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

Deliverable 4-3: Option Year 1 Technical Expert Panel (TEP) Meeting 2 Summary Report

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DRAFT: MAY 28, 2026
FINAL: JULY 9, 2026

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Technical Expert Panel Overview

The Centers for Medicare & 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 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 are:

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

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 when there is no planned endpoint for the relationship; expertise is needed for the ongoing management of a chronic disease or condition; care is during a defined period and circumstance, such as hospitalization; or care is 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.

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

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**

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 on the basis of 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 Option Year 1 via Zoom teleconference on May 14, 2026. Eleven 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 lists CMS staff and project team members in attendance. Appendix C. TEP Agenda is a copy of the full meeting agenda. Appendix D. Option Year 1 TEP Meeting 2 Handout provides specifications for measures discussed during this meeting.

The objectives of the May 14, 2026, EC eCQM TEP meeting were to

- review the role of the TEP;
- briefly review TEP feedback provided at the December 5, 2025, TEP meeting, including patient and caregiver reflections on the ways in which evolving technologies, like telehealth or remote screening and monitoring of chronic health conditions affect the quality of patient care;
- hear new insights from TEP members with lived experience in managing chronic conditions and navigating the health care system about what makes it easier and what makes it more difficult for patients to get preventive mental and physical health screenings;
- share updates and seek feedback on the development of CMS1331: Foot Assessment and Follow-Up for Patients with Diabetes; and
- share updates and seek feedback on four CMS-stewarded quality measures that are under maintenance:
  - 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 #335: Maternity Care: Elective Delivery (Without Medical Indication) at < 39 Weeks (Overuse)
  - Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients (QID #102/CMS129)

Exhibit 1 summarizes the TEP members' discussion of potential measure updates and recommendations from the May 14, 2026, TEP meeting.

Exhibit 1. TEP Member Discussion Summary and Recommendations From the May 14, 2026, TEP Meeting

Topic/measure	TEP meeting discussion topics	Discussion summary and recommendations
CMS1331: Foot Assessment and Follow-Up for Patients with Diabetes	• The project team shared that usability and feasibility testing ended in fall 2025 and beta testing is ongoing. The team identified several workflow concerns during testing that led to measure specification revisions, including the following: – refining the value sets to clarify foot assessment capture; – revising the numerator to require at least one neurological exam (either a monofilament or Ipswich soft touch test); – removing the foot care education requirement; and – simplifying the specification to reflect real-world documentation (e.g., structured documentation in the electronic medical record of dry, cracked heels in a diabetic foot exam template rather than explicit reference to both the visual exam and its results). • Based on findings, the team determined that additional testing sites would be beneficial. Site recruitment is underway.	• The TEP discussed the prevalence of incidental findings for the foot assessment and follow-up measure and how providers can treat these findings without addressing them in the diabetes plan of care if they are not related. • A TEP member asked for clarification of what was being measured during testing: the assessment during the encounter or the exam result. The project team confirmed using exam results as the clinical finding in their testing of the measure as the exam result is a measurable indicator of an assessment taking place. • A TEP member asked about the consistency of the foot assessment template across electronic health record (EHR) vendors and whether the template was mappable to a structured codable concept. The project team confirmed that for the purposes of testing, a structured foot exam and the results documented at the provider sites were mapped to the codes within the measure's value sets. • The TEP asked to review the measure value sets, and the project team committed to sending updated versions of those materials to the TEP after the meeting.

Topic/measure	TEP meeting discussion topics	Discussion summary and recommendations
QID #134/CMS2: Preventive Care and Screening: Screening for Depression and Follow-Up Plan	• The team discussed two analysis questions for this measure: – What is the exception rate, and which "Medical Reasons" exceptions are being documented? – For both adolescent and adult patients not screened for depression and not identified as a denominator exception or exclusion, are there documented reasons in the clinical notes for not screening that are not captured in the measure? • The project team reviewed data from Calendar Year 2024 from the UC Davis Health (UCDH) EHR to address these questions.	• The TEP discussed that two different populations of patients—those who screen negative and those who screen positive and have a documented follow-up plan— are included in the numerator and discussed the possibility of dividing the measure into two measures. TEP members also suggested that the measure could remain a single measure with two rates: (1) the rate of screening for depression among all eligible patients; and (2) the rate of documented follow-up plans among patients who screen positive for clinically significant depression. The project team clarified that combining screening and follow-up into a single measure aligns with CMS's goal of implementing a manageable number of measures but agreed that additional changes to numerators could be considered in future measure development cycles. • The project team explained that they had received preliminary approval from CMS to add an exclusion for patients with a depression diagnosis who are in active treatment during the measurement period. • The TEP noted that there are many qualifying encounters for this measure, including physical therapy visits, and that decreasing the number of qualifying encounters would improve the measure performance rate. • The TEP discussed the importance of the setting and context of screening, noting that some patients might screen positive in an acute setting and that it might not be appropriate for some types of providers, such as physical therapists, to assess whether a positive screening is clinically significant. One TEP member strongly recommended standardizing this measure's specifications to include clinically significant thresholds to ensure valid determinations of depression. The project team explained that some encounter types, such as physical and occupational therapy encounters, are included in the measure at CMS's direction and that the measure's intent is to document a follow-up plan for a positive depression screening rather than to diagnose or treat depression. This nuance addresses the concern that not all providers reporting the measure have the content knowledge to accurately diagnose or treat depression, but all can act on making a follow-up plan. The project team will consider including clinically significant thresholds in a future iteration of the measure.

Topic/measure	TEP meeting discussion topics	Discussion summary and recommendations
QID #128/CMS69: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	• The team discussed two questions: – For patients in the underweight and overweight categories who meet the measure numerator, how frequently is each follow-up plan documented and which follow-up plans are not documented? – For patients in the underweight and overweight populations who do not meet the measure numerator, is there documentation in the clinical notes of a follow-up plan that is not being captured by the codes in the measure specification? • The project team presented results of queries from structured data in the UCDH EHR to address the first question and reviewed findings with the TEP. • To address the second question, the project team reviewed data from a sample of UCDH medical records.	• The TEP discussed the importance of having separate follow-up plan requirements based on whether a patient falls into the overweight or obese categories within the BMI screening due to the differences in clinical approaches to weight management for these two groups of patients. The TEP recommended separating the measure logic to distinguish between patients categorized as obese versus those categorized as overweight. The project team agreed and noted that it is actively working on how to tailor the measure to better account for the difference between a BMI of 25 to 30 (overweight) and a BMI of over 30 (obese). • The TEP discussed that the results presented might demonstrate relatively higher rates of medication treatment for patients in the obese category because of the limited region where the testing was conducted. A TEP member cautioned that many patients do not have access to medicinal intervention because of the prohibitive cost of glucagon-like peptide-1 receptor antagonist (GLP-1) medications. • A TEP member cautioned that the education and counseling component of this measure requires time-based billing codes that might not be accessible to all clinicians (e.g., residency-based clinics that are not able to use time-based codes). The project team responded that there might be some SNOMED CT codes included in the follow-up plan that do not require time components. However, those codes must be available to document within local EHRs. The TEP member added that it is possible to access those codes if a clinic's infrastructure supports them. The project team discussed which codes could be used to receive credit for education and counseling activities.

Topic/measure	TEP meeting discussion topics	Discussion summary and recommendations
QID #102/CMS129: Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	The team discussed the measure with the Prostate Cancer Expert Workgroup (EWG) to examine how to improve the measure and make it more meaningful. The EWG recommended the following updates: • Update the measure so that the title and measure specification align with the avoidance of advanced/whole body imaging, not only bone scan. • Remove the requirement for prostate cancer treatment for inclusion in the denominator. • Update the measure logic so that the denominator allows tumor staging results for T1a and T2a to be either null or not null. • Implement an index date on which to base advanced imaging. – The index date will be based on the last low-risk or very low-risk Gleason score from biopsy. – Advanced imaging should be avoided for 12 months or until treatment is initiated, whichever comes first. • Update the measure so that it is telehealth eligible.	• A TEP member asked if the measure addresses use or nonuse of bone scan imaging for prostate cancer patients. The project team confirmed that the measure captures nonuse of a bone scan for the denominator population. • A TEP member asked if MRIs would be permitted, and the project team confirmed that MRIs of only the prostate are permitted but that full-body MRI scans would not meet the requirements of avoiding overuse of bone scanning posited by the measure. The project team will ensure that the definition of advanced imaging is clearly defined in the measure. • A TEP member questioned whether tumor staging should be required in the denominator, noting concerns about inclusion of patients without defined staging. The project team explained that including staging as a requirement would exclude too many patients and risk capturing more advanced cancers; however, the TEP member recommended testing a modification allowing T1a and T2a staging results to be optional (null or not null).
QID #335: Maternity Care: Elective Delivery (Without Medical Indication) at < 39 Weeks (Overuse)	• Not discussed because of time constraints.	• Not discussed because of time constraints.

The following sections of this report provide details about the information that the project team shared with TEP members and feedback provided by TEP members 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 conflict-of-interest disclosures, 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 these recommendations are considered fully. The project team will also provide clear rationale for those situations in which CMS is unable to implement specific TEP recommendations.

- Two TEP members noted that the stated responsibility of the TEP, per the meeting materials, is to review eCQMs; however, CQMs are included in the meeting agenda. The project team acknowledged the TEP members' observation and clarified that the EC eCQM contract encompasses several CQMs, which the team maintains on behalf of CMS. The team will revise meeting materials to include CQM reviews moving forward.

December 5, 2025, TEP Meeting Recap

During the May 14, 2026, TEP meeting, the project team provided an overview of the first TEP meeting of the project's second option year, held via Zoom teleconference on December 5, 2025. Fifteen of the 18 TEP members attended the December meeting. This recap included review of

- the December meeting objectives, which were to share updates and seek feedback on the Foot Assessment and Follow-up for Patients with Diabetes eCQM and potential updates to two CMS-stewarded quality measures under maintenance;
- how TEP feedback informed updates to measure development and final plans for maintenance testing; and
- a summary of TEP feedback on the Foot Assessment and Follow-up for Patients with Diabetes eCQM and the two measures under maintenance:
  - 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

Exhibit 2 summarizes the TEP members' discussion of potential measure updates and recommendations from the December 5, 2025, TEP meeting. The detailed December 2025 TEP meeting summary report is available on the CMS Measures Management System (MMS) website.

Exhibit 2. TEP Member Recommendations From the December 5, 2025, TEP Meeting

Topic/measure	TEP meeting discussion topics	Discussion summary and recommendations
CMS1331: Foot Assessment and Follow-up for Patients with Diabetes	• Most patients currently receive **only one neurological foot exam** (usually a monofilament test) rather than multiple foot exams. • **Foot self-care education documentation is inconsistent**; however, guidelines do not need to be overly prescriptive, and they do not need to require annual foot care education for all patients with diabetes • The TEP emphasized **data fidelity and robustness** to ensure that measure elements match what is being evaluated.	• Recommended change: Update the numerator to require at least one neurological exam that includes a 10-gram monofilament (or Ipswich soft touch as an alternative). • Recommended change: Make the foot care education requirement less prescriptive, potentially removing it from the numerator. The panel agreed that foot self-care education is important but suggested requiring it primarily for patients with abnormal foot exams, not those with normal findings.
QID #134/CMS2: Preventive Care and Screening: Screening for Depression and Follow-Up Plan	• Testing Objective #1: Assess whether standardized depression screenings and their results can be captured electronically using LOINC codes designated for the specific screening. • Testing Objective #2: For patients who do not meet the measure numerator, determine whether there is documentation in the clinical notes of a follow-up plan that is not being captured in the measure. • Testing Objective #3: Assess whether patient-specific characteristics warrant the introduction of new denominator exceptions or exclusions within the measure to improve accuracy and clinical relevance	• The TEP shared that there is a need to account for the use of different depression screening tools and the different thresholds for positive screenings. The TEP also discussed the burden of follow-up documentation given the current specifications and the need for a separate workflow to capture the data discretely. • The TEP discussed the necessity of medical exceptions and noted the need to distinguish between an exception and an exclusion in the measure. • TEP members cautioned against adding more detailed exclusion requirements because doing so would increase clinician burden.
QID #128/CMS69: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	• Objective #1: Assess whether the measure specification includes appropriate follow-up requirements for patients who screen into the BMI categories of “underweight” and “overweight.” • Objective #2: Assess whether patient-specific characteristics warrant the introduction of new denominator exceptions or exclusions within the measure to improve accuracy and clinical relevance.	• The TEP discussed reasons that patients may fall into the screening categories of “overweight” or “underweight” and requested more information on the follow-up activities currently specified for patients who screen as underweight. • The TEP did not endorse BMI as an accurate measure of health risk, noting that it does not reliably determine whether a patient is over- or underweight. The panel recommends evaluating the ongoing use of BMI for this measure. The TEP voiced support for researching and analyzing alternative screening tools that do not rely on BMI to prompt weight screening and management conversations with providers.

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 December 5, 2025, TEP meeting, which included discussions of the role of technologies like telehealth and remote monitoring, and the quality of patient care. Key takeaways from that meeting included the following:

- Telehealth reduces the cost per visit, reduces exposure to illness in a clinical setting, and facilitates multidisciplinary collaboration. It also enables patients to live healthily at home and receive proper care.
- Telehealth also makes routine follow-ups more manageable and facilitates early detection of health issues.
- Telehealth has made routine follow-ups more manageable and enabled patients to catch issues early, with minimal disruption to daily life. One TEP member expressed concern about potential changes to telehealth coverage, particularly for patients receiving home-based treatments.
- A TEP member noted that telehealth has not worked well for them but expressed appreciation for its potential and for remote monitoring technology.
- One TEP member said it would be helpful for patients to have access to free apps that encourage exercise, meditation, and other activities to improve well-being.

The project team then shifted to the discussion topic for this meeting, which focused on patients' access to health screenings. 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:

Question Posed to Patient and Caregiver TEP Members

Thinking about preventive mental and physical health screenings, what makes it easier—and what makes it harder—for patients to get those screenings?

One TEP member with lived experience as a patient and patient advisor attended the TEP meeting and shared their perspectives:

- The patient advisor TEP member emphasized the importance of shared decision making and communication between providers and patients about preventive screenings. The TEP member shared an example of speaking with another patient who was reluctant to undergo a mammogram screening despite its importance. The TEP member also noted that they had

personally completed a mental health screening in advance of an appointment with their primary care physician and felt that some questions were designed to confirm that respondents were reading carefully and thoughtfully completing the survey. The TEP member emphasized the importance of providers asking patients during screenings about what matters to them and if they have any concerns.

- The patient advisor TEP member also highlighted the difficulties patients are facing with accessing primary care because of insurance changes, noting that telehealth could help patients maintain connection with their providers. The TEP member concluded by sharing the importance of providers' delivering kind and thoughtful care when conducting screenings to encourage people to take the screenings and understand that people's mental health is as important as their physical health.

Updates on the Foot Assessment and Follow-up for Patients with Diabetes Measure

The project team provided an update on the development of CMS1331: Foot Assessment and Follow-up for Patients with Diabetes. The team first reviewed the measure specifications.

Description. This measure refers to the percentage of patients 18 years of age and older with diabetes who receive all of the following: a lower extremity neurological examination, vascular examination, and visual inspection, and have a documented follow-up plan of care if any of the results are abnormal during the measurement period

Definition. As Exhibit 3 shows, the project team reviewed the measure definition.

Exhibit 3. CMS1331: Foot Assessment and Follow-up for Patients With Diabetes eCQM Definition

Measure population	Definition
Initial population	• Patients 18 years of age and older at the beginning of the measurement period who have diabetes and at least one qualifying encounter during the measurement period
Denominator	• Equals initial population
Denominator exclusions	• Patients who had a bilateral amputation at the foot or above, or both a left and right foot amputation before the start of the first eligible encounter • Patients who are in hospice care for any part of the measurement period
Numerator	• Patients who receive all of the following: a lower extremity neurological examination, a vascular examination, and a visual inspection, and have: – All normal or incidental exam findings or – At least one abnormal exam finding and have a documented follow-up plan of care within 7 calendar days of the qualifying encounter where an abnormal finding was documented

The TEP held the following discussion about these specifications:

- One TEP member noted that the inclusion of incidental exam findings in the numerator might add evaluation burden. The TEP member suggested that the numerator could be modified to include all normal findings or none of the abnormal findings and still be comprehensive.
  - The project team explained that the option for incidental findings was included on the basis of initial testing results because the results revealed substantial documentation of nonnormal foot exams relative to what is expected for a diabetic foot exam. The project team expressed appreciation for the TEP member's suggestion to reframe the numerator to indicate normal or abnormal results.
  - The project team further explained that, when reviewing data related to the visual inspection component of the exam, the data revealed that often a provider completed a visual inspection but the findings did not fit into normal or any of the defined abnormal categories. The incidental findings language was included to allow providers to accurately indicate that a visual inspection was completed.
- In the meeting chat, one TEP member asked if abnormal findings include blisters and ulcers or diminished sensation. The project team shared the following excerpt from the draft measure specification narrative for reference:
  - "Lower extremity neurological exam—abnormal findings: Sensation diminished, absent, or abnormal in one or both feet
  - Lower extremity vascular exam—abnormal findings: Pulse(s) diminished, absent, or abnormal in one or both feet
  - Lower extremity visual inspection—abnormal findings: Presence of ulcer, deformity, fissure, or blister in one or both feet."
- The TEP member and project team discussed the measure's definition of abnormal as findings of ulcer, deformity, fissure, or blister. The finding cannot be null or blank, so if it does not meet those qualifications for abnormal, it could fall into the normal category to simplify the evaluation, even if there were abnormal findings unrelated to those that pertain to the measure.
- Another TEP member agreed that, if the abnormality is not specific to a patient's diabetes, it could be categorized as normal for the measure to avoid confusion between abnormal, incidental, and normal. Providers may be addressing incidental findings, but it may not be related to the diabetes plan of care.
- A patient advisor TEP member discussed the experience of a friend who had a bump on their ankle, which they noted could be an incidental finding like those discussed for the measure if

it is not considered an ulcer. The patient advisor also emphasized that providers should ask whether their patients have seen an eye doctor recently given the potential for visual issues in patients with diabetes.

Testing timeline and update. The project team then shared updates about the measure testing timeline.

- Usability and feasibility testing concluded in fall 2025, and the team found that, overall, the measure's data elements could be captured within structured fields.
- Beta testing began in fall 2025 to collect the data and analyze the data element validity. Based on testing thus far, the team identified some workflow concerns that led to several revisions to the measure specification:
  - The names and underlying metadata in value sets were refined and clarified to indicate that the measure captures assessment of the foot.
    - During testing, the team noticed that some codes are not specific to feet, but the information comes directly from diabetic foot assessment templates, so it is related to the feet.
  - The numerator was revised to require at least one neurological exam, either the 10 g monofilament test or the Ipswich (soft) touch test.
    - The testing team conducted a query of the tests that were removed from the measure specification (e.g., pinprick, vibration) and determined that only five of approximately 450 practices documented using those neurological exams, and fewer than 30 had result findings.
  - The numerator was revised by removing foot care education as a requirement for all patients.
    - Testing showed that the data were frequently being documented in nonstructured fields or that providers were using generic diabetes care education information, which is too general to consider foot care education for the measure.
  - The numerator requirements were simplified to ensure consistency across exam types and to reflect real-world documentation (e.g., structured documentation in the electronic medical record of dry, cracked heels in a diabetic foot exam template rather than explicit reference to both the visual exam and its results).

The TEP held the following discussion on these testing updates:

- One TEP member asked for clarification on how the measure determines that a foot exam has been performed. The project team commented that the finding of the foot exam

indicates that the test was performed, as the team found use of diabetic foot assessment templates with specific drop-down options that indicated the exam finding.

  - The TEP member expressed concern that the exam finding recorded in the measure may not always align with that exam actually being performed. In other words, sometimes the results are not tied to a particular exam being performed. The TEP member acknowledged the testing team's observation that findings indicating an abnormality are always associated with the exam in the EHR systems reviewed, so they are comfortable with making that connection. However, they expressed hesitation about broad applicability. They also cautioned that requiring documentation of the assessment rather than the exam results would increase clinician burden. The project team acknowledged the concern and noted that clinicians often do not separately document the exam conducted. The team members also confirmed that they looked across multiple vendor platforms and instances.

- Another TEP member asked whether the diabetic foot assessment template was consistent across vendor instances and whether the template was mappable to a structured codable concept. The project team noted that the template used SNOMED CT codes to capture the results of the foot assessments but these codes were not always found in the data. The CBE feasibility criteria inquire about whether information required for the measure is encoded using standard terminologies or if it can be mapped to a structured codable concept. For the purposes of testing, the project team mapped the structured foot exam and result responses documented at the provider sites to the codes within the measure's value sets.
  - The TEP member expressed interest in hearing about interrater reliability of the validations during the next TEP meeting, which the project team acknowledged.
- A TEP member noted that many clinicians do not use the structured template or use their own template, and unless the template matches what is in the structured Epic note, it will not be captured by eCQMs. The TEP member also acknowledged that this method of measuring a foot exam—measuring the outcome of the test rather than the way the outcome was tested—is similar to many existing measures. The TEP member agreed that structuring the measure in this way is simpler and avoids additional documentation burden. They also expressed the need to trust that clinicians are performing the test for this and other measures.
- Another TEP member asked if the measure value sets are available to review. The project team confirmed that an email update had been sent to the TEP with the value set directory and Fast Healthcare Interoperability Resources (FHIR) specifications on January 14, 2026. The team will also share updated versions in follow-up to this TEP meeting.

Measures under consideration (MUC)/CBE submission update. On the basis of the findings described above and the desire to ensure more representative results, the testing team determined that it would be beneficial to add one or more testing sites. The measure was not submitted for CBE endorsement or to CMS's Measures Under Consideration (MUC) list for the spring 2026 cycle.

Testing site recruitment is currently underway, and the team is continuing to analyze testing data. One TEP member confirmed with the project team that large language models (LLMs) were not used for data analysis.

Updates for Measures Under Maintenance

As Exhibit 4 shows, the project team provided updates on comprehensive measure maintenance activities for two CMS-stewarded quality measures and limited measure maintenance activities for one CMS-stewarded measure.

Exhibit 4. Comprehensive Maintenance Measures Discussed at the May 14, 2026, TEP Meeting

Measure	Description
QID #134/CMS2 Preventive Care and Screening: Screening for Depression and Follow-Up Plan	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 2 days after, the date of the qualifying encounter
QID #128/CMS69 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	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 normal parameters
Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients (QID #102/CMS129)	Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low (or very low) risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy who did not have a bone scan performed at any time since diagnosis of prostate cancer

Note. QID #335: Maternity Care: Elective Delivery (Without Medical Indication) at < 39 Weeks (Overuse) was not discussed because of time limitations.

The project team outlined the activities that comprised comprehensive and limited maintenance, as provided below.

Comprehensive maintenance activities. The team's comprehensive maintenance activities include a literature and guideline review, expert work groups (EWGs), professional society

outreach, review of implementer feedback submitted to CMS, and data analysis to support potential changes.

Limited maintenance activities. The team's limited maintenance activities include a guideline review, professional society outreach, and review of implementer feedback. Select measures also discussed in EWGs.

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

Results from data analysis. The team evaluated two maintenance analysis questions:

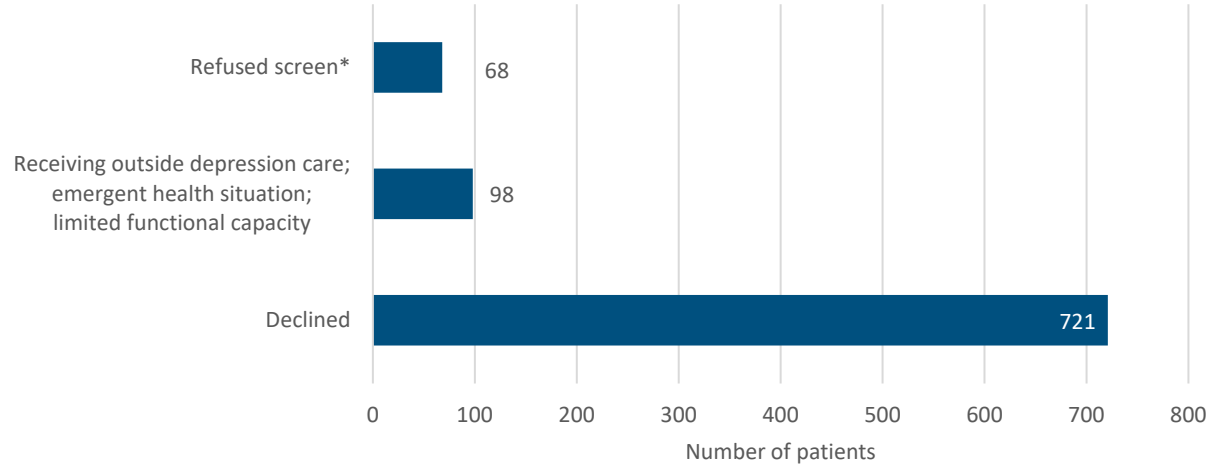
1. What is the exception rate, and which "Medical Reasons" exceptions are being documented?
2. For both adolescent and adult patients not screened for depression and not identified as a denominator exception or exclusion, is there a documented reason for not screening in the clinical notes that is not being captured in the measure?

Data from these questions helped the project team determine whether frequently used medical exceptions should be proposed as denominator exclusions and whether additional codes, conditions, or situations should be included as exceptions under "Medical Reasons."

The project team examined Calendar Year 2024 data from UCDH. Regarding the first analysis question, a total of 186,563 patients were eligible for the measure, that is, met the denominator criteria. The numerator, or the number of patients who met both the depression screening and documented follow-up plan components of the measure, was 87,366 patients.

The data show that 887 of the 186,563 eligible patients met the criteria for denominator exception, leading to an exception rate for the measure of 0.47%. As Exhibit 5 shows, of the exceptions documented, most (721 of 887) were because of patients' declining screening. Additional documented exceptions included patients receiving outside depression care, emergent health situations, limited functional capacity of the patient, and screening refusal (a catch-all category used when nothing is selected for the depression screening prompt in the patient's medical record).

Exhibit 5. Denominator Exceptions for Depression Screening at UC Davis Health in 2024



Note. From University of California, Davis, Health system electronic health record data for Performance Year 2024 (January 1, 2024–December 31, 2024). **Refused screen occurs when the clinician opens the "Exception" pop-up screen in the medical record but does not select one of the exception options.*

Regarding the second analysis question, the project team reviewed a random sample of 147 records that met the denominator but failed to meet the screening component of the numerator. As shown in Exhibit 6, of these 147 records, 47 (32%) contained documentation of depression screening, 26 (21%) had evidence of a potential exclusion or exception, and 74 (21%) had no documentation of depression screening.

Exhibit 6. Documented Reasons for Not Screening for Depression Not Captured by the Measure for Quality ID #134/CMS2: Screening for Depression and Follow-up Plan at UC Davis Health in 2024

Finding	*N*	Details
Documentation of depression screening	47/147 (32%)	• 22/47 records had screening conducted by an outside health system or diagnostic evaluation for a specific clinical purpose. • 14/47 records had screening conducted with a tool other than that specified in the measure (PROMIS, *n* = 9; RAND SF-36, *n* = 5), but only PROMIS has a depression-specific scale. • 11/47 records had screening conducted but tool not mentioned
Documentation of denominator exclusion or exception	26/147 (21%)	• 26/26 records had documentation of a current denominator exclusion or exception but not in a structured field, or included documentation of a potential denominator exclusion (active depression treatment, current psychiatric care, or a comorbidity contraindicating or complicating screening)
No documentation	74/147 (47%)	• 74/74 records had no documentation of depression screening or denominator exclusion/exception.

Note. From University of California, Davis, Health system electronic health record data for Performance Year 2024 (January 1, 2024–December 31, 2024).

The project team then posed the following question to the TEP for discussion:

Question Posed to the TEP

What feedback do you have on these proposed measure updates?

The TEP held the following discussion on this measure:

- One TEP member expressed concern about the numerator of the depression screening measure being a combination of people who screen negative for depression and those who screen positive and had a documented follow-up plan. The TEP member felt that the measure combines two different populations of patients, which makes it hard to discern whether the population is healthy. A second TEP member agreed that the measure's numerator answers two different questions and asked whether the measure was interested in treatment as the outcome. Another TEP member commented that the current design could result in a high screening rate but that does not necessarily mean that there is adequate follow-up.
  - The project team acknowledged the TEP's concerns and noted that some quality measures intentionally combine two steps, screening and follow-up, into a single measure. The team noted that while this design is not ideal for clinical quality improvement because it merges distinct concepts, it is a common approach across measures (e.g., BMI and hypertension). The rationale behind this approach is that it aligns with CMS' goals of implementing a manageable number of measures and ensuring that screening results lead to meaningful action. Specifically, it helps ensure that abnormal screening results lead to appropriate, individualized follow-up care.
  - One TEP member suggested the measure be divided into two distinct measures, one for screening and one for follow-up. A patient advisor TEP member highlighted the importance of keeping follow-up as part of the screening process from a patient perspective. Another TEP member cautioned against adding more measures because of provider burden.
  - One TEP member suggested that the measure remain as one measure with two rates: (1) the rate of screening for depression among all eligible patients and (2) the rate of documented follow-up plans among patients who screen positive for clinically significant depression. The member stated that, to assess clinical significance, the screening tool would need to be specified in the system and a

programmed threshold could automatically place people into this second population.

  - The project team responded that combining screening and follow-up into a single measure aligned with CMS's goal of implementing a manageable number of measures and that the team has considered improving the measure by refining the numerator to capture information about the exact tools used and the specific results rather than grouping them into broad SNOMED CT categories. The change could also support stratifying the measure into two distinct groups for more precise reporting.

- Another TEP member noted that there are a large number of qualifying encounters for this measure, including physical therapy visits, and that the performance rate would not likely be high, given the number of qualifying encounters and the effect that has on the denominator size. The member felt that decreasing the number of qualifying encounters would improve the performance rate and added that this measure requires annual screening and documentation of a follow-up plan, regardless of whether the patient already has a plan and a treatment in place.
  - The project team clarified that the measure does not require a screening on every eligible encounter and rather looks at all the eligible encounters during the performance year to see when the last screening was performed. The measure then uses this encounter to ascertain whether the screening was negative or positive and if positive, whether follow-up was performed.
  - The project team also responded that the TEP's concern has also been shared by measure implementers. The team explained that the measure has received preliminary approval to include an exclusion for patients who have a depression diagnosis and are in an active treatment plan for depression during the measurement period. Additional exclusions include the diagnosis of personality disorder, schizophrenia, or psychotic disorder, and pervasive development disorder, which are in line with the current exclusion of bipolar disorder. These exclusions also aligned with the exclusions for CMS159: Depression Remission at Twelve Months. The team pointed out that the changes were intended to bring the measure back to its original intent of a screening and follow-up measure. Three TEP members agreed with the plans for exclusions and aligning the measures. One TEP member suggested ensuring that cognitive conditions also apply as an exclusion if the patient is unable to participate in the screening.

- One TEP member shared that the setting and context of the screening is important. The member suggested that patients may screen positive for depression without having depression as a condition because they are screened in the context of an acute setting such as urgent care or an emergency department. The member commented that limiting the

settings in which the screening is provided (e.g., to primary care) might make the measure more reliable.

- Two TEP members questioned the need for physical or occupational therapists to screen for depression because they might not have the clinical expertise to assess whether a positive screening is clinically significant. Another TEP member shared that when their practice screens for depression, it is often difficult to refer the patient to psychiatry because of provider availability. The member noted that this makes the measure lose some of its utility. Two additional members expressed concerns about the difference between screening positive and meeting the clinical threshold for diagnosis with depression, noting that many clinicians are not aware of the clinically significant thresholds for each instrument. One TEP member strongly recommended standardizing this measure's specifications to include clinically significant thresholds to ensure valid determinations of depression.
- The project team remarked that some encounter types, such as physical and occupational therapy encounters, are included in the measure at CMS's direction and that the measure's intent is to document a follow-up plan for a positive depression screening rather than diagnose or treat depression. This nuance addresses the concern that not all providers reporting the measure have the content knowledge to accurately diagnose or treat depression because all can act on making a follow-up plan. The project team will consider including clinically significant thresholds in a future iteration of the measure. The team confirmed that only certain types of providers can diagnose and treat depression, while other providers can refer patients to their primary care providers or to specialists.
- One TEP member who is also part of the EWG for this measure commented that the list of qualifying encounters had been reviewed extensively by the EWG and that the group has made recommendations for removal of encounters in settings where depression screening and follow-up are not expected to take place. However, the project team noted that some encounter types, such as physical and occupational therapy encounters, are included in the measure at CMS's direction.

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

Results from data analysis. The team evaluated two maintenance analysis questions:

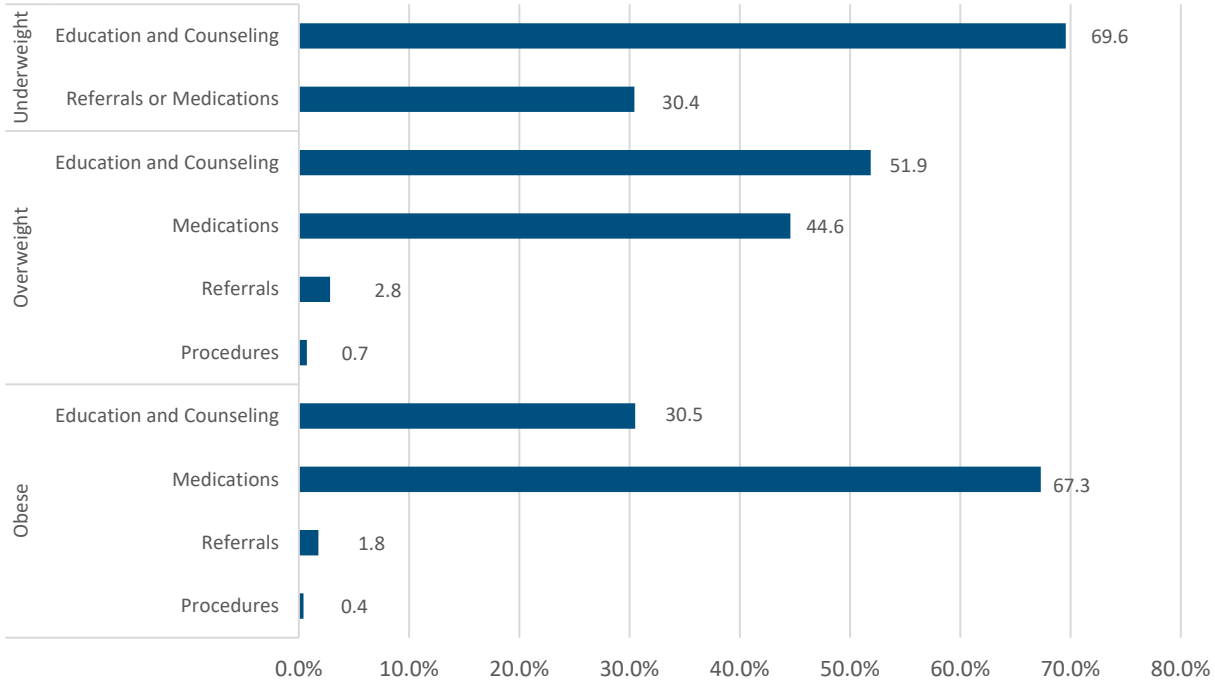
1. For patients in the underweight and overweight categories who meet the measure numerator, how frequently is each follow-up plan documented and which follow-up plans are not documented?

2. For patients in the underweight and overweight populations who do not meet the measure numerator, is there documentation in the clinical notes of a follow-up plan that is not being captured by the codes in the measure specification?

Data from these questions can help identify whether the follow-up plan value sets include appropriate codes. Findings can also help identify opportunities to expand value sets for frequently used concepts, opportunities to replace or remove follow-up plan concepts with 0% usage, and coding gaps when commonly used follow-up plan codes are missing from the value set.

Regarding the first analysis question, the project team queried the structured data in the UCDH EHRs to identify documented follow-up plans for patients meeting the measure numerator. The team reviewed the data to determine how frequently follow-up plans were documented. As shown in Exhibit 7, the project team found that most patients in the underweight category (*n* = 207) receive follow-up related to education and counseling, while most patients in the overweight category (*n* = 3,046) receive follow-up related to education and counseling or medication. Most patients in the obese category (*n* = 6,147) receive follow-up related to medication. The analysis found two types of follow-up plans with no usage across all BMI categories: dietary assessment (e.g., assessment of nutritional status, nutrition intake assessment, dietary intake assessment using food frequency) and regimen/therapy (e.g., nutritional therapy, weight monitoring, nutritional monitoring).

Exhibit 7. Percentage of Follow-up Type, by BMI Category in 2024



Note. From University of California, Davis, Health system electronic health record data for Performance Year 2024 (January 1, 2024–December 31, 2024).

To address the second analysis question, the AIR EC eCQM team reviewed a sample of medical records from UCDH patients classified as "underweight" or "overweight" but who did not meet the numerator criteria for follow-up. Among 97 patients in the underweight category, 19 (20%) had documentation of follow-up related to their weight/BMI identified during manual chart review. Some of these patients received a referral to a specialist – either a dietician, gastroenterology, or endocrinology. Other records included documentation of healthy weight education in free text notes or documentation of relevant procedures (e.g., gastrostomy tube placement). The remaining 78 patients in the underweight category did not have evidence of follow-up in their medical records. In addition, nearly all 47 patients in the overweight category whose records were sampled for review did not have documentation of follow-up in their medical records.

On the basis of these findings, consultation with the EWG, and supporting evidence from the literature, the project team proposed refining the measure as follows:

- adding a Medical Reason exception for patients whose body adiposity measures do not warrant follow-up;

- adding follow-up options such as procedures for endoscopy, imaging, or laboratory testing to account for medical-related interventions for patients in below- or above-normal BMI categories;
- adding referral codes for medical evaluations, such as endocrinology, hematology, and oncology, to the follow-up options for patients in below- or above-normal BMI categories; and
- updating the encounter code value set by removing certain behavioral health codes that are not associated with medical or psychiatric visits and singular gynecologic service codes.

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

Question Posed to the TEP

What feedback do you have on these proposed measure updates?

The TEP held the following discussion on this measure:

- One patient advisor TEP member emphasized the importance of approaching BMI screenings in ways that considered patient privacy and comfort.
- Another TEP member noted that there is often not a formal follow-up plan recorded for patients who were barely overweight, which influences the performance rate because obese and overweight patients are grouped together. The member suggested making a distinction between overweight and obese patients. For example, if a BMI of 25 to 30 is overweight and above 30 is obese, but only a BMI of above 30 would require a follow-up plan and documentation. Another TEP member suggested to have a minimal plan for the overweight category and a more prescriptive intervention for the obese category. The member acknowledged the previously discussed flaws in using BMI to measure weight health and the prevalence of glucagon-like peptide-1 receptor antagonist (GLP-1) medications for patients in the obese category. Another TEP member agreed with this point and added that there are variations around the meaning and clinical relevance of the overweight category particularly for elderly adults.
  - The project team members responded that they would consider this separation in the measure logic to distinguish between patients in the obese and overweight categories. Another member of the project team added that, because of the epidemiologic data showing that an aggressive approach is not supported in clinical practice for the overweight category, the team is actively looking at ways to tailor the measure to better account for the difference between a BMI of 25 to 30 and a BMI of over 30.

- Another TEP member noted that access to GLP-1 medication is a significant problem and that the UCDH population might have relatively higher rates of medication use whereas other patient populations might have more barriers to getting medication treatment. A second TEP member agreed with this concern about patient access to medications because of the cost.
    - The TEP member also cautioned the project team that this measure was one of the measures for the Maryland Medicare model of value-based care and it had to be excluded from the model for technical reasons. The member noted for the team's awareness that there was an issue in the measure's implementation. The project team thanked the member for this information.
- One TEP member commented that the education and counseling components of this measure relies on time-based billing codes for clinicians to provide the information. Residency-based clinics do not use time-based codes and might be excluded from being captured by this measure for that reason. The project team acknowledged this limitation.
    - The TEP member also shared that primary care physicians managing weight loss might see patients regularly without patients needing specialist referral, but these visits are not easily trackable. If patients do not meet minimum time requirements or consistent measurements (like weight), the counseling code often cannot be applied.
    - The project team responded that, depending on the accessibility of certain SNOMED CT codes included in the follow-up plans, there are some options that might not require time components. The TEP member agreed that those options could be used if the clinician's technology infrastructure supports them. However, an academic center has more resources than a small rural clinic. The project team agreed and noted that many academic clinics still bill by time and use Z codes to indicate that counseling have been addressed. Specifically, there are codes such as an ICD-10CM diagnosis code, and so there are other ways to get the credit for the education and counseling component.

QID #102/CMS129: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients—Proposed Measure Updates

Results from expert workgroup. The team discussed the measure with a prostate cancer EWG to examine ways to improve the measure and make it more meaningful. The EWG recommended the following updates:

- Update the measure so that the title and measure specification align with the avoidance of advanced/whole body imaging, not only bone scan.

- Remove the requirement for prostate cancer treatment for inclusion in the denominator.
- Update the measure logic so that the denominator allows tumor-staging results for T1a and T2a to be either null or not null.
- Implement an index date on which to base advanced imaging.
  - The index date will be based on the last low-risk or very low risk Gleason score from biopsy.
  - Advanced imaging should be avoided for 12 months or until treatment is initiated, whichever comes first.
- Update the measure so that it is telehealth eligible.

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

Question Posed to the TEP

What feedback do you have on these proposed measure updates?

The TEP held the following discussion on this measure:

- One TEP member noted that this measure is unusual because it is counting the absence of a bone scan rather than the presence of one. The member noted that normally this type of measure is an inverse measure in which lower is better.
  - The project team confirmed that, for this measure, the affirmative response is for not recommending a bone scan and so a high rate for this measure would indicate a high rate of not recommending a scan.
- Another TEP member asked what was meant by "advanced imaging" and whether MRIs are considered advanced imaging, as those tests are often used on the prostate as part of surveillance in low-risk cancer cases. The member said that the definition of "advanced imaging" was not clear in the measure specifications.
  - The project team clarified that scans of the prostate itself are allowable, but imaging of other parts of the body would not meet avoidance criteria. The project team will make sure that the avoidance-of-prostate-cancer-imaging definition is clearly stated in the measure specifications. The project team added that the intent of the measure is to focus on the avoidance of bone imaging, which may be performed through a variety of modalities (e.g., PET scan, full-body MRI).
- One TEP member asked if it was necessary to include Tumor, Node, Metastasis (TNM) cancer -staging results in the denominator. The member asked if, in the case of metastatic prostate cancer, a patient would still be included in the denominator if their staging is not defined.

  - The project team responded that a patient without staging defined would be included in the denominator, but their Gleason score would still be at low or very low risk. The team felt that too many patients would be excluded if tumor staging were a requirement. Additionally, most patients are no longer receiving digital exams, but the inclusion remains. Without it, the measure could incidentally include patients with N- or M-stage cancer, which is far more advanced than T-stage
  - The TEP member suggested testing the proposed change with users to allow tumor-staging results for T1a and T2a to be either null or not null.

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 patient advisor TEP member reiterated the need to consider the distinction between the overweight and obese BMI categories, as many people who fit into those categories may have significant muscle mass. Further, the TEP member noted that it may be more useful to measure the waist to hip differential.
- They also advocated for more attention to and treatment for those who are underweight, explaining that frailty is a significant problem among the elderly, as well as younger individuals who might be more likely to fall or break a bone. The TEP member noted the importance of bone scans and that bone density scan results may indicate larger issues.

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.
- Consider potential future changes to the measures under maintenance.

The next TEP meeting is tentatively planned for fall 2026. The project team will follow up with TEP members via email to schedule the meeting and share updates.

Appendix A. TEP Members

EC eCQM TEP attendance: Base Year Meeting 2	Meeting attendance
Hadeel Alkhairw, MD, FACP, MS-HQSM, Dip ABOM	Yes
Ashley Bates, CNA, CMA	No
Karri Brown, MBA, LPN	No
Zahid Butt, MD, FACG	Yes
Jessica Dale, DNP, BS, RN	No
Stephen Foster, MD	Yes
Ben Hamlin, DrPH, FAMIA	Yes
Michael Hansen, MD, MPH, MS	No
Jenel Lansang, MSN, RN, MEDSURG-BC	Yes
Luming Li, MD	Yes
Robert McClure, MD	Yes
Precious McCowan, PhD	No
Samantha Pitts, MD, MPH	Yes
Anthony Sanchez	No
Christa Starkey	No
Andrew Talal, MD, MPH	Yes
Janice Tufte	Yes
Sandeep Vijan, MD, MS	Yes

Appendix B. EC 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
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
Zoe Sousane, QDM annual update lead

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

CDQ Solutions attendees
Chana West, testing lead

Appendix C. TEP Agenda

EC eCQM Technical Expert Panel 2025-2026 Project Year Meeting 2 Agenda

May 14, 2026 | 1:00—3:00 p.m. Eastern Time (ET)
Meeting ID: 987 1017 0667 **| Passcode:** .0nb8rTw81
Web Conference URL:
https://air-org.zoom.us/j/98710170667?pwd=CInauf8pCUJqnsvukoM0WyWGt1Y1j4.1

Time (ET)	Topic
1:00-1:20 pm	**Welcome and Roll Call** 1. Welcome members. Review meeting agenda and objectives. 2. Conduct TEP member roll call and review conflict of interest disclosures.
1:20-1:25 pm	**Technical Expert Panel (TEP) Roles and Responsibilities** • Review TEP member expectations.
1:25-1:30 pm	**TEP 2025-2026 Meeting 1 Recap** 3. Briefly review TEP feedback provided at the December 5, 2025 TEP meeting.
1:30-1:45 pm	**Patient and Caregiver Reflections: Lived Experience** 4. 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. 5. **Prompt:** Thinking about preventive mental and physical health screenings, what makes it easier—and what makes it harder—for patients to get those screenings?
1:45-2:05 pm	**Updates on CMS1331: Foot Assessment and Follow-up for Patients with Diabetes eCQM** • Share testing updates and next steps.
2:05-2:45 pm	**Updates for Measures Under Maintenance** • Discuss updates for measures under maintenance: (1) QID #134/CMS2: Preventive Care and Screening: Screening for Depression and Follow-Up Plan (2) QID #128/CMS69: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan (3) Other maintenance measures with potential changes
2:45-2:55 pm	**Patient and Caregiver Reflections: TEP Discussion** 6. **Prompt:** Considering today's discussion, do you have any additional thoughts, concerns, or recommendations?
2:55-3:00 pm	**Meeting Wrap-Up and Next Steps** • Review next steps and action items.

Appendix D. Option Year 1 Meeting 2 Handout

Eligible Clinician Electronic Clinical Quality Measure
Development, Evaluation, and Implementation Project

2025-2026 Project Year Technical Expert Panel Meeting 2

Measure Specifications Handout

Background

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

- **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.
- **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.

As part of the annual update process, the project team is working with CMS, 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 the current (i.e., Performance Year 2026) specifications for **three eCQMs and one CQM undergoing maintenance** that the EC eCQM project team anticipates will need changes in next year's annual update (see Exhibit 1). The project team will discuss these eCQMs with the TEP at the May 14, 2026 TEP meeting. The handout also includes **updated specifications for the measure under development, an endocrinology category measure currently titled, *CMS1331: Foot Assessment and Follow-Up for Patients with Diabetes.*** We look forward to discussing plans for these measures in greater detail at the upcoming TEP meeting.

Exhibit 1. Measures Under Maintenance for Discussion at the 2025-2026 Project Year TEP Meeting 2

Category and measure type	Measure ID	Measure name
Behavioral Health/Psychiatry (eCQM)	Quality ID 134/ CMS2	Preventive Care and Screening: Screening for Depression and Follow-Up Plan
Body Mass Index (eCQM)	Quality ID 128/ CMS69	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
Prostate Cancer/Urology (eCQM)	Quality ID 102/CMS129	Prostate Cancer Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients
Maternity Care (CQM)	Quality ID 335	Maternity Care: Elective Delivery (Without Medical Indication) at < 39 Weeks (Overuse)

Maintenance Measure Specifications

Quality ID 134/CMS2: Preventive Care and Screening: Screening for Depression and Follow-Up Plan

2026 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.

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

2026 eCQM Specifications (Version Number: 14.0.000)

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.

Quality ID 102/CMS129: Prostate Cancer Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients

2026 eCQM Specifications (Version Number: 15.0.000)

MEASURE TYPE:

Process

DESCRIPTION:

Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low (or very low) risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy who did not have a bone scan performed at any time since diagnosis of prostate cancer

DENOMINATOR:

All patients, regardless of age, with a diagnosis of prostate cancer at low (or very low) risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy

DENOMINATOR EXCLUSIONS:

None

NUMERATOR:

Patients who did not have a bone scan performed after diagnosis of prostate cancer and before the end of the measurement period

The full measure specifications are available here.

Quality ID 335: Maternity Care: Elective Delivery (Without Medical Indication) at < 39 Weeks (Overuse)

2025 CQM Specifications

MEASURE TYPE:

Outcome – high priority

DESCRIPTION:

Percentage of patients, regardless of age, who gave birth during a 12-month period, delivered a live singleton at < 39 weeks of gestation, and had elective deliveries (without medical indication) by cesarean birth or induction of labor.

DENOMINATOR:

All patients, regardless of age, who gave birth during a 12-month period delivering a live singleton at < 39 weeks of gestation

NUMERATOR:

Patients who had elective deliveries (without medical indication) by cesarean birth or induction of labor

The full measure specifications are available here.

Measures Under Development Specifications

CMS1331: Foot Assessment and Follow-Up for Patients with Diabetes – Draft Narrative Measure Specifications

MEASURE TYPE:

Process

DESCRIPTION:

Percentage of patients 18 years of age and older with diabetes who receive all of the following: a lower extremity neurological examination, a vascular examination, a visual inspection, and have a documented follow-up plan of care if any of the results are abnormal during the measurement period.

DENOMINATOR:

Patients 18 years of age and older at the beginning of the measurement period who have diabetes and at least one qualifying encounter during the measurement period.

DENOMINATOR EXCLUSIONS:

Patients who had a bilateral amputation at the foot or above, or both a left and right foot amputation, before the start of the first qualifying encounter.

Patients who are in hospice care for any part of the measurement period.

NUMERATOR:

Patients who receive all of the following: a lower extremity neurological examination, a vascular examination, and a visual inspection during the measurement period, and have:

- All normal or incidental exam findings or
- At least one abnormal exam finding and have a documented follow-up plan of care within 7 calendar days of the qualifying encounter where an abnormal finding was documented.

DEFINITIONS:

Lower Extremity Exams:

- **Lower extremity neurological exam:** A documented evaluation of foot sensory abilities using at least one test consisting of either a 10-g monofilament or Ipswich (soft) touch test
- **Lower extremity vascular exam:** A documented evaluation of foot vascular status, including at least one pulse exam
- **Lower extremity visual inspection:** A documented evaluation of foot dermatological and musculoskeletal status to assess for skin and/or toenail integrity and presence of deformity

Lower Extremity Exams – Normal or Incidental Findings:

- Lower extremity neurological exam – normal findings: Normal sensation or touch discrimination present
- **Lower extremity vascular exam – normal or incidental findings:** Findings indicative that a lower extremity vascular foot exam was performed, however, incidental findings (e.g., bounding pedal pulses) are not always attributed solely to diabetic foot conditions
- **Lower extremity visual inspection – normal or incidental findings:** Findings indicative of a lower extremity foot exam being performed, however, incidental findings (e.g., intact skin, fungal infections, thickened toenails, calluses, bunions) are not always attributed solely to diabetic foot conditions

Lower Extremity Exams – Abnormal Findings:

- **Lower extremity neurological exam—abnormal findings:** Sensation diminished, absent, or abnormal in one or both feet
- **Lower extremity vascular exam—abnormal findings:** Pulse(s) diminished, absent, or abnormal in one or both feet
- **Lower extremity visual inspection—abnormal findings:** Presence of ulcer, deformity, fissure, or blister in one or both feet.

Follow-Up Plan of Care:

- **Follow-up plan of care:** Documentation of treatment to be conducted as a result of at least one abnormal foot exam finding. A follow-up plan includes any of the following and must be documented within 7 calendar days of the qualifying encounter where an abnormal finding was documented:

- Referral to a footcare specialist (for example, to a podiatrist, vascular specialist, neurologist, physical therapist, orthopedic/foot surgeon, general surgeon, or wound care specialist)
- Order or intervention for therapeutic footwear
- Order or intervention for offloading
- Order to follow-up within 12 months (repeat visit with clinician)
- Documentation that the patient is under the active care of a specialist who provides diabetic foot care

About the American Institutes for Research®

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