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Memo

To: Joel Andress, Centers for Medicare & Medicaid Services (CMS)

From: Sarah Paliani, Keirsha Thompson (National Committee for Quality Assurance), Jayanti Bandyopadhyay (Mathematica)

Date: 3/23/2022

Subject: March 3, 2022, Technical Expert Panel Meeting 4, Session 1: Review of Diabetes-Related Amputation Measure Information Gathering and Potential Concepts

On March 3, 2022, the Electronic Clinical Quality Measures Development and Maintenance for Eligible Clinicians (EC eCQM) project convened the first session for Meeting 4 of its technical expert panel (TEP) via webinar. The goal of this meeting was twofold: (1) provide an overview of the information-gathering efforts we used to generate the initial set of potential quality measure concepts related to reducing diabetes-related amputation and (2) solicit TEP input on the importance, usability, and feasibility of the measure concepts. Nine TEP members attended the call, including two guest experts with clinical expertise in diabetes care (see Appendix A for a list of meeting participants).

This memo summarizes the TEP meeting discussion, including the TEP's comments on the importance, usability, feasibility, face validity, and prioritization of measure concepts, and it describes next steps.

Introduction and background

The Centers for Medicare & Medicaid Services (CMS) directed the EC eCQM team to develop new clinical quality measures focused on diabetes care, with an emphasis on prevention of diabetes-related amputation. First, we reviewed recent literature and conducted a scan of existing quality measures related to diabetes. We then identified five concepts (Table 1) that are the strongest options for implementation in the Merit-Based Incentive Payment System (MIPS) program, given that they address key points of risk for diabetes-related amputation along the clinical care pathway. To open the meeting, the TEP members briefly introduced themselves and the EC eCQM team provided a high-level overview of the task. The team reviewed why diabetes-related amputation is important, presented a care pathway for diabetes-related amputation (Figure 1), and provided an overview of clinical topic areas that inform potential measure concepts related to reducing diabetes-related amputation rates.

Figure 1. Understanding the pathway to amputation

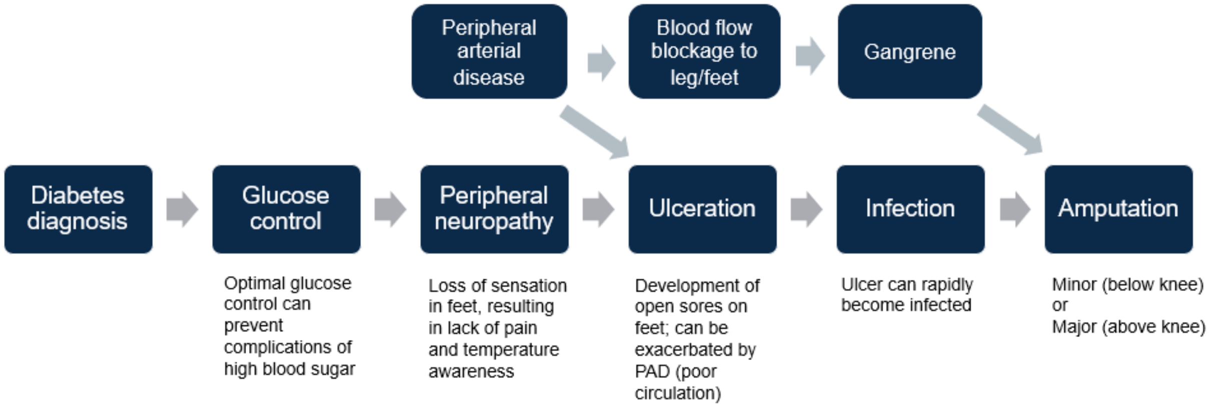

Table 1. Potential concepts for the diabetes-related amputation measure

Measure concept option	Intent/Rationale	Measure description
Option 1: Peripheral arterial disease (PAD) screening for patients with diabetes	Promote early identification of PAD and connect patients with treatment to prevent subsequent complications of PAD which lead to amputation	The percentage of patients with diabetes who receive a vascular assessment to assess for PAD during the measurement period. Vascular assessment includes a foot pulse exam and an ankle-brachial index for patients with abnormal findings on the pulse exam.
Option 2: Assessment of ulcer risk and follow-up for high-risk patients	Facilitate clinicians' ability to identify patients at high risk for lower extremity ulcer and ensure they receive treatment to mitigate their risk for ulceration and subsequent amputation	The percentage of patients with diabetes who are assessed for ulcer risk and receive timely follow-up if identified as high risk
Option 3: Therapeutic footwear for high-risk patients	Encourage diabetic patients at high risk for lower extremity ulcers to wear footwear that properly protects their feet, addresses foot abnormalities, and minimizes ulcer risk	The percentage of patients who are at high risk of ulcers who receive therapeutic footwear to prevent ulcers
Option 4: Offloading for diabetic foot ulcer	Promote healing and prevent worsening infection in patients with ulcers	The percentage of patients with a diabetic foot ulcer who receive offloading treatment
Option 5: Patient-reported knowledge of or engagement in foot self-care	Facilitate patients' knowledge of or confidence in the behaviors that prevent infection and ulcer formation	The percentage of patients who report knowledge of, self-efficacy or engagement in foot self-care practices such as daily foot inspection, foot hygiene, and appropriate footwear

Summary of TEP discussion

The EC eCQM team identified five potential measure concepts for development that would contribute to the prevention of diabetes-related amputation: (1) peripheral arterial disease (PAD) screening, (2) foot ulcer risk assessment and follow-up, (3) footwear for ulcer prevention, (4) offloading for ulcer treatment, and (5) patient self-care education, knowledge, or self-efficacy. We reviewed each concept with the TEP to collect their input on the relative significance of each component of diabetes care to inform the development of process and composite measures addressing diabetes-related amputation.

Overall, the TEP agreed that prevention of diabetes-related amputation is an important topic for measurement. The TEP commented on the clinical care pathway presented (Figure 1) and noted that it correctly captures the key areas to focus on for measure development. Experts provided feedback on the clinical topic areas and potential measure concepts presented, as described in the sections below. In addition, the TEP highlighted considerable equity concerns that must be taken into account in pursuing any of the potential measure concepts.

PAD screening. Overall, the TEP agreed that a process measure addressing PAD screening is important, but the group expressed concern about whether this concept is the highest priority for a measure aimed at reducing amputations. Experts suggested that a PAD screening measure may be too late in the clinical pathway to amputation to improve outcomes. They encouraged the team to focus on upstream aspects of diabetes-related amputation prevention, such as home-based care or patient education on self-management of diabetes. One TEP member shared that if this measure was developed, incentives would be needed to encourage clinicians to conduct PAD screenings regularly. Overall, the group felt that the body of evidence highlighting the benefits of PAD screening is not substantial enough to support a measure at this time. Further, one member highlighted that this measure concept would not solve health equity issues regarding access to vascular specialists and treatment that also play a large role in the prevalence of amputations, although it could highlight those disparities.

Foot ulcer risk assessment and follow-up. The TEP discussed the importance of ulcer risk assessment as a part of comprehensive diabetic foot exams in preventing PAD and diabetes-related amputation. The group expressed interest in this potential measure concept, noting that evidence links regular foot exams (which include ulcer risk assessment) to reduction of diabetes-related amputation risk. Some TEP members expressed concern that clinicians may not currently use formal risk assessment tools (or at least do not document the use of such tools) and would therefore need to implement a new process to encourage the use of these tools. The TEP noted that this measure would run the risk of underutilization, with most providers not selecting this measure for reporting because it would require them to adopt new risk assessment tools, processes, and documentation. In addition, several members noted the importance of clearly defining the appropriate follow-up needed after a patient undergoes a foot ulcer risk assessment. The group noted that without clearly defining appropriate follow-up, there may be wide variation in the types of follow-up provided to patients, leading to potential disparities in care.

Therapeutic footwear for high-risk patients. The TEP expressed strong interest in developing a measure focused on therapeutic footwear, with clear support from the diabetes care experts. The group felt that therapeutic footwear is underutilized, but critical to preventing ulcer formation, and subsequent amputation, in high-risk individuals. The TEP noted that Medicare stipulates clear criteria for patients for whom therapeutic footwear is considered medically necessary and is a covered benefit. However, one diabetes care expert noted that there is considerable administrative effort required to certify the medical necessity of therapeutic footwear and obtain Medicare coverage. Another diabetes care expert highlighted an equity issue, noting that many high-risk patients cannot access or afford appropriate footwear and become frustrated when directed to purchase therapeutic shoes. One of the patient representatives underscored that in order for a therapeutic footwear measure to meaningfully reduce amputations, such barriers to access must be addressed. Overall, the TEP concluded that therapeutic footwear would be a meaningful clinical topic area to assess, and the measure should capture not only whether the patient is provided therapeutic footwear, but also whether the provider follows up with the patient after the initial fitting of the shoe.

Offloading for diabetic foot ulcer. The TEP expressed interest in developing a measure focused on the use of offloading devices, with clear support from the diabetes care experts. The group felt that offloading is underutilized and critical to promoting ulcer healing, and therefore preventing subsequent amputation. One of the diabetes care experts shared that although clinical practice guidelines underscore the usefulness of offloading devices in reducing amputation risk, getting patients to comply with offloading rarely occurs because patients find it difficult to stay off their feet and keep the device on consistently. TEP members raised many of the same concerns as they did for therapeutic footwear related to affordability, access, convenience, and patient compliance. They reiterated that for offloading, as for therapeutic footwear, it would also be important for patients to receive follow-up after the initial offloading device fitting.

Patient reported education, knowledge, or self-efficacy. TEP members expressed strong support for a measure that assesses patient reported education, knowledge, or self-efficacy on diabetic foot care. The group felt that clinicians fail to properly educate patients on what they can do to mitigate amputation risk. Diabetes care experts highlighted that foot care specifically is an area in which education is lacking; although clinicians may sufficiently provide education about other areas of diabetes self-care, patients consistently do not demonstrate sufficient knowledge of how diabetes leads to amputation and prevention tactics. TEP members discussed that a measure in this area could take the form of a patient-reported outcome measure (PROM), as this might provide a useful way to track patient understanding of their own diabetes management. One TEP member shared a published systematic review of existing PROMs related to diabetic foot and ankle care that could be considered for use in the measure. The TEP noted that such a measure would need to be culturally sensitive and include components that account for related areas that impact a patient's understanding of their condition, such as health literacy and social determinants of health. A few experts suggested that a PROM of diabetes self-management should also capture the caregiver's knowledge, given the critical role that caregivers play in diabetes management strategies for some patients. The patient representative suggested that this measure would need to provide guidance on what clinicians can do to improve patient knowledge of self-care, such as demonstrated best-practice education approaches. Overall, the TEP agreed that patient education and advocacy is a critical component of successful management of diabetes and amputation prevention.

Prioritization of clinical concepts. The TEP did not identify a single potential measure concept as the most important for development. Overall, there was an evenly split interest between the ulcer risk assessment and patient education concepts, with the therapeutic footwear concept also garnering substantial support from the TEP. Although the group felt that all presented concept areas are important in preventing amputation, they expressed the least enthusiasm for developing a measure that captures PAD assessments, given the limited body of evidence related to PAD screening. Throughout the discussion, the experts emphasized the importance of creating a measure that encourages providers to help patients gain the skills and knowledge needed to support their health and prevent adverse outcomes such as amputation.

Composite measure considerations. The EC eCQM team presented a potential composite quality construct that would seek to reduce diabetes-related amputations by encouraging high-quality care across the clinical pathway, from diabetes diagnosis to nontraumatic lower-extremity amputation. The potential construct included measures focused on prevention of diabetes and cardiovascular complications, trauma prevention (that is, footwear), peripheral neuropathy management, PAD management, and wound care. The TEP shared that although the proposed composite quality construct captured important factors contributing to amputation, they did not support the development of a composite measure specifically focused on reducing amputation. Members found that it did not make sense to combine upstream and downstream factors along the clinical pathway to amputation, especially given the fact that the measure would not account for variability of clinician experience with each component of the pathway assessed. One expert shared an example of how one clinician in the care pathway may have experience with wound care, while other providers might not. Thus, it would be unfair to implement a measure that holds providers accountable for all aspects of the clinical pathway. Several members noted the difficulty in weighing the various components of the construct to create an actionable, combined score; TEP members did not express confidence that a composite measure would produce a meaningful score that could be used for quality improvement efforts to reduce diabetes-related amputations. One expert pointed out that this composite would involve an interdisciplinary clinical team, rendering the construct less useful at the individual clinician level of accountability. The group explained that different clinicians may be responsible for various components of the composite measure, making it difficult to hold one individual clinician accountable for all elements of the composite. Overall, the TEP suggested that the team move forward with development of a process measure and eventually consider a more meaningful composite measure topic.

Next steps

The EC eCQM team will present the information gathered for the diabetes amputation-related measure concepts to CMS, who will decide on a final measure concept(s) to pursue for development. Once CMS selects a concept(s), the team will draft measure specifications and present our chosen concept(s) to our Expert Work Group (EWG) to solicit additional feedback ahead of measure testing. The EWG is a separately convened group of practicing clinicians and experts focused on diabetes care. This group will advise the EC eCQM team on measure specification details throughout measure development and testing.

Appendix A

Meeting Participants

Table A.1. TEP members and affiliations

TEP member name	Credentials	Organization affiliation/location	Attended meeting?
Donald Casey	M.D., M.B.A, M.P.H.	Rush University; Chicago, IL	Yes
James Colbert	M.D.	Blue Cross Blue Shield of Massachusetts; Boston, MA	No
Fran Cunningham	Pharm.D.	Department of Veterans Affairs; Hines, IL	Yes
Barbara Kivowitz	Patient representative	Sutter Health; San Francisco, CA	Yes
Luming Li	M.D.	The Harris Center for Mental Health and IDD; Houston, TX	No
Bridget Lynch	M.D., M.P.H.	Presbyterian Medical Group; Albuquerque, NM	Yes
Precious McCowan	Patient representative	End-Stage Renal Disease Network 14; Dallas, TX	Yes
Robert McClure	M.D.	MD Partners, Inc.; Lafayette, CO	Yes
Michael Perskin	M.D.	American Geriatrics Society; New York, NY	Yes
Lori Popejoy	Ph.D., R.N., F.A.A.N.	University of Missouri; Columbia, MO	No
Christa Starkey	Patient representative	Lone Oak, TX	No

Table A.2. TEP guest members and affiliations

TEP member name	Credentials	Organization affiliation/location	Attended meeting?
Vickie Driver	D.P.M., M.S., FACFAS	Wound Care and Hyperbaric Centers at INOVA Healthcare	Yes
Jennifer Green	M.D.	Duke University School of Medicine	Yes

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Memo

To: Joel Andress, Centers for Medicare & Medicaid Services (CMS)

From: Nikkilyn Morrison, Alaya Martin, Erin Finnessy, Jayanti Bandyopadhyay, and Llew Brown

Date: 3/23/2022

Subject: March 4, 2022, Technical Expert Panel—Meeting 4, Session 2: Review of Health Equity Measure Information Gathering and Potential Concepts

On March 4, 2022, the Electronic Clinical Quality Measures Development and Maintenance for Eligible Clinicians (EC eCQM) project convened the second session for Meeting 4 of its technical expert panel (TEP) via webinar. The goal of this meeting was twofold: (1) to provide an overview of our information-gathering efforts used to generate the initial concepts for a health equity measure and (2) to solicit TEP input on the importance, usability, and feasibility of the health equity measure concepts. Twelve TEP members attended the call, including three guest experts with clinical expertise in health equity (see Appendix A for a list of meeting participants).

This memo summarizes the meeting discussion, including the TEP's comments on the importance, usability, feasibility, face validity, and prioritization of the measure concepts, and it describes the next steps for the health equity measure.

Background on the Health Equity Measure

CMS directed the EC eCQM team to generate and prioritize new measure concepts for a broadly applicable health equity measure for potential use in the Merit-Based Incentive Payment System (MIPS) program. For this task, CMS indicated that (1) measure concepts should be related to access, treatment, outcomes, and prescriptions; (2) measures should apply to all clinician types and not be disease specific; and (3) measures should not be limited by data source, though administrative Medicare claims are preferred.

After reviewing recent literature, assessing the availability and quality of potential data elements, and soliciting feedback from health equity and measurement experts, we determined the three concepts in Table 1 to be the strongest options for implementation in the MIPS program.

Table 1. Potential concepts for the health equity measure for implementation in MIPS

Measure concept option	Rationale	Measure description
Option 1: Develop a de novo measure to assess the completeness of patient demographic data, specifically race, ethnicity, and preferred-language data collected at the patient level	Would fill a critical gap in CMS's ability to assess equity in MIPS, specifically in the ability to stratify quality measures by these characteristics	Percentage of patients with self-reported race, ethnicity, and preferred language recorded as structured data in the electronic health record

Measure concept option	Rationale	Measure description
Option 2: Require clinicians to report on a recently developed measure of screening for social drivers of health in MIPS (MUC2021-136)	Would be available to implement as soon as it is approved and will prompt implementers to prepare for future measures that focus on equity-related priorities	Percentage of beneficiaries 18 years and older screened for food insecurity, housing instability, transportation problems, utility help needs, and interpersonal safety
Option 3: Respecify a measure on the receipt of appropriate language services	Would improve access to services that are the foundation of health literacy to fill the population health measurement gap CMS identified in MIPS	Percentage of limited-English-proficient patients with documentation that they received the initial assessment and discharge instructions supported by trained and assessed interpreters, or from bilingual providers and employees assessed for language proficiency

Summary of TEP Discussion

The EC eCQM team presented the health equity measure concepts, along with the benefits and challenges of each, to the TEP. We solicited feedback on the concepts, using the National Quality Forum Measure Evaluation Criteria to guide discussion around measure importance, usability, and feasibility. We also asked for feedback from the TEP on whether each concept had face validity or potential unintended consequences. Twelve TEP members were in attendance: 9 of the 11 original TEP members, plus 3 guests with expertise in health equity. A full list of TEP members and their affiliations can be found in Appendix A. Dr. Tiffany Wiggins, of CMS, also observed part of the discussion.

Overall, the TEP was supportive of and agreed with the importance of developing a health equity measure. However, the TEP noted various considerations and concerns about each of the three concepts and their usability and feasibility, described in the sections below. Of the options presented, the TEP agreed that Measure Concept Option 1 should be prioritized for continued development based on its potential to improve demographic data collection and reporting in MIPS. However, the TEP also supported a health equity measure that combined the three concepts: collection of data on demographics and social determinants of health (SDOH) as well as provision of language services.

Option 1: Develop a de novo measure to assess the completeness of patient demographic data, specifically race, ethnicity, and preferred-language data collected at the patient level

Importance

- **TEP members agreed that a de novo measure that assesses the completeness of data on patient race, ethnicity, and preferred language would be an important addition to MIPS.** The TEP supported this concept as a foundational step toward collecting accurate data to monitor disparities in patients served by clinicians who participate in MIPS. A TEP member said adding this measure as a MIPS requirement would encourage the collection of demographic data on Medicare and non-Medicare patients alike, and another member said other equity initiatives might also benefit from having these data available, emphasizing the importance of collecting accurate information. However, one TEP member questioned whether it was more appropriate to hold health systems, rather than clinicians, accountable, noting that demographic data are usually collected during intake by nonclinician staff. Another member said that people forgoing care are those most affected by health inequities, and this measure would not capture this population.

Usability

- **TEP members said collecting demographic data would help solve data availability and quality issues to better monitor progress toward health equity.** However, one TEP member raised concerns that collecting race and ethnicity data without SDOH data, such as education level or income, could overemphasize the role of race on health outcomes. In response, other members said including SDOH data could severely limit the uptake of the measure and limit CMS's ability to look at racial and ethnic disparities that exist outside of SDOH needs. Another member said that although high-quality evidence of disparities exists, there is a lack of high-quality evidence to suggest that use of this measure (or one similar to it) would effect the change needed to eliminate these disparities.
- **One TEP member said creating a MIPS measure for the standardization of these data would help push electronic health record (EHR) vendors to make changes to their products.** This member said their organization cannot currently stratify its quality measures, even though it collects patient demographic data, due to barriers in its EHR and resistance from its EHR vendor to make changes that are not required. The member said tying the demographic data standardization to a MIPS measure and payment would facilitate changes that EHR vendors are otherwise not motivated to make, and it might also push health systems to connect race, ethnicity, and language to quality metrics.

Feasibility

- **All TEP members noted that, although this concept is an important first step to addressing health equity, there will be various implementation challenges for clinicians.** A few members said many patients have expressed concern about disclosing demographic information because (1) the categories offered on forms might not match the way patients self-identify or (2) patients might fear their demographic information could be used to discriminate against them. To address concerns that existing categories of demographics might not reflect local nuances, one TEP member said a "base minimum" of racial, ethnic, and language categories should be determined for reporting the measure, but the measure should also allow for additional categories that align with the local communities that clinicians serve.

  One TEP member expressed concern that, even if there are data standards to collect these data, clinicians will have trouble implementing these standards in uniform ways. Another member suggested looking to the "We Ask Because We Care" campaign, which tested and made final recommendations for best practices that can be used to collect patient demographic data, for guidance on how to ask these questions. The TEP also said patient education on why the data are being collected and how they will be used will be important to ensure that this measure functions as intended.

  Finally, TEP members all agreed that using claims forms, whether by creating new or using existing fields, would place a heavy burden on clinicians because they would need to submit these fields every time they filled out a claim. Given that many clinician practices collect patient demographic data in their EHR, the TEP agreed that this measure concept should be specified as an electronic clinical quality measure (eCQM), CQM, or both using EHR data.

Face validity

- **TEP members suggested two main modifications to improve this concept.** Several members said this concept should capture both demographic and SDOH data, instead of one or the other. According to the TEP, capturing SDOH elements could provide more context about patients' outcomes and prevent inaccurate conclusions about race being a biological reason for unequal outcomes. However, these TEP members acknowledged that there might be greater implementation concerns related to capturing SDOH data, as described in the Option 2 section. One member cautioned against the use of "self-reported" language in the measure description to describe patient data collected. Although self-reporting is considered the gold standard for collecting demographic data from patients, this quality measure itself could not capture or assess whether the data were actually self-reported. Instead, the measure could only capture if, not how, clinicians collected and reported the data to CMS.

Option 2: Require clinicians to report on a recently developed measure of screening for social drivers of health in MIPS (MUC2021-136)

Importance

- **TEP members said that although it is important to screen patients for social risk factors, there are ethical concerns with requiring screening but not follow-up**. However, clinicians who work in rural or underserved communities might not have the resources needed to adequately address patients' SDOH needs, and thus they could be unfairly penalized if the measure required follow-up. Overall, TEP members said it would be difficult to determine what appropriate follow-up would be for this measure, but they firmly believed the measure should not focus solely on screening.

Usability

- **The TEP generally had doubts about the usefulness of SDOH data when no additional action is required and questioned whether it was the clinician's responsibility to address these needs**. TEP members said requiring clinicians to screen for social risk factors places the burden of social issues on health care, which they felt was not the right attribution. One member said cross-sector partnerships with social or human services organizations could help health care organizations follow up with patients to meet their SDOH needs. But these partnerships, another member said, might be a flawed solution due to variation in the availability of community resources and issues with tracking and sharing SDOH data across organizations.

Feasibility

- **TEP members did not agree on accountability for reporting—specifically, whether reporting should be required from primary care clinicians only or from primary care clinicians *and* specialists.** Several TEP members said requiring primary care clinicians and specialists to report the measure would burden patients, who would be asked to complete these screenings for each clinician (and potentially for health plans that screen for social risk factors as well). They said it might be more appropriate to require primary care clinicians to screen for, follow up on, and track patients' needs, with acknowledgment that this would increase burden on primary care clinicians. In opposition, other TEP members said the sickest patients have several specialists and see their primary care clinicians less frequently. Therefore, if specialists are not required to report the measure, it might not capture these patients. One member said the goal of the measure should be to screen patients once annually and make that information available to all the patients' providers. As a rebuttal, another member noted issues related to data sharing across providers and said screening once annually might not be adequate because socioeconomic situations can change drastically during a one-year period.

- **The TEP said the measure should focus on screening patients across standard SDOH domains (such as food, housing, and transportation) instead of encouraging clinicians to use the same screening tool**. For health systems that already screen for social risk factors, they likely already have a preferred screening tool and processes to ensure screening results are documented. To reduce burden, CMS should try not to disturb existing workflows.
- **One TEP member noted potential issues with screening for interpersonal safety, which by law might require an immediate clinician response after a safety concern is expressed.** Because of these restrictions, it might not be feasible or appropriate to screen the patient asynchronously (for example, through intake paperwork or a patient portal). Another TEP member disputed this rationale and said screening for safety concerns is an important consideration.

Option 3: Respecify a measure on the receipt of appropriate language services

Importance

- **The TEP reached a consensus that patient language is an important SDOH domain and driver of health disparities, but a measure concept focused on language is too narrow in scope to have a meaningful impact on health equity**. To increase the scope, TEP members said the respecified measure would need to include language services not only for initial assessment and discharge, but for communication between visits and online (via telehealth or otherwise). One member also said communication preferences should not be limited to language alone but should include the preferences of patients who are neurodivergent or hearing impaired.

Usability

- **TEP members said the best practice is to collect data on both preferred written and spoken languages.** Because patients might prefer to speak one language and read and write in another, collecting both will ensure that clinicians and health systems can provide language services that meet patients' needs.

Feasibility

- **TEP members said the biggest challenge for this measure revolves around ensuring that services can address the diversity of languages preferred by patients**. One member said there are over 20 dialects of Arabic that are spoken and used this example to warn that clinicians might be unfairly penalized if there are no staff or resources available for patients who prefer less-common languages.

- **The TEP also said tracking language services provided at every encounter would significantly increase documentation burden for clinicians and health systems, which could further limit measure uptake**. One TEP member said this concept might be better specified as a structural measure rather than a process measure to focus on how and when language services are incorporated into a clinician's practice. This member said it might be more feasible to attest to whether a practice had language services available at scheduling (or during the encounter or elsewhere), instead of reporting the provision of appropriate language services at every encounter.

Face validity

- **Because local language needs differ, one TEP member expressed concerns about comparing clinicians with others outside their local area.** Instead, this TEP member suggested that comparisons be made between clinicians in the same geographic area.
- **TEP members said this measure concept would not be useful unless accurate preferred-language data are available.** The TEP further said this concept could lead to selection bias, in which clinicians might only choose to report the measure if they are already collecting data on preferred language. The TEP pointed back to the first measure concept as a better starting point to reduce the chance of selection bias, or for the language measure to require a certain percentage of patients with documented preferred languages to reduce selection bias.

Next Steps

The EC eCQM team will present information gathered for the health equity measure concepts to CMS in March, after which CMS will select a concept for continued development and testing. Once CMS selects a concept, and based on the type of measure selected, we will follow the steps described in the CMS Measures Management System Blueprint, develop specifications, and conduct testing. As noted in the blueprint, the development steps might vary by measure type, the data source for the measure concept, and whether we are creating a new measure or respecifying an existing one.

Appendix A

TEP Members

Table A.1. TEP members and affiliations

TEP member name	Credentials	Organization affiliation/location	Attended meeting?
Donald Casey	M.D., M.B.A., M.P.H.	Rush University; Chicago, IL	Yes
James Colbert	M.D.	Blue Cross Blue Shield of Massachusetts; Boston, MA	Yes
Fran Cunningham	Pharm.D.	Department of Veterans Affairs; Hines, IL	Yes
Barbara Kivowitz	Patient representative	Sutter Health; San Francisco, CA	Yes
Luming Li	M.D.	The Harris Center for Mental Health and IDD; Houston, TX	Yes
Bridget Lynch	M.D., M.P.H.	Presbyterian Medical Group; Albuquerque, NM	Yes
Precious McCowan	Patient representative	End-Stage Renal Disease Network 14; Dallas, TX	Yes
Robert McClure	M.D.	MD Partners, Inc.; Lafayette, CO	No
Michael Perskin	M.D.	American Geriatrics Society; New York, NY	Yes
Lori Popejoy	Ph.D., R.N., F.A.A.N.	University of Missouri; Columbia, MO	No
Christa Starkey	Patient representative	Lone Oak, TX	Yes

Table A.2. TEP guest members and affiliations

TEP member name	Credentials	Organization affiliation/location	Attended meeting?
Andrew Anderson	Ph.D.	Tulane School of Public Health and Tropical Medicine; New Orleans, LA	Yes
Jessica Galarraga	M.D., M.P.H.	MedStar Health; Washington, DC	Yes
Erin Giovannetti	Ph.D.	MedStar Health Research Institute; Hyattsville, MD	Yes
Monica Peek	M.D., M.P.H.	University of Chicago Medicine; Chicago, IL	No