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

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

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Draft: April 21, 2025; Final: May 21, 2025

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Contents

Technical Expert Panel Overview

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

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

- Identifying, developing, specifying, and testing new electronic clinical quality measures (eCQMs) for potential implementation in CMS quality programs that align with 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 Medicare Part B Claims measures in the Merit-based Incentive Payment System (MIPS).

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.

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 advocates, clinicians, electronic health record (EHR) vendor representatives, quality improvement experts, and health system representatives.

The TEP's specific duties include the following:

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

The EC eCQM TEP will provide input to the AIR project team throughout the measure development life cycle. The project team will consider the TEP's recommendations and will convey those recommendations to CMS; however, the project team and 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 provider burden considerations
- Measurement gaps
- Quality of evidence regarding measure concept and clinical actions that can be taken to improve measured outcome
- Importance to providers
- 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 inputs. The project team will formalize its recommendations based on TEP feedback through other deliverables, including Deliverable 4-5: Draft Documentation Set and Deliverable 4-6: Final Documentation Set.

Meeting Summary

The project team convened the first TEP meeting of the Base Year via Zoom teleconference on Monday, April 7, 2025. Sixteen of the 18 TEP members attended the meeting. After the meeting, the project team followed up with TEP members via email to seek additional insights into topics discussed during the meeting. The project team also confirmed agreement with the TEP Charter among members who did not attend. Post-meeting feedback is integrated into the report, where appropriate.

Appendix A. TEP Members presents a list of TEP members in attendance. Appendix B. EC eCQM Project Team Meeting Attendees includes a list of CMS staff and project team members in attendance. Appendix C. TEP Agenda includes a copy of the full meeting agenda. Appendix D. TEP Charter includes the EC eCQM TEP Charter language.

The objectives of the April 7, 2025, EC eCQM TEP meeting were to

- Conduct project team and TEP member introductions;
- Provide an overview of the goals, tasks, timeline, and anticipated outcomes of the EC eCQM project;

- Review TEP member roles and responsibilities and ratify the TEP Charter;
- Hear from TEP members with lived experience in managing chronic conditions and navigating the health care system; and
- Gather TEP insights and feedback on
  - The comprehensive reevaluation of the claims-based CQM, Adherence to Antipsychotic Medications for Individuals with Schizophrenia; and
  - The proposed eCQM measure for development in the base year, Foot Assessment and Follow-Up for Patients with Diabetes.

Exhibit 1 summarizes the recommendations the TEP members made at the April 7, 2025, TEP meeting.

Exhibit 1. TEP Member Recommendations From the April 7, 2025, TEP Meeting

Topic/Measure	Recommendations
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	• The TEP generally endorsed the measure but expressed concerns about the measure's ability to indicate whether good quality clinician care is provided. • The TEP noted that the measure relies on prescription refills rather than patient monitoring to assess good quality care. Prescription refills are not necessarily evidence of medication adherence, and keeping prescriptions active without monitoring can be deleterious, specifically in this patient population. In addition, providers who value monitoring and adjusting patient treatments to include electroconvulsive or drug holiday therapy over continuous days of coverage would fail this measure despite seeing better patient outcomes. Lastly, the TEP noted that adherence to prescription medication is a measure of patient compliance rather than clinician performance. • TEP members suggested future measure development activities that included identifying patient- or outcome-based mechanisms for assessing adherence to medications. Examples of technological approaches to monitoring adherence include video documentation of medication adherence, electronic pill counts, and systems that permit self-documentation of medication consumption. • The TEP also advised exploring why there are differences in performance on the measure between states.
Foot Assessment and Follow-Up for Patients with Diabetes	• The TEP largely endorsed the measure for its relevance and importance for improving patient outcomes. One TEP member positively considered the measure's requirement for a follow-up plan specifically to be a patient-centered activity. • TEP members recommended increasing clinician efforts to support patient education and health literacy about foot care and follow-up. • TEP members cautioned that the measure carries a high documentation burden for clinicians due to the number of components in the measure that clinicians need to understand and track. The TEP recommended several ways to reduce this burden, including (1) Clarifying that there is flexibility in the options for follow-up care. For example, if a referral was made in a previous year, an "encounter with a specialist" (to whom the patient has already been referred) should be sufficient to meet measure requirements. (2) Limiting or clearly defining the time window required for each type of follow-up (e.g., within 1 week or within 12 months. (3) Being less prescriptive with the type of foot exam required.

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

Welcome and Introductions

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

Project Overview

The project team provided an overview of the eCQM project including a brief review of the measure development lifecycle and the project team's expectations for the TEP throughout the process. The overview topics that were covered are summarized below.

- **Project Timeline:** The base year of the project runs from July 27, 2024, to July 26, 2025. The project has four additional option years.
- **Project Purpose:** The AIR project team supports the translation of eCQMs for clinicians to a standard that will
  - bolster CMS's goals of digital transformation to advance interoperability,
  - improve alignment with clinical decision support,
  - enhance health care, and
  - minimize the time clinicians spend on administrative tasks.
- **Intended Use of the Measures:** Through their use in quality reporting and value-based payment programs such as MIPS, the measures developed and maintained under this contract support CMS efforts to improve care and safety for Medicare beneficiaries.
- **Measure Development Lifecycle:** The measure development lifecycle is an iterative process with five stages that begins with measure conceptualization. Development is not necessarily sequential—all stages of development are iterative and can occur concurrently.
- **Measure Evaluation Criteria:** The decision to incorporate new measures or sustain extant measures in quality programs is based on an evaluation of each measure's (a) importance, (b) scientific acceptability, (c) usability and use, and (d) feasibility. These criteria are used by a variety of experts including clinicians, patients, measure experts, and health information technology specialists to review qualified measures during the CMS Partnership for Quality Measurement (PQM) CBE endorsement process.
- **TEP Expectations:** TEP members are expected to be involved throughout the measure development lifecycle from conceptualization to specification, testing and

implementation, and reevaluation and maintenance. Depending on timing and the goals of the project, TEP members may be asked to (a) advise on prioritizing clinical topics or measure concepts; (b) review draft measure specifications or research questions; (c) offer recommendations for updating measure specifications, based on public comment or other external feedback; (d) react to measure testing findings and inform final measure specifications; and (e)support the CBE endorsement process.

After providing this overview, the project team asked TEP members if they had additional comments, questions, or reactions.

- One TEP member asked whether the measure evaluation criteria are applicable to both new and maintenance measures. The project team confirmed that the criteria are applicable to all measures.

TEP Roles and Responsibilities and Ratification of TEP Charter

The project team shared information about the purpose and structure of the TEP and member expectations for meeting attendance and participation, to include the following:

- **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 each 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 we may not be able to implement all TEP recommendations, we will ensure that they are fully considered. We will also provide

clear rationale for those situations in which CMS is unable to implement specific TEP recommendations.

After reviewing TEP responsibilities, The project team asked each TEP member in attendance to confirm their agreement with the terms of TEP participation as outlined in the draft TEP Charter (Appendix D. TEP Charter) by responding to a poll question or in the Zoom chat. All TEP members who responded to the poll agreed to the terms; members did not request changes to the Charter language. The two TEP members who missed the meeting confirmed their agreement with the terms of participation via email. Accordingly, the TEP Charter was ratified, and the project team updated the Charter to include the 2024–2025 EC eCQM TEP Membership List.

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 a patient and/or caregiver. The project team asked each patient and caregiver TEP member in attendance to share reflections in response to the following questions, which were shared in advance:

Questions Posed to Patient and Caregiver TEP Members:

How can we better measure the quality of health care based on your experiences with navigating the health care system?

What role do you see eCQMs playing in advancing quality measurement?

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

- One TEP member shared that they are a three-time kidney transplant recipient and advocate for individuals with kidney disease nationwide. Through their experience navigating the health care system, they have learned the importance of quality of life and the need for clinicians to consider quality of life when recommending medications or treatments. It is a struggle when treatment affects a patient's life in a negative way. The focus should be on specific patient-reported outcomes that can be measured and that can help the patient's care team understand what approach to take. The TEP member added that surveys for patients about their experience are helpful, as are questions about health literacy, which can help to determine whether patients have received adequate information about their condition(s), treatment options, and care expectations. This feedback can indicate how well the health care system is preparing patients to make informed health care decisions. Care coordination and understanding

the patient's experience are important. Patient care transitions, in particular the transition from one provider to another and the transition from pediatric care to adult care, could also be measured. The TEP member's personal transition was challenging and thus, they stressed the importance of listening to patients and learning from both patients and providers about what works best for each patient.

  - A TEP member who is a clinician asked this TEP member to share more about their challenges with transitioning from pediatric to adult care, as this topic is not something that is typically discussed in conversations about care transitions. People often think about transitions between ambulatory and inpatient care or from primary care to specialist care, but not the transition from pediatric care to adult care.
  - The TEP member who is a patient noted that there were challenges due to both the change to a new provider and the healthcare system. They had to explain to their new physicians what treatments were effective for their body, yet they still had to undergo trial and error testing of various therapies again due to the physicians disregarding their previous experiences. They also shared that in pediatrics, physicians were more attentive and involved with their care. When they first moved to adult care, the patient did not have the support needed to be effective in managing their care.

- A second TEP member with lived experience as a patient agreed with these points and added that, given their personal experience with chronic health conditions, they recommended looking more at the role of repurposed drugs. This includes medications that were once used for specific conditions with great success but are now used for other purposes. They noted that they are currently taking one such medication and have experienced better results. The TEP member also expressed the need to move away from disease management and focus more on ways to improve the medical conditions patients have. Disease management often leads to predictable results, and predictable results do not always lead to improvement in ways that are important to patients. Also, conditions typically get worse as we age. Patients are less concerned about managing their condition and more concerned about improving their condition. Thus, allopathic medicine also plays a role. Another major issue is insufficient communication among providers on a care team, which can lead to preventable issues or slowed care.
- A third TEP member who is a patient and patient adviser added that it is often confusing and challenging for people with chronic conditions to obtain good care due to the fact that they often have multiple providers and concurrent health issues. The TEP member sees eCQMs as a way to help advance interoperability. Interoperability is a priority of

the U.S. Department of Health and Human Services because systems need to communicate with each other; if they cannot communicate with each other, reports or other patient information will not be transferred or received in a timely manner. The TEP member has been involved with developing measures for patients who are being prescribed opioids and benzodiazepines. In doing so, the TEP member stresses the importance of educating patients, providers, and the entire medical community on the importance of quality measures. By encouraging patients to know, understand, and monitor their own health numbers, we can help them understand what a specific measure is being used for and where they fall relative to it.

- A fourth TEP member who is a patient and caregiver shared that the patient's lived experience is a huge factor when it comes to navigating the health care system. There is a lot of trial and error when it comes to treatments and navigating care. It is very helpful for providers to gather input from patients and caregivers and to give them a seat at the table to help ensure the quality of the care being provided. Sharing input as a patient has made a tremendous difference and helped a lot with their own care and their children's experience with care. The TEP member emphasized the importance of taking the time to listen to and consider patients' views and to listen to what they have gone through because they know their bodies.

Maintenance of Endorsement: Comprehensive Reevaluation of Adherence to Antipsychotic Medications for Individuals with Schizophrenia Measure

The project team discussed a CQM that is under maintenance and that will be submitted to the CMS CBE for review and consideration for endorsement in Spring 2025. The measure is, Adherence to Antipsychotic Medications for Individuals with Schizophrenia (Quality ID# 383, Consensus-Based Entity# 1879). The team provided the following details on the measure:

- **Measure Description:** This is a measure of the percentage of individuals at least 18 years of age as of the beginning of the performance period with schizophrenia or schizoaffective disorder who had at least two prescriptions filled for any antipsychotic medication and who had a Proportion of Days Covered (PDC) of at least 0.8 for antipsychotic medications during the 12-month performance period.
- **Measure Denominator**: The percentage of individuals at least 18 years of age as of the beginning of the performance period with schizophrenia or schizoaffective disorder who had at least two prescriptions filled for any antipsychotic medication during the performance period.
- **Measure Denominator Exclusion:** Individuals with a diagnosis of dementia during the measurement period.

- **Measure Numerator:** Individuals in the denominator who have a PDC of at least 0.8 for antipsychotic medications.
- **Definition of PDC:** The numerator is the sum of the days covered by the supply of all antipsychotic medications. The denominator is the count of days from the day within the performance period when the first prescription is filled through the end of the performance period or death, whichever comes first.
- **Previous Measure Testing:** In previous testing using 2019 claims data, the overall performance rate was 80% and the 10th and 90th percentiles were 57%–64% and 94%–96%, respectively. The median reliability was 0.76 (IQR 0.65–0.87) and 0.82 (IQR 0.72–0.92) for clinician groups and clinicians, respectively. Face validity was established by previous TEP review and the validity of the measure score was established through correlation with a similar medication adherence measure for bipolar disorder.
- **Updated Measure Testing:** The project team tested the measure using 2023 claims data for all Medicare beneficiaries enrolled in Part D prescription drug coverage. The project team applied updated methods for assessing entity-level reliability using improved beta binomial methods and also analyzed recently submitted CQM data from participating clinicians.
  - The overall performance rate was 78%, and the 10th and 90th percentiles were 58%–59% and 92%–93%, respectively. The project team found that wide variation exists across states, and there is some variation based on patient characteristics. Patients under 35 years of age demonstrate lower overall adherence. The median reliability was 0.76 (0.63–0.91) for clinicians and 0.76 (0.63–0.91) for clinician groups. Among entities reporting voluntarily, the performance distribution is shifted to the right (mean 94–96%, 10th percentile 87–94%).

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

Questions Posed to the TEP:

Do you anticipate any questions or concerns that may be raised through the CBE (Partnership for Quality Measurement) review process?

Do you have any suggestions that we should consider as we complete testing and reevaluation of the measure?

TEP members provided the following feedback on the Adherence to Antipsychotic Medications for Individuals with Schizophrenia measure:

- One TEP member who was unable to attend the meeting provided feedback via email in advance, noting that the team should consider the impact of episodes of hospitalization or other types of institutionalizations on counting the number of days covered by prescriptions. It may also be necessary to account for medication changes that require a weaning period before the start of a different medication.
- During the meeting, one TEP member expressed concern that, despite being a CQM, the measure uses the EHR as the primary source of data, and fill data are difficult to obtain from EHR data on the ambulatory side. The TEP member also asked why the measure requires two schizophrenia encounters in the ambulatory practice but only one diagnosis event in a single patient encounter. A patient may meet the requirements for the prescription fills but not meet the requirements for the number of encounters.
  - The project team acknowledged the issue of EHR variation. They also mentioned that the measure was tested in the University of California system, where it could be implemented as an eCQM due to consistent and accurate two-way communication in which pharmacies provide notification of prescription pickup. The project team acknowledged that this communication is not universal across ambulatory practices and may vary according to implementation and vendor platforms. The team also clarified that the measure is not specified as an eCQM.
  - The project team also confirmed that the two-encounter requirement is intended to ensure that an ambulatory diagnosis is not the only diagnosis as those have been validated less consistently. A single inpatient diagnosis is considered sufficient to meet the requirements of the measure because these diagnosis events have been extensively validated for payment purposes by the inpatient facilities.
- Two TEP members asked why the results vary by state.
  - The project team responded that the performance variation by state is an open question. They also shared that the PQM is interested in reviewing this variation to ensure that there are potential performance gaps that can be addressed through quality improvement and policy interventions. If all states were performing at 90% or 95%, then it would weaken the case for continuing to use the measure, but this is something the project team wants to understand more. It is also possible that providers in some states have more problems and more difficulty with promoting adherence in their patients because of local resource constraints or other factors.

- One TEP member asked whether patients would show up as nonadherent for a specific medication because they were switched to a different medication. The member also asked whether the use of injectable antipsychotic medications could mean that the PDC is not accurate because calculating days supply is not straightforward.
  - The project team explained that in the case of switching medications, all antipsychotics that the patient received during the performance period are rolled together. In the event of coverage overlap before the old medication expires, the PDC is truncated for the first medication on the day of the new medication order. In terms of injectable medications, the project team added that long-acting injectable medications are typically prescribed at specific intervals and the days covered can be taken from the timing between prescriptions and number of units dispensed. The project team noted that they welcomed any additional thoughts from the TEP on how to address special circumstances.
- Four TEP members, including one patient, expressed concern about the rate of refills determining the PDC and the fact that this measure is used to signify the degree of adherence to a medication. Members noted that without monitoring patient-specific outcomes, the problem of adherence is not being viewed wholly. One member raised the concern that picking up a prescription does not necessarily signify compliance with taking the medication. Another member cautioned that the measure incentivizes prescription refills over monitoring because the measure is mainly looking to see that there are no gaps in prescription coverage. The member added that providers could be less motivated to make sure a patient comes in for an evaluation before renewing a prescription; many of these medications would need either blood work or exams conducted on at least a 6-month basis.
  - The project team acknowledged that the measure requires a completed prescription fill to meet the criteria for adherence. But a completed fill, including fills by a mail order pharmacy, does not mean the patient actually adheres to taking the prescribed medication. For example, they may complete the fill and then store the medications without taking them.
- One TEP member asked how unstructured data in prescriptions are handled in the measure. Another TEP member answered that this measure requires claims information with additional information attached from a pharmacist to calculate the PDC, such as the days supply field for each dispensing event.
- One TEP member, a patient, noted that the affordability of medications may influence the rate of refill. Two TEP members agreed and added that insurance coverage gaps can be a real problem for PDC calculation.

- One TEP member with the patient perspective asked if jail and prison populations were included in the data presented for this measure.
  - The project team clarified that the data used for testing may capture individuals who have brief incarcerated status but data would not include those who have prolonged incarceration status. For example, if an individual is in a long-term incarceration, they would not have any eligible Medicare claims to contribute to the measure denominator. However, if a person was incarcerated for 6 months of the 12-month performance period and had eligible claims during those 6 months, then they could be included in the measure.
- One TEP member asked if there are any future plans to reopen this measure construct for an update to account for a more modern measurement data ecosystem. The member shared that there has been a lot of work done in the last decade, which presents an opportunity for more person-centered approaches to measuring adherence and improving outcomes.
  - The project team shared that there may be interest in moving the measure to an eCQM and modernizing it potentially to add a patient-centered element to the measure. The project team welcomed TEP comments and suggestions for these future activities and shared that the priority at the time is to keep the current measure endorsed while working on efforts to modernize it. The TEP member expressed support for keeping a measure in play until a better alternative is ready to replace it in quality programs. The TEP member cautioned that converting to eCQM or digital quality measure (dQM) format will require great care because the PDC calculation was validated primarily for use with pharmacy claims and it should not be assumed that using EHR data will yield similar reliability and validity results.
  - The project team followed up with this TEP member via email and requested additional information about possible constructs that the team could explore for the eCQM. The TEP member responded that using proxies like PDC to assert outcomes is a model that works in a limited environment and that relies on administrative claims for accountability at the population level. A person-centered, quality-improvement-focused measurement strategy requires assessing factors that inform why the person is, or is not, adherent to their prescribed medications. It does so in such a manner that direct action can be taken to use this information to improve the outcome. This approach requires a more holistic assessment and also must include the use of self-reported information alongside clinical information. A good example of a newer measure that accomplishes this is the Depression Remission and Response (DRR) metric (see Appendix E). The DRR uses patient-reported outcome

measures (PROMs) to appropriately monitor depression symptoms and directly assesses response to treatment at the individual patient level.

  - Another TEP member responded to this request via email and shared that the measurement of adherence to antipsychotic medications measure offers an opportunity to encourage the use of technological approaches to monitoring adherence. The TEP member added that potential approaches to improve the patient-centeredness of the intervention include video documentation of medication adherence, electronic pill counts, and systems that permit self-documentation of medication consumption. The member shared that there may also be opportunities for enhanced medication delivery tracking through procedures such as community paramedics or community health workers who might be able to distribute the medications.

- Two TEP members stated that while the measure is important, it does not constitute good quality of care. One TEP member commented that they do not believe the measure is comprehensive enough to indicate that doctors are providing good quality care because there are many other factors that are important. Another TEP member agreed and added that given the gap between medication adherence and outcomes, this measure is most effective at a systems level, where it can measure trends in a larger population. This TEP member shared that the measure works for accountability at the payer level because payers have much more control over coverage gaps and medication costs such as copays, which are factors in the reliability of the PDC calculation.
- Following the TEP meeting, one TEP member raised a follow-up question, asking for clarification about why the second refill is required to qualify for the denominator for this measure since the PDC days start with the first fill. Their concern was that, under the current logic, cases with only one fill during the performance period will not be included in the denominator but this may actually be due to deficiency in performance based on the measure's intent.
  - The project team clarified that, similar to the two-encounter requirement for establishment of care, the two-fill prescription requirement is used to determine whether the prescription is being refilled consistently. The project team further noted that these antipsychotic medications can be prescribed on a trial basis, or used for episodic therapy in patients whose symptoms are mild. The two-prescription restriction ensures that we are excluding patients who received a trial (presumably unsuccessful) of antipsychotic therapy as well as patients who are on acute rather than chronic therapy. The requirement also has the secondary

advantage of stabilizing observed rates by ensuring a longer minimum denominator period (typically 60 days or more) for the PDC calculation.

- The project team met separately with one TEP member who missed the polling portion of the call to confirm their thoughts on both measures. The TEP member shared that there are new and evolving ways to treat schizophrenia and psychosis beyond the use of antipsychotics, which can have deleterious health effects and contribute to shorter life spans in this population. The member recommended that these other therapies, such as electroconvulsive therapy and drug holidays, be considered in the future. The TEP member also shared a general concern about how the measure addresses the situation of patients stockpiling extra medications without adequate monitoring. In this members' clinical experience, their team prioritizes monitoring over prescribing because it is more dangerous for people to have extra medication on hand. They added that drop-offs in care are common as this population can experience transience and other issues that result in breaks in care. For these reasons, the member did not think that the rate of prescription and days covered were accurate measures of adherence to antipsychotic medications.

Face Validity Polling: Adherence to Antipsychotic Medications for Individuals with Schizophrenia Measure

Following TEP discussion, the project team asked TEP members to respond to three poll questions (Exhibit 2) to capture TEP feedback on the face validity and meaningfulness of the measure. As previously mentioned, the project team followed up with TEP members after the meeting to obtain missing votes, where possible, and clarify rationales as needed. Exhibit 2 includes the final polling results.

Exhibit 2. Face Validity Polling Questions and Results for Adherence to Antipsychotic Medications for Individuals with Schizophrenia Measure

Face Validity Poll Questions	Polling results			
	Yes	No	Total votes	Missing*
Poll 1. Face validity is the extent to which a measure appears to reflect what it is supposed to measure "at face value." It is a subjective assessment by experts about whether the measure reflects its intended assessment. We will start by considering whether the measure is clearly and precisely specified. Please indicate "yes" if you agree that the measure is clearly specified and appears to reflect the concept of medication adherence among patients with schizophrenia.	13 (81%)	3 (19%)	16 (100%)	2

Face Validity Poll Questions	Polling results			
	Yes	No	Total votes	Missing*
Poll 2. Do you agree with the following statement? "The measured process (the rate of antipsychotic medication adherence in patients with schizophrenia) is meaningful to measure and can help improve care for patients."	13 (81%)	3 (19%)	16 (100%)	2
Poll 3. Do you agree with the following statement? "Performance scores resulting from the measure Adherence to Antipsychotic Medications for Individuals with Schizophrenia, as specified, can be used to distinguish good from poor eligible clinician quality of care provided to patients with schizophrenia."	9 (60%)	6 (40%)	15 (100%)	3

**Note*. The "Missing" column includes TEP members who did not attend the meeting, have not responded to post-meeting follow-up, and/or abstained from voting. Missing votes are not included in the calculated percentages.

For Poll 1, 81% of the TEP voted "yes" to the Adherence to Antipsychotics measure being clearly specified and reflecting the concept of medication adherence among patients with schizophrenia. For Poll 2, the TEP was asked to vote negatively or affirmatively to their agreement with the statement that the measured process proposed is meaningful to measure and can help improve care for patients. Eighty-one percent (81%) of the TEP voted "yes," confirming agreement with the statement. In Poll 3, the TEP was asked to vote negatively or affirmatively to their agreement with the statement that the performance scores resulting from the measure, as specified, can be used to distinguish good from poor eligible clinician quality of care provided to patients with schizophrenia. Sixty percent (60%) of the TEP voted "yes," confirming agreement with the statement.

Proposed Measure for Development: Foot Assessment and Follow-Up for Patients with Diabetes

The project team discussed a proposed eCQM for measure development during the base year of the project—Foot Assessment and Follow-Up for Patients with Diabetes.

- **Background:** The American Podiatric Medical Association (APMA) is the steward of the CQM Diabetic Foot and Ankle Care, Peripheral Neuropathy (Quality ID 126) quality measure, which uses codes appended to claims to assess whether an annual foot exam was performed for patients with diabetes during the measurement period. To achieve CMS's goal of further reducing foot amputations and other foot-related complications among patients with diabetes, CMS determined that this CQM should be translated into an eCQM and enhanced by adding a follow-up component to ensure that patients receive appropriate follow-up when neuropathy (loss of protective sensation [LOPS]) or peripheral vascular disease is diagnosed. A previous TEP supported this plan.

- **Expert Input:** In January 2025, the project team received expert input on clinical practice guidelines that resulted in the following recommendations for refinement to the follow-up component of the eCQM under development:
  - Clarifying the definition of "lower extremity neurological examination" (consistent with the most recent American Diabetes Association and American Association of Clinical Endocrinology guidelines) to allow for the use of any two tests (including a 10-gram [g] monofilament test, a soft touch test, a vibration test with a tuning fork, a pinprick test, and a temperature discrimination test) rather than requiring the use of the 10-g monofilament test plus one additional test;
  - Eliminating "ankle reflexes" from the list of "lower extremity neurological examination" as accuracy is poor in older adults and clinicians may not be proficient in assessing ankle reflexes; and
  - Expanding the definition of a follow-up referral to include specialties beyond a podiatrist, vascular specialist, or wound care specialist, such as endocrinologists, neurologists, physical therapists, vascular surgeons, orthopedic (foot) and general surgeons, etc.
- **Measure Description:** Percentage of patients aged 18 years of age and older with diabetes who receive all of the following: a lower extremity neurological examination, vascular examination, visual inspection, and foot care education, and who have a documented follow-up plan of care if any of the results of the neurological, vascular, or visual inspection are abnormal during the measurement period, which is defined as 1 calendar year.
- **Measure Denominator:** Patients 18 years of age and older at the beginning of the measurement period who have diabetes and have at least one eligible encounter during the measurement period.
- **Measure Denominator Exclusions:** Patients who have had a bilateral amputation at the foot or above, or who have had both a left and right foot amputation before the start of the measurement period. Patients who are in hospice care for any part of the measurement period.
- **Measure Numerator:** Patients who receive all of the following during the measurement period:
  - Lower extremity neurological examination:

    - » A documented evaluation of motor and sensory abilities using any two tests: a 10-g monofilament test, an Ipswich (soft) touch test, vibration sensation using a 128 Hz tuning fork, pinprick sensation, or temperature discrimination
  - Lower extremity vascular examination:
    - » A documented evaluation of vascular status, including at least one pulse exam
  - Lower extremity visual inspection:
    - » A documented evaluation of dermatological and musculoskeletal status to assess for skin integrity, presence of deformity, or ulcer
  - Foot care education:
    - » Structured foot care education that includes, at a minimum, instructions for foot self-inspection
  - Lower extremity neurological examination, a vascular examination, visual inspection, and foot care education during the measurement period, and have:
    - » Normal exam findings; **or**
    - » Any abnormal exam finding and have a documented follow-up plan of care within 1 week of the eligible encounter
      - Definitions of abnormal exam findings are as follows:
        - Lower extremity neurological exam—abnormal findings: Sensation diminished, absent, or abnormal in one or both feet
        - Lower extremity vascular exam—abnormal findings: Pulses diminished, absent, or abnormal in one or both feet
        - Lower extremity visual inspection—abnormal findings: Presence of callus, ulcer, or deformity in one or both feet
- **Definition of follow-up plan of care:**
  - The follow-up plan of care is documentation of the treatment to be conducted as a result of any abnormal foot exam results and may include any of the following:
    - » Referral (for example, to a podiatrist, vascular specialist, neurologist, physical therapist, orthopedic/foot surgeon, general surgeon, or wound care specialist)
    - » Order or referral for therapeutic footwear
    - » Order or referral for offloading interventions
    - » Plan for repeat visit with clinician within 12 months from the eligible encounter

- **Next Steps for Measure Development:** The project team will develop the measure specifications and value sets as a Fast Healthcare Interoperability Resources (FHIR)-based eCQM. Subsequently, the project team will draft an updated test plan; undertake feasibility, reliability, and validity testing; and propose further refinements to measure specifications, if needed, based on test results. The AIR team will update the TEP on the team's progress at the next TEP meeting.

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

Questions Posed to the TEP:

Does the TEP have any questions, comments, or concerns about the measure?
Does the TEP have any considerations that they would like to share specific to the follow-up plan of care for numerator compliance?
Does the TEP have any specific suggestions as we proceed with field testing of this measure in primary care and academic practices?

TEP members provided the following feedback on the Foot Assessment and Follow-Up for Patients with Diabetes measure.

- One TEP member shared that in the measurement specifications, the terms "measurement period" and "performance period" are used interchangeably, which is confusing. The member suggested that if the measurement period is the performance period and the term "performance period" is used in the measure description, then it could just be called the "performance period."
  - The project team confirmed that in this instance, the performance period and the measurement period are the same but acknowledged that that is not always the case in quality measures. For clarity and consistency, the project team will use the term "performance period."
- Another TEP member shared concerns about remodeling measures as they are converted to eCQMs without a complete reassessment of the codes and terminologies used. In future remodeling, developers should choose more appropriate terminology in terms of sensitivity and specificity as well as reducing clinicians' burden (avoiding checkboxes). Three other TEP members agreed.
- Another TEP member, a patient, asked a clarifying question about whether all the tests are necessary. The TEP member also asked if two specific tests were required or if any two tests could be used. The project team confirmed that the measure specifies that at least two tests, among any in the specified list of tests, be performed.
- One TEP member shared that they thought 1 week seemed like a long period for a plan of care when the assessment findings are generated immediately. Another member added

that the timing of the referral, if one is needed, is usually on the same day as the visit. This discussion prompted a third TEP member to ask if the 1-week window is for the order to be placed or for the actual follow-up appointment to occur. A fourth member noted that in their clinical experience, they do not always write their notes the same day of clinic and it may take them a day to finish it. For this reason, they thought that 1 week provided some leeway that would be fine for those follow-up requirements.

  - In response, a patient TEP member emphasized that wound care is so important to patients and clinicians, and that early intervention should be a priority. A TEP member recommended clarifying the language about the time window for follow-up care such that the 1-week time window is the plan of care in the case of a referral and the follow-up is within 12 months.
  - The project team confirmed that the 1-week timing was intended to give providers leeway in recording or executing next steps for patients.

- One TEP member questioned whether referring a patient with an ulcerative wound to surgery immediately would fail the requirements as it would not meet the two-test requirement.
  - The project team confirmed that both a visual and neurological exam should be completed based on guidelines for a lower extremity exam. Also, the project team confirmed that without a neurological exam, the proper treatment plan would be unclear.
- One TEP member asked if the measure was a patient-based measure or an encounter-based measure and suggested that the project team provide clarity in the measure documentation.
  - The project team confirmed that the measure is patient-based.
- One TEP member voiced their approval for this measure with the reasoning that it has been a long time coming and is very patient-centered. For example, the severity of diabetes, whether type 1 or type 2, and other social determinants may affect the degree and frequency of follow-up, which is a nuance that would be more readily captured through a patient-centered measure.
- Four TEP members expressed concerns about the amount of documentation required for providers to be compliant with the measure. One asked if it would be possible to measure "foot exam" without specifying what should be done in a foot exam. Another suggested that the testing includes reviewing and assessing documentation in different platforms, which may require consultation with vendors but also may require direct observation. A TEP member in this group agreed and shared that the measure could use

"an encounter with a specialist" or a prescription rather than a referral. Another TEP member suggested considering how AI Scribe tools may or may not affect documentation. The fourth member shared their concerns over clinician burden due to the amount of documentation and components necessary to assess the outcome.

- Two TEP members commented that because EHRs are often automated or designed to optimize documentation, there are more likely to be text boxes rather than physical exam features to select. As such, they suggested focusing more on the patient outcome than on the process. Another TEP member countered this point, stating that high-grade evidence is relied upon for most quality measures and intermediate outcomes are closer to that goal than process measures. The follow-up component is a great step forward in accomplishing that goal.
- Three TEP members were concerned about a referral being required to pass the measure, citing that multiple referrals could overburden patients. One member added that many family medicine, wound care, and dual-trained professionals could handle these patient needs without providing a referral to a podiatrist.
  - The project team clarified that a referral is not required by the measure, it is just one option.
- One TEP member, a patient and caregiver, shared how important patient education and awareness are to compliance and follow-up, and noted that without this health literacy component, care is not effective for patient outcomes. Three additional TEP members agreed with this point, including another patient.
- One TEP member shared that there is a Person-Centered Outcomes Implementation Guide that focuses on goal setting and care planning and they noted that this may be a helpful reference as the project team continues to develop this measure concept.

Face Validity Polling: Foot Assessment and Follow-Up for Patients with Diabetes Measure

Following TEP discussion, the project team asked TEP members to respond to two poll questions to capture TEP feedback on the face validity of the measure. The project team followed up with TEP members after the meeting to obtain missing votes, where possible, and clarify rationales as needed. Exhibit 3 includes the final polling results.

Exhibit 3. Face Validity Polling Questions for Foot Assessment and Follow-Up for Patients with Diabetes Measure

Face validity poll questions	Polling results			
	Yes	No	Total votes	Missing*
Poll 4. Face validity is the extent to which a measure appears to reflect what it is supposed to measure "at face value." It is a subjective assessment by experts about whether the measure reflects its intended assessment. We will start by considering whether the measure is clearly and precisely specified. Please indicate "yes" if you agree that the measure is clearly specified and appears to reflect the concept of foot assessment and follow-up for patients with diabetes.	14 (87.5%)	2 (12.5%)	16 (100%)	2
Poll 5. Do you agree with the following statement? "The measured process (the rate of foot assessments with appropriate follow-up for patients with diabetes) is meaningful to measure and can help improve care for patients."	15 (94%)	1 (6%)	16 (100%)	2

**Note*. The "Missing" column includes TEP members who did not attend the meeting, have not responded to post-meeting follow-up, and/or abstained from voting. Missing votes are not included in the calculated percentages.

For Poll 4, 87.5% of the TEP voted "yes" to the Foot Assessment measure being clearly specified and appearing to reflect the concept of foot assessment and follow-up for patients with diabetes. For Poll 5, the TEP was asked to vote negatively or affirmatively to state their agreement with the statement that the measured process proposed is meaningful to measure and can help improve care for patients. Ninety-four percent (94%) of the TEP voted "yes," confirming agreement with the statement.

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 in the chat (due to time constraints):

Questions Posed to Patient and Caregiver TEP Members:
Considering today's discussion, do you have any additional thoughts, concerns, or recommendations?

Patient and caregiver TEP members did not share additional reflections.

Meeting Wrap-Up and Next Steps

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

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

The next TEP meeting is tentatively planned for May or June 2025.

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

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
Cindy Van, Deputy Project Director
Michelle Lefebvre, Quality Measure Development Lead, Deputy Project Director
Kelly Burlison, Quality Measure Maintenance Lead
Katie Magoulick, eCQM Measure Documentation Lead
Britt Kent, Quality Measure Maintenance
Susan Heil, Senior Quality Assurance Reviewer
Coretta Lankford, Senior Advisor

University of California, Davis, Attendees
Patrick Romano, Clinical Lead
Meghan Weyrich, Information Gathering Lead
Irina Tokareva, Quality Improvement Specialist
John Kennedy, Clinical Coding Specialist
Monika Ray, Analytic Lead

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

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

Lazy Labs Attendees
Chris Millet, Value Set Lead

Appendix C. TEP Agenda

Meeting Agenda

EC eCQM TEP Base Year Meeting 1

Monday, April 7, 2025 | 3:00–5:00 p.m. Eastern Time (ET)

Meeting ID: 950 2363 7863 | **Passcode:** ji2JzYm03*

Web Conference URL:
https://air-org.zoom.us/j/95023637863?pwd=ql5bsuQhSXo0pH5yqhHbYxSBcfNmbv.1

Time (ET)	Topic
3:00–3:30 p.m.	**Welcome and Introductions** • Welcome members. Review meeting agenda and objectives. • Introduce AIR and CMS project teams. • Take TEP member roll call, make introductions, and review conflict of interest disclosures.
3:30–3:35 p.m.	**Project Overview** • Provide an overview of the EC eCQM project goals, tasks, timeline, and anticipated outcomes. • Briefly review the measure development process.
3:35–3:40 p.m.	**Technical Expert Panel (TEP) Roles and Responsibilities** • Discuss TEP roles/responsibilities and finalize TEP Charter.
3:40–3:55 p.m.	**Patient and Caregiver Reflections: Lived Experience** • Hear from TEP members with lived experience in managing chronic conditions and navigating the health care system to ground TEP discussions in real-world experiences. • Prompt: How can we better measure the quality of health care based on your experiences with navigating the health care system?
3:55–4:20 p.m.	**Maintenance of Endorsement: Comprehensive Re-evaluation** • Review and discuss measure resubmission for maintenance of endorsement to the Partnership for Quality Measurement (PQM) in spring 2025: – Adherence to Antipsychotic Medications for Individuals with Schizophrenia
4:20–4:45 p.m.	**Proposed Measure for Development** • Review measure under development in the base year and gather TEP feedback: – Foot Assessment and Follow-Up for Patients with Diabetes
4:45–4:55 p.m.	**Patient and Caregiver Reflections: TEP Discussion** • Prompt: Considering today's discussion, do you have any additional thoughts, concerns, or recommendations?
4:55–5:00 p.m.	**Meeting Wrap-Up and Next Steps** • Review next steps and action items.

Appendix D. TEP Charter (Ratified on 4/7/25)

Electronic Clinical Quality Measure (eCQM) Development and Maintenance for Eligible Clinicians (EC) Technical Expert Panel (TEP) Charter

Project Title: Electronic Clinical Quality Measure (eCQM) Development and Maintenance for Eligible Clinicians (EC)

TEP Expected Time Commitment and Dates:

The technical expert panel (TEP) will advise the American Institutes for Research (AIR) and its partners over the course of the project. The project has been funded for one base period of 12 months with four optional 12-month periods of performance. As part of the commitment to the TEP, panelists will be asked to attend up to four meetings per contract year for a minimum 2-year commitment between January 2025 and July 2029. All meetings will occur via teleconference, and meeting materials will be distributed in advance of each meeting to allow adequate time to review prior to the meeting.

Project Overview:

The Centers for Medicare & Medicaid Services (CMS) contracted AIR and its partners to develop, electronically specify, and maintain eCQMs for eligible clinicians for potential consideration and use in CMS quality programs. The contract name is Electronic Clinical Quality Measure (eCQM) Development and Maintenance for Eligible Clinicians (EC). The contract number is 75FCMC18D0027. As part of its measure development process, AIR convenes groups of stakeholders who contribute direction and thoughtful input to the measure developer during measure development and maintenance.

Project Objectives:

The primary measure development objectives of this project include:

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

Technical Expert Panel (TEP) Objectives:

As part of its measure development and maintenance process, AIR and its partners (the project team) request input from a broad group of eCQM stakeholders to evaluate and provide guidance on the selection and development of eCQMs through participation in the project's TEP.

TEP Requirements:

A TEP of approximately 18 individuals will convene periodically to provide input on the prioritization and development of eCQMs that support CMS's quality program goals throughout the development lifecycle. The TEP will be composed of individuals with different areas of expertise and perspectives, including but not limited to patients, caregivers, patient advocates, clinicians, electronic health record vendor representatives, quality improvement experts, and health system representatives. Patients can provide unique and essential input on quality measures based on their own experiences and perspectives. A well-balanced representation of stakeholders on the TEP will help to ensure the consideration of key perspectives in the measure selection and development processes.

Scope of Responsibilities:

The TEP will provide input to the project team to aid in prioritizing and developing eCQMs that will be considered for implementation in CMS quality programs. The TEP will also provide feedback about potential changes to existing EC eCQM measures stewarded by CMS. The TEP's specific duties include the following:

- Review, prioritize, and evaluate eCQM measure concepts for development and maintenance. Dimensions for prioritization could include:
  - Alignment of concept with quality program goals
  - Technical feasibility
  - Workflow feasibility, including patient and provider burden considerations
  - Measurement gaps
  - Quality of evidence about measure concepts and clinical actions that can be taken to improve measured outcomes
  - Importance to providers
  - Importance to patients
  - Alignment with existing (competing) measures
  - Potential for unintended consequences

- Review and provide guidance on the measures in response to feedback from expert work groups, public comments, and testing results regarding eCQM feasibility, usability, validity, and reliability.

Guiding Principles:

Participation as a TEP member is voluntary and the measure developer records the participant's input in the meeting minutes, which the measure developer will summarize in a report that they may disclose to the public. If a participant has chosen to disclose private, personal data, then related material and communications are not covered by patient-provider confidentiality. Patient/caregiver participants may elect to keep their names confidential in public documents. TEP organizers will answer any questions about confidentiality.

All potential TEP members must disclose any significant financial interest or other relationships that may influence their perceptions or judgment. It is unethical to conceal (or fail to disclose) conflicts of interest. However, there is no intent for the disclosure requirement to prevent individuals with particular perspectives or strong points of view from serving on the TEP. The intent of full disclosure is to inform the measure developer, other TEP members, and CMS about the source of TEP members' perspectives and how that might affect discussions or recommendations.

The TEP will provide input throughout the measure development and maintenance process. The project team will consider the TEP's recommendations and convey those recommendations to CMS; however, the project team and CMS will ultimately make decisions about measure selection and development. The project team will write and share summary reports of TEP proceedings after meetings to highlight discussions and document decisions.

The project team will ensure confidentiality in TEP reports by summarizing discussion topics and removing the names of TEP members who make specific comments during the meetings.

Estimated Number and Frequency of Meetings:

Members of the TEP will meet up to four times in a 12-month period via webinar. The TEP is intended to be a standing committee that meets throughout the duration of the Electronic Clinical Quality Measure (eCQM) Development and Maintenance for Eligible Clinicians (EC) project, which has been funded for a 12-month period with four additional 12-month optional periods of performance.

Date Approved by TEP:

April 7, 2025

TEP Membership:

We have selected these individuals and they have agreed to serve as the TEP for this project:

Name, Credentials, Professional Role	Organizational Affiliation, City, State	Consumer/ Patient/ Family/ Caregiver Perspective	Clinical Content	Methodological Expert	Performance Measurement	Coding and Informatics	Conflict of Interest Disclosure
Hadeel Alkhairw, MD FACP MS-HQSM Dip ABOM	Society of General Internal Medicine; Icahn School of Medicine at Mount Sina, White Plains, NY		⊙		⊙		Member of the Performance Measurement Committee with the American College of Physicians.
Ashley Bates, CNA, CMA	Team Josiah 2k22 Foundation, Quinter, KS	⊙					None reported
Zahid Butt, MD, FACG	Medisolv, Columbia, MD		⊙	⊙	⊙	⊙	Medisolv implements eCQMs and is a CMS QCDR[1] in QPP and IPPS.
Jessica Dale, DNP, RN	TruLite Health, Deforest, WI	⊙	⊙				None reported
Stephen Foster, MD	University of Arkansas for Medical Sciences, Jonesboro, AR		⊙	⊙		⊙	None reported
Terri Godar	Advocate Health, Rolling Meadows, IL			⊙			None reported
Ben Hamlin, DrPH, FAMIA	IPRO, Washington, D.C.			⊙	⊙	⊙	None reported
Michael Allen Hansen, MD, MPH, MS	Baylor College of Medicine, Houston, TX		⊙	⊙	⊙	⊙	None reported
Jenel Lansang, MSN, RN, MEDSURG-BC	American Academy of Otolaryngology—Head and Neck Surgery, Woodbridge, VA		⊙		⊙	⊙	None reported
Luming Li, MD	The Harris Center for Mental Health and IDD, Houston, TX		⊙		⊙	⊙	None reported
Robert McClure, MD	MD Partners, Lafayette, CO		⊙	⊙		⊙	Consultant for ICF[2]
Precious McCowan, PhD	ESRD Network 14 of Texas, Lancaster, TX	⊙					None reported

[1] Qualified Clinical Data Registry (QCDR): A CMS-approved entity that demonstrates clinical expertise in medicine and quality measurement development that collects medical or clinical data on behalf of a MIPS eligible clinician for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients (CMS).

[2] ICF is a global advisory and technology services provider. CMS is among ICF's clients.

Name, Credentials, Professional Role	Organizational Affiliation, City, State	Consumer/ Patient/ Family/ Caregiver Perspective	Clinical Content	Methodological Expert	Performance Measurement	Coding and Informatics	Conflict of Interest Disclosure
Samantha Pitts, MD, MPH	Society of General Internal Medicine; Johns Hopkins University School of Medicine, Baltimore, MD		⊙			⊙	None reported
Anothony Sanchez	Albuquerque, NM	⊙					None reported
Christa Starkey	Lone Oak, TX	⊙					None reported
Andrew Talal, MD, MPH	University at Buffalo, Department of Medicine, Division of Gastroenterology, Hepatology and Nutrition, Buffalo, NY		⊙		⊙	⊙	Nonfinancial support from Abbott Laboratories. Grants from Gilead Sciences, Novo Nordisk, AstraZeneca, Salix. Committee/advisor for Gilead Sciences, AbbVie, Novo Nordisk, and Madrigal. President of Empath Medical. Owner of Andrew Talal, MD, PLLC.
Janice Tufte	Seattle, WA	⊙					None reported
Sandeep Vijan, MD, MS	American College of Physicians, Ann Arbor, MI		⊙	⊙	⊙		Uses Medisolv for ACO data submissions.

Appendix E. Depression Remission or Response for Adolescents and Adults (DRR-E)

Description

The percentage of members 12 years of age and older with a diagnosis of depression and an elevated PHQ-9 score, who had evidence of response or remission within 120−240 days (4–8 months) of the elevated score:

- **Follow-Up PHQ-9.** The percentage of members who have a follow-up PHQ-9 score documented within 120−240 days (4–8) months after the initial elevated PHQ-9 score.
- **Depression Remission.** The percentage of members who achieved remission within 120−240 days (4–8) months after the initial elevated PHQ-9 score.
- **Depression Response.** The percentage of members who showed response within 120−240 days (4–8) months after the initial elevated PHQ-9 score.[3]

[3] *Depression Remission or Response for Adolescents and Adults (DRR-E).* (n.d.) National Committee for Quality Assurance. https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/depression-remission-or-response-for-adolescents-and-adults-drr-e/

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