# Meeting Summary

## Core Quality Measures Collaborative Full Collaborative Meeting – April 29, 2026

Battelle convened the Core Quality Measures Collaborative (CQMC) Full Collaborative on Wednesday, April 29, 2026, to review and discuss updates from the Behavioral Health, Pediatrics, Medical Oncology, and Obstetrics and Gynecology (OB/GYN) workgroups.

### Welcome and Opening Remarks

Kate Buchanan, Battelle CQMC lead, welcomed participants to the Full Collaborative meeting. Ms. Buchanan reviewed the anti-trust compliance statement and noted that CQMC is a membership-driven and -funded effort, with additional support from Centers for Medicare & Medicaid Services (CMS) and AHIP.

### Review of Core Set Maintenance Process and Voting Process

Ms. Buchanan then provided an overview of the CQMC processes for core set maintenance and voting and outlined the measure-selection principles. As a part of the process, workgroups review proposed additions or removals from the core set. The workgroups meet, discuss proposed changes, and, if they decide to move forward, vote on the proposed changes. The CQMC Steering Committee reviews the vote and approves convening the Full Collaborative to discuss and finalize changes.

Following the meeting, the Full Collaborative reviews the workgroup voting results. As with the workgroups, the Full Collaborative follows a supermajority voting threshold: for a measure to be added or removed, at least 60% of participants cast an affirmative vote and a representative from each of the provider and payer voting participant categories casts an affirmative vote. Ms. Buchanan noted that abstentions are not included in the denominator.

### Behavioral Health Workgroup Update

Ms. Buchanan introduced the workgroup co-chairs, Sharat Iyer, MD, and Vikram Shah, MD, and provided an overview of the November 2025 Behavioral Health Workgroup meeting during which the workgroup engaged in a full maintenance review of the Behavioral Health Core Set. The current core set has 14 measures, and the workgroup voted to add five measures, not to add two measures, to remove one measure, and to retain one measure in the core set.

- Added to the core set:
  - Depression Remission or Response for Adolescents and Adults (DRR-E)
  - Postpartum Depression Screening and Follow-up (PDS-E)
  - Prenatal Depression Screening and Follow-up (PND-E)

  - CMS Measures Inventory Tool (CMIT) #1713 Initiation, Review, and/or Update to Suicide Safety Plan for Individuals with Suicidal Thoughts, Behavior, or Suicide Risk
  - CMIT #377 Improvement or Maintenance of Functioning for Individuals with a Mental and/or Substance Use Disorder

- Not added to the core set:
  - CMIT #1692 Reduction in Suicidal Ideation or Behavior Symptoms
  - Consensus-based entity (CBE) #1365e Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment

- Removed from the core set
  - CBE #1884 Depression Response at Six Months - Progress Towards Remission

- Retained in the core set
  - CBE #1885 Depression Response at Twelve Months - Progress Towards Remission

Battelle received 15 votes out of a total of 18 voting members in the Behavioral Health Workgroup. Ms. Buchanan provided an overview of the voting results, including a summary of the measure and workgroup discussion.

A workgroup member asked about attribution of measures CMIT #1713 and CMIT #377. The measure steward replied that the measures are applicable beyond behavioral health clinicians and may also be applied to other clinicians (e.g., primary care physicians).

The workgroup co-chairs noted that the workgroup had a rich discussion about the depression measures. Although the workgroup added an overlapping depression remission measure, CBE #1885 was retained in the core set. The added measure, DRR-E, monitors response or remission within 4-8 months, while CBE #1885 monitors response and remission at 12 months. Clinicians who treat patients with more complex depression may benefit from this measure being retained in the core set. However, the workgroup may want to revisit CBE #1885 in the future to reduce overlap in the core set.

A workgroup member had questions about what triggers the use of CMIT #1713. The steward responded that the measure is triggered by 1) clinician assessment of suicidal ideation (e.g., via Suicide Assessment Five-Step Evaluation and Triage [SAFE-T]), 2) patient response that they are having suicidal ideation (e.g., screening positive on the Columbia Suicide Severity Rating Scale [C-SSRS]), and 3) diagnosis of any mental health condition. A workgroup member wondered if history of suicidal ideation decades ago would trigger use of the measure. The steward noted that the patient would need to screen positive to be included in the measure. The C-SSRS, for example, only classifies someone at moderate or high risk if the suicidal ideation is recent or current. A workgroup co-chair emphasized that this measure closes an important gap in the core set and that safety planning has strong evidence base for suicide prevention. The workgroup member was concerned about emergency departments, where many people might qualify for the measure. The steward responded that the measure is specified only for outpatient ambulatory settings.

***Behavioral Health Key Topics***

Ms. Buchanan provided an overview of measurement gap areas identified in previous workgroup meetings, including:

- Need for meaningful, bi-directional integration measures between primary care and behavioral health, as both sectors often feel unprepared to address the other's domain.
- Lack of measures focused on autism and applied behavioral analysis (ABA) treatment, despite the high prevalence of autism in children.
- Gaps in geriatric mental health and child/adolescent mental health, with attention-deficit/hyperactivity disorder (ADHD) currently being the only measured condition.
- Limited measurement of anxiety, with the only existing measure restricted to a non-public registry.
- Need for psychosocial rehabilitation and recovery-oriented measures that emphasize person-centered care and supporting individuals' chosen ways of living with their illness, not solely remission.

## Pediatrics Workgroup Update

Ms. Buchanan introduced one of the workgroup co-chairs, Lily Higgins, MD, and shared that Lee Beers, MD, will be a co-chair in the next maintenance cycle. Ms. Buchanan provided an overview of the July 2025 Pediatrics Workgroup meeting during which the workgroup engaged in a full maintenance review of the Pediatrics Core Set. The current core set has 17 measures, and the workgroup voted to add seven measures and remove two measures from the core set.

- Added to the core set:
  - Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)
  - CBE #1360 Audiological Evaluation no later than 3 months of age
  - Initiation and Engagement of Substance Use Disorder Treatment (IET)
  - CBE #3488 Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
  - CBE #2517 Oral Evaluation, Dental Services
  - Follow-Up After Acute and Urgent Care Visits for Asthma (AAF-E)
  - Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)
- Not added to the core set:
  - Depression Remission or Response for Adolescents and Adults (DRR-E)
- Removed from the core set:
  - CBE #2811e Acute Otitis Media - Appropriate First-Line Antibiotics
  - CBE #1800 Asthma Medication Ratio

Ms. Buchanan also noted that CQMC staff performed a crosswalk of core set measures with those in the Medicaid Child Core Set and there was a fair amount of overlap between the two sets.

Battelle received 11 votes out of a total of 13 voting members in the Pediatric Workgroup. Ms. Buchanan provided an overview of the voting results by measure, including a summary of the measure and workgroup discussion.

A workgroup member asked about the exclusion of the DRR-E measure, which was added to the Behavioral Health Core Set. The workgroup member said that the Pediatrics Workgroup was concerned about access to care and wanted if DRR-E is stratified. In a follow-up communication, the steward said that the measure is not stratified. Ms. Buchanan noted that the workgroup was hesitant about use of this measure in the pediatric population. She also emphasized that each core set can contain different measures as each set can be used independently.

### *Pediatrics Key Topics*

Ms. Buchanan provided an overview of measurement gap areas identified in previous workgroup meetings, including:

- Gaps remaining in pediatrics quality measurement include:
    - A workgroup co-chair stated that, among American Academy of Pediatrics members, obesity, care coordination, and telehealth are high-priority gaps in measurement.
    - A workgroup co-chair noted that a Healthcare Effectiveness Data and Information Set (HEDIS) measure on obesity could be added to the core set: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC).
    - A workgroup co-chair emphasized the importance of contraceptive care, especially long-acting reversible contraceptives (LARC), in the pediatric population.

## Medical Oncology Workgroup Update

Ms. Buchanan introduced the workgroup co-chairs, John Cox, DO, and Mohamed Rahdi, MD, a new co-chair who is replacing Bryan Loy, MD, who co-chaired the workgroup discussion. She then provided an overview of the Medical Oncology Workgroup meeting held in September 2025 during which the workgroup conducted a light maintenance review of the core set. The workgroup considered the removal or retention of two measures:

- Removed from the core set
    - CBE #0420 Pain Assessment and Follow-Up
- Retained in the core set:
    - CBE #1860 Patients with metastatic colorectal cancer and RAS gene mutation spared treatment with anti-epidermal growth factor receptor monoclonal antibodies

Battelle received 10 votes out of 14 total voting members in the Medical Oncology Workgroup. Ms. Buchanan provided an overview of the voting results by measure and noted that most of the discussion centered on key topics for the Medical Oncology Core Set.

Ms. Buchanan noted that CBE #1860 received a supermajority vote for removal but was retained in the core set because no members in the provider voting category voted for removal. The CQMC charter requires a positive vote from at least one payer and at least one provider member. CMS removed the measure from the Merit-based Incentive Payment System (MIPS) because not enough clinicians/practices reported 20 or more cases, so CMS could not establish a benchmark. The Steering Committee asked about measure usage, and the measure steward noted that in MIPS, practices may bypass measures without established benchmarks due to their lower point value. Additionally, smaller practices may lack sufficient patient volume to receive full reporting credit. The measure also has higher reporting burden as genomic results are often returned as PDFs. The American Society of Clinical Oncology is working with the Fast Healthcare Interoperability Resources® (FHIR®) CodeX Accelerator to expand genomic FHIR implementation guidelines.

The steward noted that the American Cancer Society estimates that there are 15,300 newly diagnosed cases of metastatic colorectal cancer positive for RAS mutation each year. They emphasized that the measure is reliable and adheres to guidelines, and that the guidelines are ideal for quality measurement because they are binary. The steward also noted that unnecessary anti-epidermal growth factor receptor (EGFR) therapies can cost $10,000-$15,000 per month. With approximately 20,000 patients at risk for unnecessary treatment, payers could save hundreds of millions of dollars. The steward said that the measure is most reliable when used with registry-based reporting or structured lab data (as opposed to claims data) to generate the denominator because the mutation status is clearly captured.

A workgroup member noted that new research has shown that for certain RAS gene mutations, anti-EGFR therapy is approved as a second- or third-line therapy. The member noted that this measure may already be outdated, and, if the core set retains the measure, perhaps the measure should exclude RAS gene mutations where anti-EGFR therapy can be provided. The steward emphasized that the field of genomics is moving fast, and they are exploring a broader colorectal biomarker testing measure.

### *Medical Oncology Key Topics*

Ms. Buchanan provided an overview of measurement gap areas identified in previous workgroup meetings, including:

- **Patient-Reported Outcomes & Patient Experience:** Persistent gaps remain in capturing real-time patient-reported symptoms, pain control, functional status, anxiety and stress levels, patient education needs, and care-coordination challenges.
- **Molecular & Biomarker-Driven Care Measures:** There is strong demand for measures that reflect modern oncology—particularly molecular testing, biomarker interpretation, and appropriate use of targeted therapies and immunotherapies. A high-priority example includes measuring molecular testing for metastatic non-squamous non-small cell lung cancer, which the workgroup cites as urgently needed for development and implementation.

- **Avoidable Acute Care: Emergency Room (ER), Hospitalizations & Overtreatment:** Unplanned ER visits, avoidable hospitalizations, and inappropriate treatment intensity (under- or overtreatment) remain major quality gaps.
- **Prospective Palliative, End-of-Life, & Side-Effect Management Measures:** Current end-of-life measures are retrospective and lag behind clinical need. There is a critical gap in prospective measures that identify palliative care needs earlier and proactively manage treatment side effects to prevent ER visits, improve quality of life, and align care with patient goals and preferences.
- **Choosing Wisely–Aligned Measures:** Key gaps remain in adopting and operationalizing Choosing Wisely oncology recommendations, such as avoiding unnecessary imaging for low-risk prostate cancer, limiting combination chemotherapy in metastatic breast cancer unless clinically essential, and ensuring targeted therapies are only used with the correct biomarker. These represent ready-made, evidence-supported opportunities for measure development.

## Obstetrics and Gynecology Workgroup Update

Ms. Buchanan introduced the workgroup co-chairs, Dean Dagermangy, MD, and Sam Bauer, MD, and then provided an overview of the OB/GYN Workgroup meeting held in September 2025 during which the workgroup conducted a light maintenance review of the core set. The workgroup considered the removal of one measure:

- Removed from the core set
  - Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)

Battelle received 11 votes out of 14 total voting members in the OB/GYN Workgroup. Ms. Buchanan provided an overview of the voting results and noted that most of the discussion centered on key topics for the OB/GYN Core Set. A workgroup co-chair noted that non-recommended cervical cancer screening for those younger than 21 years old has fallen to about 0%, so the evidence supports removal of the measure from the core set.

### *OB/GYN Key Topics*

Ms. Buchanan provided an overview of measurement gap areas identified in previous workgroup meetings, including:

- **Maternal Mortality & Morbidity:** Preventable maternal deaths remain a major issue, with racial gaps persisting. Members highlighted severe maternal morbidity (SMM), tracked through 21 ICD-10 indicators, as a valuable, measurable metric with long-term health and financial impacts.
- **Measurement Challenges:** While states and hospitals are working to reduce maternal mortality, determining causes is complex. SMM is easier to measure, and review committees often assess whether health systems are evaluated for it.
- **Menstrual & Pre-Conception Health:** Menstrual health is under-addressed, with missed diagnoses of conditions such as endometriosis, fibroids, and polycystic ovary syndrome (PCOS). Members emphasized the need for measures on menstrual cycle evaluation, education, and pre-conception health to avoid “catch-up” care after pregnancy begins.

- **Chronic Disease & Preventive Care:** Workgroup members discussed incorporating diet, exercise, and chronic disease screening (e.g., diabetes for PCOS patients) into well-woman visits. The workgroup suggested preconception counseling measures using Z-codes to strengthen preventive care.
- **Menopause & Care Transitions:** A gap exists in menopause care, with many providers lacking training to counsel patients. The workgroup proposed screening measures for menopause symptoms and gaps in care. Additionally, better transition-of-care guidance is needed after pregnancy complications, including preventive interventions such as aspirin for hypertension in future pregnancies.

## Next Steps

Ms. Buchanan shared that voting would open directly after the meeting. The voting email will contain the workgroup meeting summaries and the current core sets. Voting will be open for 4 weeks. The meeting summary for the Full Collaborative meeting will be sent in the next 2 weeks. All materials will come from cqmc@battelle.org. Ms. Buchanan thanked the workgroup co-chairs and the rest of the Full Collaborative for their time and adjourned the meeting.