assessment into decision support and that it should retain a focus of being a quality measurement tool.
- One TEP member supported the exclusion for dental encounters. Another TEP member supported the dental encounter exclusion and asked about ophthalmology as another appropriate encounter for exclusion. This member also questioned why some specialties were to be specifically excluded if this was a voluntary reporting measure.
  - The project team shared that implementer feedback on dental encounters showed issues for Federally Qualified Health Centers and other similar locations where the

practice reported as a group and would have primary care encounters and dental care encounters in the same reporting year. The project team reiterated that in general, MIPS measures are voluntarily chosen and reported by clinicians who are interested in quality measurement and improvement in a particular clinical domain. Exceptions arise when clinicians are part of a group where the group makes overall reporting decisions on their behalf.

- A patient and advisor TEP member asked a clarifying question on the follow-up required by the measure and whether this follow-up period included time before or after the encounter. The member advised that sharing information on healthy eating and exercising is beneficial for every patient following a care visit.
  - One TEP member responded that documenting a plan before the follow-up encounter may sound odd, but it is likely a result of reviewing the BMI from the prior encounter, which triggered the need to document a plan. The member added that you can have multiple encounters in the performance period when the BMI was taken, and that the measure should not force documentation of BMI or a plan for each of those encounters.
  - The project team acknowledged that the logic can be confusing regarding follow-up, especially as expressed in the eCQM. The follow-up is currently written as before or during the diagnosis of the clinical condition of overweight/underweight/obesity and not necessarily tied to the encounter. The project team has considered reviewing the logic to determine if it can be revised for clarity. The project team clarified that the specifications are written so that if a follow-up plan is in place at the time of the encounter (documented prior to the encounter), it does not have to be documented again.

QID #438/ CMS347: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

The project team provided the following details on the measure:

- **Measure Description:** This is a measure of the percentage of the following patients—all considered at high risk for having a cardiovascular event—who were prescribed or were on statin therapy during the performance period:
  - All patients who were previously diagnosed with or currently have a diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD), including an ASCVD procedure; *or*
  - Patients 20–75 years of age who have ever had a low-density lipoprotein cholesterol (LDL-C) level of 190 mg/dL or higher or who were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia; *or*
  - Patients 40–75 years of age with a diagnosis of diabetes; *or*
  - Patients 40–75 years of age with a 10-year ASCVD risk score of 20% or higher.

- **Potential Changes:**
  - Update the rhabdomyolysis exclusion from "diagnosed during the measurement period" to "diagnosed prior to the end of the measurement period."
    - Logic Reviewers and the Expert Workgroup recommended this change due to clinical relevance.
  - Add patients who are pregnant at any time during the measurement period as an exclusion.
    - This proposed change was identified in Information Gathering activities due to the fact that pregnancy is a contraindication to statins.
  - Limit Population 1 denominator to patients 18–75 years of age.
    - Implementer feedback indicated that pediatric patients who are not indicated for statin use are being captured in the measure.

The project team posed the following questions to the TEP for discussion:

Questions Posed to the TEP:

Do you anticipate any questions or concerns about the proposed changes to this measure?

Do you have additional suggestions for proposed changes that we should consider as we reevaluate this measure?

The TEP held the following discussion on the potential changes to this measure:

- One TEP member raised concerns about the change in the exclusion of rhabdomyolysis. They noted that it requires them to have a patient take a statin every year if they do not have an active diagnosis of rhabdomyolysis or a diagnosis within the measurement period. Because an active diagnosis is necessary for exclusion, they would need to have the patient take the medication again to cause the rhabdomyolysis reaction to count for the measure, which would effectively cause patient harm.
  - A TEP member shared in the meeting chat that it would be helpful if the diagnosis could be documented prior to the measurement period, and one patient TEP member agreed. A second TEP member agreed, adding that it is important especially as patients move between payers.
- A TEP member shared that they interpreted the potential change to the rhabdomyolysis exclusion language as being inclusive of a previous diagnosis of rhabdomyolysis and suggested that the language be clarified to convey that. They also noted that rhabdomyolysis is not the most common reason why patients refuse statins and suggested

that the exclusion be expanded to include rhabdomyolysis plus all other diagnoses that fall under the category of patients having problems with side effects.
  - The same TEP member asked the project team if any alternative medications are considered exclusions in the measure. The project team shared that those medications are not currently considered exclusions. The TEP member noted that there are patients who switch to alternative medications due to side effects who would fail the measure.
  - The project team shared that evidence-based guidelines still suggest that statins are the first-line therapy, and other medications are primarily used as an adjunct to statins. The project team added that although some patients are now being treated with alternative medications alone, there is not yet strong evidence to support alternative medications as first-line treatment.
- Another TEP member reiterated that it would be helpful if a diagnosis of rhabdomyolysis could include documentation of previous diagnoses. They also commented that improvements in capturing intolerances to statins would help, as some clinicians see patients who are intolerant to statins and proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitors are prescribed as an alternative. The TEP member noted that they find it difficult for this measure to be meaningful when these drugs are used as an alternative to statins when a patient has an intolerance to statins.
  - The project team clarified that the proposed change for rhabdomyolysis would extend the ascertainment period for a diagnosis to include any time during a patient's medical history.
  - A TEP member commented that they agree with considering exclusions for other medications and noted that PCSK9 inhibitors are more potent than statins and do not have to be used in combination with them.
- A TEP member asked in the meeting chat for clarification on whether the exclusion includes patients with statin-associated muscle symptoms or an allergy to statin medication. The project team replied that the specification does include statin-associated types of myalgia and myopathy, not just rhabdomyolysis.
- A TEP member raised two key concerns. First, they emphasized the importance of documenting any instance of a patient being offered a therapy but choosing not to use it. They suggested that this component be included in the measure, noting that such information has been captured in eCQMs for years. Second, they emphasized the distinction between what is known about care and the care that is appropriate for different segments of the patient population. They cautioned that quality measures are designed as population-level assessment tools and are not well suited for evaluating individual clinicians or patients. The TEP member noted that attempting to add nuances for different patient

populations risks misapplying the measure's intended purpose, which is to be a quality measure and not a decision support tool.

- Another TEP member shared that this could be an opportunity for a patient opt-out as part of an exclusion, allowing for patient-provider shared decision-making without punishing the clinician. Two TEP members agreed with this suggestion in the meeting chat. The project team noted that it is difficult to operationalize patient opt-out in the context of an eCQM but they are open to suggestions.
  - A patient advisor TEP member noted in the meeting chat that the word "declines" could be used instead of "refused" if adding patient opt-out language to the measure is possible. Another patient TEP member agreed with this suggestion.
  - In the meeting chat, a TEP member shared a link to the value set used in Fast Healthcare Interoperability Resources (FHIR)-based measures (but aligned in QDM [Quality Data Model]) to represent "negation" to capture when something is expected but not done for a specific reason.
- A TEP member commented that the team could use the new Current Procedural Terminology (CPT) code G0538 for ASCVD risk reduction to count as satisfying the measure for those without documented ASCVD disease, rather than prescribing a statin.
- A TEP member emphasized that any changes to this and other measures must prioritize making CQMs meaningful and relevant to the practice rather than a "check box" measure. They summarized three potential ways of addressing issues related to this measure from their perspective:
  - Determine the feasibility of an additional exclusion: can consider patient choice (e.g., the patient declined) as part of the measure calculation.
  - Broaden the measure to include preventive counseling, which is used in a similar manner in QID 226 Preventive Care and Screening: Tobacco Use Screening and Cessation Intervention.
  - Make no changes, which would result in lower anticipated benchmarking.
- The project team requested confirmation from the TEP that there were no objections to the potential changes presented. Nine TEP members indicated that they had no objection, and none raised concerns.

QID #377/CMS90: Functional Status Assessments (FSA) for Heart Failure

The project team provided the following details on the measure:

- **Measure Description:** This is a measure of the percentage of patients 18 years of age and older with heart failure who completed initial and follow-up patient-reported functional status assessments.
- **Potential Changes:**
  - Remove the requirement for a follow-up assessment.
    - The current specification requires a follow-up FSA to be documented at least 30 days but no more than 180 days after the initial FSA; or
  - Exclude patients with an NYHA functional status of I or II.
    - The Expert Workgroup made this recommendation to avoid over-assessment of patients.

The project team posed the following questions to the TEP for discussion:

Questions Posed to the TEP:

Do you anticipate any questions or concerns about the proposed changes to this measure?

Do you have additional suggestions for proposed changes that we should consider as we reevaluate this measure?

The TEP held the following discussion on the potential changes to this measure:

- A project team member shared that the current American Heart Association (AHA)/American College of Cardiology (ACC) recommendations do not specify any particular interval for follow-up, so the interval of 30–180 days is not reflected in these recommendations.
- A TEP member agreed with removing the follow-up FSA from the numerator criteria, adding that follow-up assessment is a clinical decision support (CDS) issue and is not well suited to quality assessment.
- Another TEP member agreed with removing the follow-up FSA requirement. They shared that completing a survey is a checkbox that may or may not result in action being taken. They recommended diverting patient follow-up and appropriate management from checking a box with questionable clinical significance.
- A patient TEP member expressed concern and disagreed with removing the follow-up assessment, emphasizing the importance of following up with patients on a regular basis. They acknowledged that it can be a lot for patients, but follow-up assessments are key

interactions because medication or insurance changes affect each person and their care differently. In their experience, transitioning from a brand-name medication to a generic medication worsened their heart function, and if they were not educated about the symptoms to monitor, their condition could have become significantly worse.
  - Two patient TEP members agreed with these concerns. One patient advisor TEP member added that the responsibility falls on the patient to follow up with their doctor about adverse side effects from a medication. They emphasized the importance of reminding patients that they need to inform their health care provider right away if there are any concerns.
- In the meeting chat, four TEP members agreed with removing patients with a NYHA functional status of I or II from the measure's inclusion criteria. One TEP member added that the frequency of follow-up should depend on clinical assessment. A fifth TEP member agreed with determining the follow-up period based on severity during clinical assessment.
- Another TEP member acknowledged that the comments about the complexity of care are important and insightful. They highlighted that the goal of quality measures and quality assessment is in part to identify when clinicians are not performing well, but also highlighted the important of not creating a tremendous burden for high-performing clinicians. They noted that they believe that this measure falls in that category, adding that capturing these nuances falls under the clinical-decision-support rather than the quality assessment domain. They recommended focusing on patients with more serious conditions (i.e., patients with an NYHA functional status of III or IV).
- A TEP member expressed concern about capturing NYHA functional status and about how often this status is updated in the patient's medical chart. They shared that because of the way the chart is designed, they do not often update heart failure status, so they rely heavily on a diagnosis or label and fail to look at the patient completely at each visit. They shared that the accuracy of diagnosis, rather than the follow-up, should be the priority.
  - A project team member clarified that if included in the measure, NYHA functional status would be captured through LOINC.
- A TEP member suggested rephrasing the first proposed option to incorporate considerations of the second proposed option by requiring follow-up assessment to be documented within 30–180 days for patients with a functional status class III or IV, and only requiring one assessment for patients with an NYHA functional status of I or II. They noted that this would accomplish the goal of specifying that follow-up assessment is not necessary for patients with an NYHA functional status of I or II.
- Another TEP member questioned whether completing an FSA within 30–180 days for a patient who has an NYHA functional status of III or above is a good assessment of quality of

care. They also shared that they would prefer that the measure focus on the proper follow-ups for patients, adding that patients who are less severely affected do not need to have their FSA completed as often.

- A patient TEP member highlighted the importance of acknowledging systemic factors and stereotypes and the need for doctors to actively listen and participate, to hear and consider patient voices, and to empower patients to be active in their own health care.
  - Two TEP members agreed with these points about patient education and engagement in the meeting chat.
  - A patient TEP member asked in the meeting chat if feedback is being provided to the patient, and a project team member replied that feedback is not required in the current measure specification.
  - The project team expressed appreciation for the suggestions and the need to find the right balance with patient follow-up.

Patient and Caregiver Reflections: TEP Discussion

Prior to adjourning the meeting, the project team asked patient and caregiver TEP members in attendance to share any final reflections in response to the following questions:

Questions Posed to Patient and Caregiver TEP Members:

Considering today's discussion, do you have any additional thoughts, concerns, or recommendations?

What ideas or topics from today's discussion resonated most with you? Why?

- A TEP member reiterated the importance of the patient voice and including it in all stages as we proceed with measure development and implementation.
- A patient advisor TEP member shared that they appreciated the subject matter of this meeting and learned quite a bit from researching these topics. They noted that they know people who are affected by each of the measures and emphasized that it is important to provide insights not only from personal experience but also based on what we know from our communities.
- A patient and caregiver TEP member expressed that they found it refreshing to see that doctors are thinking the same way as patients are, especially with regard to BMI and statins, and noted that it was a good discussion.

Meeting Wrap-Up and Next Steps

The project team provided a high-level overview of the next steps for the EC eCQM project in the coming months, which will include the following activities:

- Review and summarize the feedback from TEP members;
- Share the meeting summary report with TEP members for their review; and
- Consider potential future changes to the measures under maintenance.

The next TEP meeting is tentatively planned for fall 2025.

- The project team will follow up with TEP members via email to schedule the meeting and share updates.

The TEP will resume discussion of the Foot Assessment and Follow-Up for Patients with Diabetes measure that is currently under development at a future meeting.

Appendix A. TEP Members

EC eCQM TEP Attendance: Base Year Meeting #1	X if attended
Hadeel Alkhairw, MD, FACP, MS-HQSM, Dip ABOM	X
Ashley Bates, CNA, CMA	X
Zahid Butt, MD, FACG	X
Jessica Dale, DNP, BS, RN	X
Stephen Foster, MD	X
Terri Godar	X
Ben Hamlin, DrPH, FAMIA	X
Michael Hansen, MD, MPH, MS	X
Jenel Lansang, MSN, RN, MEDSURG-BC	X
Luming Li, MD	X
Robert McClure, MD	X
Precious McCowan, PhD	X
Samantha Pitts, MD, MPH	X
Anthony Sanchez	X
Christa Starkey	X
Andrew Talal, MD, MPH	X
Janice Tufte	X
Sandeep Vijan, MD, MS	X

Appendix B. eCQM Project Team Meeting Attendees

Centers for Medicare & Medicaid Services (CMS) Attendees
Angela McLennan, Contracting Officer's Representative
Joel Andress, Quality Measurement Lead

EC eCQM Project Team Attendees
Tandrea Hilliard-Boone, EC eCQM TEP Task Lead
Emily Melluso, TEP Task Team
Emily Tesbir, TEP Task Support
Kennan Murray, EC eCQM Program Director
Cindy Van, Deputy Project Director
Michelle Lefebvre, Quality Measure Development Lead, Deputy Project Director
Kelly Burlison, Quality Measure Maintenance Lead
Sarah Mossburg, AIR Information Gathering Lead
Katie Magoulick, eCQM Measure Documentation Lead
Brittany Martin, eCQM Data Analytics Lead
Coretta Lankford, Senior Advisor

University of California, Davis Attendees
Patrick Romano, Clinical Lead
Meghan Weyrich, Information Gathering Lead
John Kennedy, Clinical Coding Specialist
Elizabeth Magnan, Clinical Leadership Team Member
Irina Tokareva, Quality Measurement Clinician Researcher

Smile Digital Health Attendees
Jason Evans, Senior Software Engineer, FHIR Specification Lead

Clinician-Driven Quality Solutions Attendees
Chana West, eCQM Testing Lead

Lazy Labs Attendees
Chris Millet, Value Set Lead

Appendix C. TEP Agenda

Meeting Agenda
EC eCQM TEP Base Year Meeting 2

June 23, 2025 | 12:00 p.m. Eastern Time (ET)
Meeting ID: 940 3564 1306 | Passcode: mTnTk75&jY
Web Conference URL:
https://air-org.zoom.us/j/94035641306?pwd=KaX26WRNIO15Gp3xNG0KaMvJmHhowa.1

Time (ET)	Topic
12:00-12:20 pm	**Welcome and Roll Call** • Welcome members. Review meeting agenda and objectives. • Conduct TEP member roll call and review conflict of interest disclosures.
12:20-12:25 pm	**Technical Expert Panel (TEP) Roles and Responsibilities** • Review TEP member expectations.
12:25-12:30 pm	**TEP Meeting 1 Recap** • Briefly review TEP feedback provided at the April 7, 2025 TEP Meeting.
12:30-12:45 pm	**Patient and Caregiver Reflections: Lived Experience** • Hear from TEP members with lived experience in managing chronic conditions and navigating the health care system to ground TEP discussions in real-world experiences. • **Prompt:** *Clinical quality measures assess the quality of patient care by evaluating processes, outcomes and patient experiences. Patient awareness of these measures can improve their understanding of the healthcare system and promote better communication and shared decision-making between patients and providers. How can we increase awareness and understanding of clinical quality measures among patients and caregivers?*
12:45-1:45 pm	**Potential Future Updates to Measures Under Maintenance** • Discuss potential updates to measures under maintenance for implementation in Payment Year (PY) 2026
1:45-1:55 pm	**Patient and Caregiver Reflections: TEP Discussion** • **Prompt:** *Considering today's discussion, do you have any additional thoughts, concerns, or recommendations?*
1:55-2:00 pm	**Meeting Wrap-Up and Next Steps** Review next steps and action items.

Appendix D. TEP Meeting 2 Handout

Eligible Clinician Electronic Clinical Quality Measure (EC eCQM) Development, Evaluation, and Implementation Project

Technical Expert Panel (TEP) Meeting 2

Handout

Contents

Background

As described in the TEP Meeting 1 Resource Guide (shared previously), there are two categories of measures relevant to the Eligible Clinician Electronic Clinical Quality Measure (EC eCQM) Development, Evaluation, and Implementation project:

1. **Measures Under Development:** New measures on which the project team will work with CMS, the TEP, and other partners from the broader clinical community to create.
2. **Measures Under Maintenance:** These measures have already been developed but are reassessed each year and updated as necessary.

Key Definitions

- **Clinical Quality Measures (CQMs)** are mechanisms for assessing the degree to which a clinician competently and safely delivers clinical services appropriate for a patient in an optimal time frame. CQMs are a subset of the broader category of quality measures.
- **Electronic Clinical Quality Measures (eCQMs)** are measures specified in a standard electronic format that use data electronically extracted from electronic health records (EHRs) and/or health information technology (IT) systems to measure the quality of health care provided.

At the first EC eCQM TEP meeting on April 7, 2025, the project team discussed and gathered the TEP's feedback on one measure under development, *Foot Assessment and Follow-Up for People with Diabetes*, and one measure under maintenance, *Adherence to Antipsychotic Medications for Individuals with Schizophrenia*. Key takeaways from this discussion are summarized in the TEP Meeting 1 Summary Report.

As part of the annual update process, the project team is working with measure stewards, developers, and other contractors to review eCQMs and CQMs that have already been developed. The goal of these annual updates is to identify and implement any necessary changes to the measures based on documented issues with how they are used in practice or feedback from people who have a vested interest in the use of the measures.

This handout includes measure specifications and potential updates for four maintenance measures that the EC eCQM project team anticipates will need changes in this year's annual update (Exhibit 1). The project team will seek TEP input on these changes at the second TEP meeting on June 23, 2025.

Please review these specifications and refer to the TEP Meeting 1 Resource Guide, as needed. We look forward to discussing plans for these measures in greater detail at the upcoming TEP meeting. If you have any questions, please reach out to our team at ecqmtep@air.org.

Exhibit D1. Measures Under Maintenance for Discussion at EC eCQM TEP Meeting 2

Category	Measure ID	Measure Name	CQM or eCQM	Potential Updates to this Measure for TEP Meeting Discussion
Behavioral Health/Psychiatry	QID #134/ CMS2	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Both	• Explore adding mental health disorders (e.g., major depressive disorder) to expand the exclusion criteria. – The current specification excludes patients with bipolar disorder; additional mental health disorders are being considered due to: » Implementer feedback indicating patients who do not need screening are being captured in the measure. » Expert Workgroup feedback indicating that the measure should focus on screening and not treatment. – The bipolar disorder exclusion is not recommended for removal.
Body Mass Index	QID #128/ CMS69	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Both	• Add an exception for dental encounters. – Per implementer feedback, dentists often do not have the ability to reliably measure height and weight or to document follow-up plans. • Expand the follow-up plan time frame. The current measure specification requires a BMI follow-up plan to be documented on or before the date of the encounter. – Expert Workgroup feedback indicated that developing a follow-up plan on the day of the encounter is often not feasible. A follow-up plan requires additional time for aspects such as testing and relationship building with patients.
Cardiovascular Health	QID #438/ CMS347	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	Both	• Update the rhabdomyolysis exclusion from "diagnosed during the measurement period" to "diagnosed prior to the end of the measurement period." – Logic Reviewers and the Expert Workgroup recommended this change due to clinical relevance. • Add patients who are pregnant anytime during the measurement period as an exclusion. – This proposed change was identified in information gathering activities. • Limit Population 1 denominator to patients 18-75 years of age. – Implementer feedback indicated that pediatric patients who are not indicated for statin use are being captured in the measure.
Cardiovascular Health	QID #377/ CMS90	Functional Status Assessments (FSA) for Heart Failure	eCQM	• Consider **one** of the two following changes: – Remove the requirement for a follow-up assessment. » The current specification requires a follow-up FSA to be documented at least 30 days but no more than 180 days after the initial FSA. – Exclude patients with a New York Heart Association functional status of I or II. » The Expert Workgroup made this recommendation to avoid over screening of patients.

Measure Specifications

Behavioral Health/Psychiatry Measures

Measure QID #134/CMS2: Preventive Care and Screening: Screening for Depression and Follow-Up Plan

2025 Clinical Quality Measure (CQM) Specifications (Version 9)

MEASURE TYPE:

Process

DESCRIPTION:

Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter

DENOMINATOR:

All patients aged 12 years and older at the beginning of the performance period with at least one qualifying encounter during the performance period

DENOMINATOR EXCLUSIONS:

Documentation stating the patient has had a diagnosis of bipolar disorder

NUMERATOR:

Patients screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized tool AND if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter

The full measure specifications are available here.

2025 Electronic Clinical Quality Measure (eCQM) Specifications (Version Number: 14.0.000)

MEASURE TYPE:

Process

DESCRIPTION:

Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter

DENOMINATOR:

All patients aged 12 years and older at the beginning of the measurement period with at least one qualifying encounter during the measurement period

DENOMINATOR EXCLUSIONS:

Patients who have ever been diagnosed with bipolar disorder at any time prior to the qualifying encounter

NUMERATOR:

Patients screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized tool AND if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter

The full measure specifications are available here.

Potential Updates to this Measure (both CQM and eCQM) for TEP Meeting Discussion

- Explore adding mental health disorders (e.g., major depressive disorder) to expand the exclusion criteria.
  - The current specification excludes patients with bipolar disorder; additional mental health disorders are being considered due to
    - Implementer feedback indicating patients who do not need screening are being captured in the measure.
    - Expert Workgroup feedback indicating that the measure should focus on screening and not treatment.
  - The bipolar disorder exclusion is not recommended for removal.

Body Mass Index (BMI) Measures

Measure QID #128/CMS69: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

2025 CQM Specifications (Version 9)

MEASURE TYPE:

Process

DESCRIPTION:

Percentage of patients aged 18 years and older with a BMI documented during the current encounter or within the previous twelve months AND who had a follow-up plan documented if the most recent BMI was outside of normal parameters

DENOMINATOR:

All patients aged 18 and older on the date of the encounter with at least one qualifying encounter during the measurement period

DENOMINATOR EXCLUSIONS:

Documentation stating the patient has received or is currently receiving palliative or hospice care OR Documentation of patient pregnancy anytime during the measurement period prior to and including the current encounter

NUMERATOR:

Patients with a documented BMI during the encounter or during the previous twelve months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the encounter

The full measure specifications are available here.

2025 eCQM Specifications (Version Number: 13.0.000)

MEASURE TYPE:

Process

DESCRIPTION:

Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the measurement period AND who had a follow-up plan documented if BMI was outside of normal parameters

DENOMINATOR:

All patients aged 18 and older on the date of the encounter with at least one qualifying encounter during the measurement period

DENOMINATOR EXCLUSIONS:

Patients who are pregnant at any time during the measurement period

Patients receiving palliative or hospice care at any time during the measurement period

NUMERATOR:

Patients with a documented BMI during the encounter or during the measurement period, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the measurement period

The full measure specifications are available here.

Potential Updates to this Measure (both CQM and eCQM) for TEP Meeting Discussion

- Add an exception for dental encounters.
  - Per implementer feedback, dentists often do not have the ability to reliably measure height and weight or to document follow-up plans.
- Expand the follow-up plan time frame. The current measure specification requires a BMI follow-up plan to be documented on or before the date of the encounter.
  - Expert Workgroup feedback indicated that developing follow-up plan on the day of the encounter is often not feasible. A follow-up plan requires additional time for aspects such as testing and relationship building with patients.

Cardiovascular Measures

Measure QID #438/CMS347: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

2025 CQM Specifications (Version 9)

MEASURE TYPE:

Process

DESCRIPTION:

Percentage of the following patients - all considered at high risk of cardiovascular events - who were prescribed or were on statin therapy during the performance period:

- All patients who were previously diagnosed with or currently have a diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD), including an ASCVD procedure; OR
- Patients aged 20 to 75 years who have ever had a low-density lipoprotein cholesterol (LDL-C) level ≥ 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia; OR
- Patients aged 40 to 75 years with a diagnosis of diabetes; OR
- Patients aged 40 to 75 with a 10-year ASCVD risk score of ≥ 20 percent

DENOMINATOR:

- All patients who were previously diagnosed with or currently have a diagnosis of clinical ASCVD, including an ASCVD procedure
- Patients aged 20 to 75 years at the beginning of the performance period who have ever had a laboratory result of LDL-C ≥ 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia
- Patients aged 40 to 75 years at the beginning of the performance period with Type 1 or Type 2 diabetes
- Patients aged 40 to 75 years at the beginning of the performance period with a 10-year ASCVD risk score of ≥ 20 percent during the performance period

DENOMINATOR EXCLUSIONS:

Patients who are breastfeeding at any time during the performance period OR Patients who have a diagnosis of rhabdomyolysis at any time during the performance period

NUMERATOR:

Patients who are actively using or who receive an order (prescription) for statin therapy at any time during the performance period

The full measure specifications are available here.

2025 eCQM Specifications (Version Number: 8.1.000)

MEASURE TYPE:

Process

DESCRIPTION:

Percentage of the following patients - all considered at high risk of cardiovascular events - who were prescribed or were on statin therapy during the measurement period:

- All patients who were previously diagnosed with or currently have a diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD), including an ASCVD procedure; OR
- Patients aged 20 to 75 years who have ever had a low-density lipoprotein cholesterol (LDL-C) level >= 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia; OR
- Patients aged 40-75 years with a diagnosis of diabetes; OR
- Patients aged 40 to 75 with a 10-year ASCVD risk score of >= 20 percent

DENOMINATOR:

Population 1: All patients who were previously diagnosed with or currently have a diagnosis of clinical ASCVD, including an ASCVD procedure

Population 2: Patients aged 20 to 75 years at the beginning of the measurement period who have ever had a laboratory result of LDL-C >=190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia

Population 3: Patients aged 40 to 75 years at the beginning of the measurement period with Type 1 or Type 2 diabetes

Population 4: Patients aged 40 to 75 at the beginning of the measurement period with a 10-year ASCVD risk score (i.e., 2013 ACC/AHA ASCVD Risk Estimator or the ACC Risk Estimator Plus) of >= 20 percent during the measurement period

DENOMINATOR EXCLUSIONS:

Patients who are breastfeeding at any time during the measurement period

Patients who have a diagnosis of rhabdomyolysis at any time during the measurement period

NUMERATOR:

Patients who are actively using or who receive an order (prescription) for statin therapy at any time during the measurement period

The full measure specifications are available here.

Potential Updates to this Measure (CQM and eCQM) for TEP Meeting Discussion

- Update the rhabdomyolysis exclusion from "diagnosed during the measurement period" to "diagnosed prior to the end of the measurement period."
  - Logic Reviewers and the Expert Workgroup recommended this change due to clinical relevance.
- Add patients who are pregnant anytime during the measurement period as an exclusion.
  - This proposed change was identified in information gathering activities.
- Limit Population 1 denominator to patients 18-75 years of age.
  - Implementer feedback indicated that pediatric patients who are not indicated for statin use are being captured in the measure.
- Add patients with a Coronary Calcium Score of 0 documented during the measurement period as an exclusion to Population 4 only.
  - The Expert Workgroup made this recommendation to avoid statin use in patients with an ASCVD 10-year risk score of >=20.

Measure QID #377/CMS90: Functional Status Assessments (FSA) for Heart Failure

2025 eCQM Specifications (Version Number: 14.0.000)

There is not a CQM version of this measure.

MEASURE TYPE:

Process

DESCRIPTION:

Percentage of patients 18 years of age and older with heart failure who completed initial and follow-up patient-reported functional status assessments

DENOMINATOR:

Patients 18 years of age and older who had two outpatient encounters during the measurement period and a diagnosis of heart failure that starts any time before and continues into the measurement period

DENOMINATOR EXCLUSIONS:

Exclude patients who are in hospice care for any part of the measurement period

Exclude patients with severe cognitive impairment in any part of the measurement period

NUMERATOR:

Patients with patient-reported functional status assessment results (i.e., Veterans RAND 12-item health survey [VR-12]; VR-36; Kansas City Cardiomyopathy Questionnaire [KCCQ]; KCCQ-12; Minnesota Living with Heart Failure Questionnaire [MLHFQ]; Patient-Reported Outcomes Measurement Information System [PROMIS]-10 Global Health; PROMIS-29) present in the EHR within two weeks before or during the initial FSA encounter and results for the follow-up FSA at least 30 days but no more than 180 days after the initial FSA

The full measure specifications are available here.

Potential Updates to this Measure (eCQM) for TEP Meeting Discussion

- Consider **one** of the two following changes:
  - Remove requirement for follow-up assessment.
    - The current specification requires a follow-up FSA to be documented at least 30 days but no more than 180 days after the initial FSA.
  - Exclude patients with a New York Heart Association functional status of I or II.
    - The Expert Workgroup made this recommendation to avoid over screening of patients.

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