Meeting Summary

Core Quality Measures Collaborative Accountable Care Organization (ACO), Patient-Centered Medical Home (PCMH), Primary Care (PC) Workgroup Meeting

Battelle convened the Core Quality Measures Collaborative (CQMC) Accountable Care Organization (ACO), Patient-Centered Medical Home (PCMH), Primary Care (PC) Workgroup on January 27, 2026, to discuss potential measure additions and removals for the ACO/PCMH/PC core set.

Welcome and Opening Remarks

Kate Buchanan, MPH, Battelle CQMC lead, welcomed workgroup members to the meeting to discuss core set updates. She reviewed the anti-trust compliance statement and said that CQMC is a membership-driven and -funded effort, with additional support from the Centers for Medicare and Medicaid Services (CMS) and AHIP. Ms. Buchanan gave an overview of the meeting agenda.

Ms. Buchanan introduced the workgroup co-chairs, Karen Johnson, PhD, AAFP, and Todd Prewitt, MD, FAAFP, and provided a list of voting and non-voting members. Ms. Buchanan then outlined the core set's intent, principles for core set measure selection, and the process for maintenance.

2024 Maintenance Review Recap

Ms. Buchanan provided a high-level recap of measures under review and results from the 2024 cycle. During the 2024 cycle, the workgroup voted to remove four measures:

- Consensus-based Entity (CBE) #3541 Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)
- CBE #1885 Depression Response at Twelve Months-Progress Towards Remission
- CBE #2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
- Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)

The workgroup also voted not to remove three measures:

- CBE #3568 Person-Centered Primary Care Measure PRO-PM
- CBE #0034 Colorectal Cancer Screening (COL)
- CBE #0052 Use of Imaging Studies for Low Back Pain

The Current Core Set

Ms. Buchanan provided an overview of the current ACO/PCMH/PC core set, noting that it includes 21 measures: 16 process measures, three outcome measures, and two patient experience measures. The set comprises one behavioral health measure, three cardiovascular care measures, two care coordination/patient safety measures, three diabetes measures, two patient experience measures, six prevention and wellness measures, two pulmonary measures, one readmissions measures, and one utilization and overuse measure.

Measures for Consideration – Addition

Ms. Buchanan reviewed the process to assess potential additions to the core set, indicating that Battelle requested feedback from workgroup members and conducted an environmental scan with a 3-year lookback period. The sources for the scan include: CMS Measures Inventory Tool (CMIT), CMS Measures Under Consideration Entry/Review Information Tool (MERIT), Partnership for Quality Measurement (PQM) Submission Tool and Repository (STAR), measures discussed in previous meetings, Quality Payment Program (QPP), and Healthcare Effectiveness Data and Information Set (HEDIS).

The workgroup considered 14 measures for addition to the core set:

1. CBE #3455 Timely Follow-Up after Acute Exacerbations of Chronic Conditions
2. CBE #4825 The percent of contraceptive care patients giving “top box” scores on a PRE-PM focused on quality of contraceptive care (the Person-Centered Contraceptive Counseling [PCCC] measure), within a 6-month lookback period
3. CBE #3666 Ambulatory Palliative Care Patients’ Experience of Receiving Desired Help for Pain
4. CBE #0326 Advance Care Plan
5. CMIT #1146 Preventive Care and Wellness (Composite)
6. Follow-Up After Acute and Urgent Care Visits for Asthma (AAF-E)
7. CBE #2940 Use of Opioids at High Dosage in Persons without Cancer
8. CMIT #33 Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse)
9. Use of Opioids at High Dosage
10. Use of Opioids From Multiple Providers
11. CBE #3558 Initial Opioid Prescribing for Long Duration (IOP-LD)
12. CBE #2483 Gains in Patient Activation Measure (PAM) Scores at 12 Months
13. CBE #4655e The percentage of patients assigned female at birth ages 15-44 who were asked the Self-Identified Need for Contraception (SINC) question with a recorded response, among patients with a qualifying encounter. (Contraceptive Care Screening eCQM)
14. Initiation and Engagement of Substance Use Disorder Treatment (IET)

Measures for Consideration – Removal

Ms. Buchanan reviewed factors to consider for removal of a measure from the core set. She noted that Battelle reviewed the current core set, looking for changes to endorsement status, changes in program use, and key topics identified by the workgroup. Ms. Buchanan said one measure was identified for removal by Battelle and workgroup members identified another five measures for potential removal:

- One measure identified by Battelle:
  - CBE #1800 Asthma Medication Ratio
- Five measures identified by workgroup members:
  - CBE #0005 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Clinician & Group Surveys (CG-CAHPS) Version 3.1
  - CBE #0058 Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)
  - CMIT #729 Transitions of Care (TRC)
  - Use of Imaging Studies for Low Back Pain
  - CBE #0421/0421e Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

Discussion

Potential Additions:

Care Coordination and Patient Safety

Ms. Buchanan noted that the ACO/PCMH/PC core set currently includes two measures related to care coordination and patient safety: Transitions of Care (TRC) and Measuring the Value-Functions of Primary Care; Provider Level Continuity of Care Measure.

- **Measure Title**: CBE #3455 Timely Follow-Up after Acute Exacerbations of Chronic Conditions

  Endorsement/Use: The measure is endorsed and is in use in the Accountable Care Organization Realizing Equity Access and Community Health (ACO REACH) Model.

  Rationale for Potential Addition and Written Member Feedback: The measure addresses the integration across settings/specialties and populations gap area. In written feedback provided prior to the meeting, a workgroup member recommended that the measure not be added to the core set, as it is difficult to implement based on claims data. Another workgroup member recommended adding the measure at the health plan level only; the measure is not tested or validated at the clinician level.

  Discussion: While workgroup members acknowledged that the measure aligns with existing clinical guidelines and promotes accountability for post-discharge care, they raised several concerns. A primary concern was the wide variation in follow-up windows, which vary based on condition. Workgroup members noted that aggregating short- and long-term follow-up requirements may mask deficiencies in urgent follow-up for higher-risk patients. They also highlighted operational challenges, particularly for practices managing multiple timelines amid delayed discharge notifications, often resulting in default scheduling of all patients within 7 days regardless of clinical need. In response to a workgroup member question, the steward said that telehealth follow-up visits can be used to satisfy the measure.

  Additional discussion focused on potential confounding factors during longer follow-up periods, including follow-up encounters with multiple providers,

unrelated readmissions, and concerns that the measure could be applied at the individual clinician level despite being designed for population-level use.

Ballot Decision: The measure will not be added to the ballot.

Patient Experience

Ms. Buchanan noted that the ACO/PCMH/PC core set currently includes two patient experience measures: CAHPS Clinician & Group Surveys (CG-CAHPS) Version 3.1 and the Person-Centered Primary Care Measure PRO-PM.

- **Measure Title**: CBE #4825 The percent of contraceptive care patients giving "top box" scores on a PRE-PM focused on quality of contraceptive care (the Person-Centered Contraceptive Counseling [PCCC] measure), within a 6-month lookback period

  Endorsement/Use: The measure is endorsed and is not currently used in public reporting.

  Rationale for Potential Addition and Written Member Feedback: The measure addresses contraceptive care and patient-reported measure gap areas. In written feedback provided prior to the meeting, a workgroup member recommended that the measure not be added to the core set because it is difficult to achieve with claims data.

  Discussion: A co-chair noted that the measure depends on identifying individuals of childbearing age and then evaluating the proportion of "top-box" responses—patients selecting the highest possible rating for their counseling experience. The co-chair noted concerns about whether focusing solely on top-box scores is an appropriate way to evaluate counseling quality, given the limitations of survey response scales and questions about how meaningful such data would be across providers. The workgroup raised additional feasibility challenges, citing that the measure uses claims data and counseling is not consistently or reliably coded, making confirming whether counseling occurred difficult.

  A workgroup member echoed these concerns, recommending against adoption of the measure. They highlighted that the narrow range of patient responses may make top-box scoring an unreliable indicator of quality and difficult for clinicians to interpret in a meaningful way.

  Ballot Decision: The measure will not be added to the ballot.

- **Measure Title:** CBE #3666 Ambulatory Palliative Care Patients' Experience of Receiving Desired Help for Pain

  Endorsement/Use: The measure is endorsed and is not currently used in public reporting.

  Rationale for Potential Addition and Written Member Feedback: The measure addresses multiple gap areas: advanced illness, hospice care and palliative care, appropriate pain management, and is a patient-reported measure.

In written feedback provided prior to the meeting, two workgroup members recommended the measure not be added to the core set. One member thought the measure would be difficult to implement with claims data. The other member was concerned about accurate use of current procedural terminology (CPT) codes, physicians failing the measure if a patient answers “no” on the survey, exclusion of non-respondents, and lack of testing in ambulatory settings.

Discussion: The measure steward explained that palliative care physicians, nurses, and interdisciplinary team members developed the measure to assess whether patients felt they received the help they wanted for their pain—not necessarily whether their pain was fully controlled. This question is intended to reflect communication, shared decision-making, and the overall relationship between patients and clinicians, and it was clinically tested in ambulatory palliative care settings. The Hospice CAHPS survey has included a similar version since 2021, and the developer is seeking performance data. CMS previously declined to include the measure in the Merit-based Incentive Payment System (MIPS), viewing it as too similar to the “Feeling Heard and Understood” measure, although the developer emphasized they capture different aspects of care.

Workgroup members raised questions about whether patients understand the distinction between pain control and receiving desired help. The developer responded that testing did not identify confusion and that patients welcomed the opportunity to report on whether they received appropriate attention to their pain. One workgroup member voiced concerns about overreliance on condition-specific patient experience measures, while also emphasizing the importance of ensuring patient voices are represented. The developer confirmed that the measure can be reported by any clinician providing a palliative care visit, not only palliative care specialists.

Ballot Decision: The measure will be added to the ballot.

Prevention and Wellness

Ms. Buchanan noted that the that the ACO/PCMH/PC core set currently includes six prevention and wellness measures: CBE #0032 Cervical Cancer Screening,
Breast Cancer Screening, CBE #0034 Colorectal Cancer Screening (COL), CBE #0028 Preventive Care Screening: Tobacco Use: Screening and Cessation Intervention, CBE #0421/0421e Preventive Care Screening: Body Mass Index (BMI) Screening and Follow-up Plan, and CBE #3059e One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk.

- **Measure Title:** CBE #0326 Advance Care Plan

  Endorsement/Use: The measure is endorsed and used in MIPS, the Maryland Total Cost of Care (MDTCOC) Model, and in the Primary Care First (PCF) Model.

  Rationale for Potential Addition: The measure addresses the advanced illness, hospice care, and palliative care gap area, and in written feedback provided prior to the meeting, a workgroup member recommended adding the measure to the core set. Although the measure is topped out in MIPS it remains endorsed as

there is opportunity for continued improvement.

Discussion:. A co-chair reminded the group that the measure has been in use for some time. A workgroup member raised a concern about the measure's performance history. They noted that although measures deemed "topped out" in MIPS are not always topped out for other populations, this measure applies only to individuals aged 65 and older. They suggested the MIPS determination might indeed reflect real topping-out in this context and asked whether any payers had noticed otherwise.

Another workgroup member noted that CMS proposed a similar Advance Care Planning measure on the 2025 Measures Under Consideration (MUC) List for MIPS. CMS ultimately pulled the measure from MIPS consideration because the measure needs to be re-specified at the clinician level of analysis.

Ballot Decision: The measure will be added to the ballot.

- **Measure Title:** CMIT #1146 Preventive Care and Wellness (Composite)

  Endorsement/Use: The measure is not endorsed and is used in MIPS.

  Rationale for Potential Addition and Written Member Feedback: The measure is not topped out in MIPS and addresses the composite measure gap area. In written feedback provided prior to the meeting, two workgroup members recommended that the measure not be added to the core set. One workgroup member was concerned about burden and the need for registry data. Another workgroup member believed that composites obscure true performance.

  Discussion: A workgroup member suggested the upper age limit (64) be removed so the measure would apply to all adults. A co-chair explained that while the measure is not topped out in MIPS, members expressed concern about the substantial data challenges associated with calculating a composite measure. Specifically, the composite cannot be reliably built using claims alone, because it requires both claims and registry data, and current systems do not support this integration in a consistent or efficient way.

  A workgroup member asked whether vaccines were included in the composite. Battelle confirmed that influenza and pneumococcal vaccines are part of the measure. The member noted that shifting national vaccine recommendations and the difficulty of measuring vaccinations make this measure more complicated, particularly when coding practices and data sources vary.

  Another workgroup member asked why claims would not adequately support measurement. Others responded that some screenings rely on Logical Observation Identifiers Names and Codes (LOINC)-coded data, which often does not flow consistently from electronic health records (EHRs) into claims, contributing to incomplete data capture. The workgroup member suggested that the measure might eventually be more feasible with broader connectivity through health information exchanges or health data utilities. A co-chair agreed that immunization data are often fragmented across providers and public health systems, and while integration efforts are underway, including work by the

Centers for Disease Control and Prevention (CDC), registries remain siloed and not yet ready to support a measure of this scope.

Additional comments from workgroup members highlighted longstanding concerns about composite measures: operational complexity, differences across cohorts, and the potential for composites to mask uneven performance among component measures.

Ballot Decision: The measure will not be added to the ballot.

Pulmonary

Ms. Buchanan noted that the that the ACO/PCMH/PC core set currently includes two pulmonary-related measures: CBE #0058 Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis/Bronchiolitis (AAB) and CBE #1800 Asthma Medication Ratio (AMR).

- **Measure Title:** Follow-Up After Acute and Urgent Care Visits for Asthma (AAF-E)

  Endorsement/Use: The measure is not endorsed and is not currently used in public reporting but is used in HEDIS.

  Rationale for Potential Addition and Written Member Feedback: The measure addresses the integration across care settings gap area. In written feedback provided prior to the meeting, a workgroup member recommended the measure be added to the core set. They said that the measure could replace CBE #1800 Asthma Medication Ratio, which the steward, National Committee for Quality Assurance (NCQA), retired.

  Discussion: The measure steward explained that the measure was developed following the retirement of the prior AMR measure. In reevaluating AMR, NCQA identified misalignment with clinical guidelines and feasibility challenges—particularly difficulties in accurately capturing inhaled medication data—leading NCQA to design a new measure that focuses not on medication usage but on appropriate follow-up care aligned with asthma guidelines. NCQA confirmed that the measure includes urgent care visits.

  The workgroup noted that the measure's 30-day follow-up window, which contrasts with the 14-day window for asthma used in CBE #3455 Timely Follow-Up after Acute Exacerbations of Chronic Conditions. NCQA explained that although 14 days is clinically preferable, clinical advisory panels recommended 30 days based on current scheduling feasibility. Despite the longer window, NCQA's testing showed relatively low average performance (about 35%) in Medicaid populations, indicating room for improvement.

  NCQA also clarified that the measure was tested at the plan level, not the individual clinician level, and has not yet been validated for clinician-level application. This prompted discussion on whether the measure should still be eligible for inclusion in the core set. A member of the Steering Committee confirmed that measures not tested at clinician level may still be put to a vote, and that the workgroup has historically been allowed to decide whether lack of clinician-level testing is a barrier. A co-chair noted that roughly half of current

ACO/PCMH/PC core set measures are not validated at the clinician level.

Ballot Decision: The measure will be added to the ballot.

Utilization and Overuse

Ms. Buchanan noted there is one utilization and overuse measure: Use of Imaging Studies for Low Back Pain (LBP).

- **Measure Title:** CBE #2940 Use of Opioids at High Dosage in Persons without Cancer

  Endorsement/Use: The CMS CBE removed the measure's endorsement because the steward said that they are no longer pursuing endorsement. The measure is still in use in the Medicaid: Adult Core Set and Medicare Part D.

  Rationale for Potential Addition and Written Member Feedback: The measure addresses multiple gap areas including unnecessary services and waste/overuse, and appropriate pain management. Written feedback provided prior to the meeting reflected differing opinions on adding the measure. One workgroup member recommended not adding the measure because its endorsement was removed. Another workgroup member was supportive of the measure's addition at the health plan level only because the measure is not tested or validated at the clinician level.

  Discussion: The measure steward noted that the measure is a population-level, retrospective tool to identify high-risk prescribing patterns and opportunities for improvement. The steward emphasized that the measure is not designed or validated for clinician-level performance assessment. A workgroup member acknowledged the importance payers and the public place on utilization and overuse measures, but argued that families define quality care differently, focusing on access, personal experience, improvement in health, and care coordination rather than utilization metrics. The member cautioned against relying too heavily on utilization-based measures to judge quality and urged consideration of patient- and family-centered perspectives.

  Ballot Decision: The measure will be added to the ballot.

- **Measure Title:** CMIT #33 Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse)

  Endorsement/Use: The measure has not been submitted for endorsement and is currently in use in MIPS.

  Rationale for Potential Addition and Written Member Feedback: The measure is not topped out in MIPS and addresses the unnecessary services and waste/overuse gap area. In written feedback provided prior to the meeting, workgroup member recommended that the measure not be added to the core set because it depends on registries and accurate coding of viral sinusitis.

  Discussion: The workgroup raised concerns about the reliability and accuracy of the measure, particularly its dependence on accurate diagnosis and the

limitations of claims data. A co-chair highlighted that symptom onset is not captured in claims, making determining whether antibiotic prescribing truly reflects overuse difficult. They also noted that some patients initially diagnosed with viral sinusitis may develop bacterial sinusitis within the 10-day window, potentially justifying antibiotic treatment and complicating interpretation of the measure. Additional comments emphasized the need to prioritize measures that are endorsed, well-tested, validated at the appropriate level, and most impactful, given the size of the existing primary care measure set.

Ballot Decision: The measure will not be added to the ballot.

- **Measure Title:** Use of Opioids at High Dosage

  Endorsement/Use: The measure has not been submitted for endorsement and is not currently used in public reporting.

  Rationale for Potential Addition and Written Member Feedback: The measure addresses two gap areas: unnecessary services and waste/overuse, and appropriate pain management. In written feedback provided prior to the meeting, a workgroup member recommended the measure be added to the core set but noted that payers may have challenges accessing pharmacy data if they are not managing the member's prescription benefit.

  Discussion: While the workgroup did not discuss the measure, the measure steward noted that the measure is adapted from the Pharmacy Quality Alliance (PQA) measure but has a different duration: 15 days compared to the PQA measure, which is 90 days. The measure will be reevaluated this summer to ensure dosage requirements align with clinical guidelines and the evidence base. Steward edits to the measure from the reevaluation would be ready for the 2028 measurement year.

  Ballot Decision: The measure will be added to the ballot.

- **Measure Title:** Use of Opioids From Multiple Providers

  Endorsement/Use: The measure has not been submitted for endorsement and is not currently used in public reporting.

  Rationale for Potential Addition and Written Member Feedback: The measure addresses two gap areas: unnecessary services and waste/overuse, and appropriate pain management. A workgroup member recommended the measure be added to the core set but noted that payers may have challenges accessing pharmacy data if they are not managing the member's prescription benefit.

  Discussion: The steward noted that this measure is also adapted from a PQA measure. There was no further discussion on the measure.

  Ballot Decision: The measure will be added to the ballot.

- **Measure Title:** CBE #3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

Endorsement/Use: The measure is endorsed with conditions; when the measure returns for maintenance, the measure developer should explore how to address nuances based on the complexity of certain medical procedures (e.g., through stratification or exclusions). The measure is currently in use in the Medicare Part D display page.

Rationale for Potential Addition and Written Member Feedback: A workgroup member proposed the measure for addition, citing the importance of prescription opioid safety.

Discussion: The measure steward explained that the goal of the measure is to discourage overly long initial opioid prescriptions. They noted that the measure includes important exclusions, such as patients in hospice or palliative care, individuals with cancer or cancer-related pain, and those with sickle cell disease. These exclusions also apply to CBE #2940 Use of Opioids at High Dosage in Persons without Cancer.

A co-chair asked whether the measure functions at a provider-group level and where the measure has been validated. The steward clarified that the measure was designed and tested at the health plan level and has not been validated for clinician-level measurement.

Ballot Decision: The measure will be added to the ballot.

Other

There are no measures in the core set in the "other" category.

- **Measure Title:** CBE #2483 Gains in Patient Activation Measure (PAM) Scores at 12 Months

Endorsement/Use: The measure is endorsed with conditions; when the measure returns for maintenance, the committee would like to see, 1) progression on EHR integration, and 2) evaluation of bias due to changes in the population over time. The measure is currently in use in MIPS and the Kidney Care Choices (KCC) Model.

Rationale for Addition and Written Member Feedback: The measure addresses two gap areas: patient-reported measures, and goals of care and patient education. Two workgroup members recommended the measure not be added to the core set. One member was concerned that the measure was not claims based. Another workgroup member believed the measured population should be narrower, that the measure would be challenging to implement, and that the measure may penalize physicians who care for older, sicker, or publicly insured patients.

Discussion: A co-chair noted several concerns raised by the workgroup, including the 50-patient minimum requirement, the fact that the measure has not been tested at the individual clinician level, and generally limited support for adding the measure despite appreciation for the measure's intent and design.

The other co-chair raised questions about the burden and licensing costs associated with using PAM, noting that it has historically been a licensed product. The lead author of the PAM explained that the measure evaluates changes in patient activation over time, rather than baseline scores. They emphasized that the measure is designed to level the playing field by focusing on improvement, rewards providers who support patient self-management, and is actionable because activation can be improved through known interventions.

The measure steward reported that while most KCC Model participants were initially unfamiliar with PAM, the majority were able to successfully implement it and related interventions. They confirmed that the PAM requires a licensing fee. The pricing is at the population level and starts at $2,200 for up to 500 beneficiaries.

Workgroup members requested more clarity on the cost range, expressing concern about potential variability and affordability. Members also raised broader questions about how the group historically considers implementation costs and proprietary measures. The Steering Committee chair explained that while proprietary measures are not categorically excluded from core sets, there has been increasing scrutiny around cost, public availability of specifications, and appropriateness for inclusion in core sets—particularly on the federal side, where public access to specifications is often expected.

In a follow-up communication, Battelle requested additional details from the measure steward on the cost of using the measure. The steward replied that the fee tiered pricing per patient would decrease as the total number of patients increased. At 1 million patients, licensing costs would be roughly $1.00-$1.50 per patient and would decrease below $1.00/patient from there as beneficiary count increases. This fee covers the license and ongoing maintenance. Any additional implementation support and system integrations would incur additional costs.

Ballot Decision: The measure will be added to the ballot.

- **Measure Title:** CBE #4655e The percentage of patients assigned female at birth ages 15-44 who were asked the Self-Identified Need for Contraception (SINC) question with a recorded response, among patients with a qualifying encounter. (Contraceptive Care Screening eCQM)

  Endorsement/Use: The measure is endorsed and is not currently used in public reporting.

  Rationale for Potential Addition and Written Member Feedback: The measure addresses the contraceptive care gap area. A workgroup member recommended the measure not be added to the core set because it is difficult to satisfy with claims data.

  Discussion: A workgroup member agreed with the recommendation not to include the measure in the core set. They explained that the measure's focus on "most or moderately effective contraception" excludes important patient

considerations and preferences. The member also raised concerns that patients may agree to contraceptive counseling yet still choose options outside those categories and emphasized the importance of avoiding coercive implications in contraceptive measurement and clinical practice.

Additional concerns noted were the feasibility of large-scale implementation, the limited scope of testing, and challenges associated with relying on claims data to accurately capture patient needs and preferences. The member also pointed out issues with how the measure was initially written in the Value Set Authority Center (VSAC), suggesting ongoing specification concerns.

Ballot Decision: The measure will not be added to the ballot.

- **Measure Title:** Initiation and Engagement of Substance Use Disorder Treatment (IET)

  Endorsement/Use: The measure has not been submitted for endorsement and is in use in the following public reporting programs: Marketplace Quality Rating System, Medicare Shared Savings Program, MIPS, Medicaid: Adult Core Set, and Medicaid: Home Health Core Set.

  Rationale for Potential Addition and Written Member Feedback: The measure addresses the behavioral health and substance use gap area. Two workgroup members recommended the measure not be added to the core set. One stated that the measure is likely part of the Behavioral Health core set.[1] The other workgroup member was concerned that the measure is not tested at the clinician level and is not consistent with evidence-based care.

  Discussion: A workgroup member noted that while the IET measure is designed for behavioral health specialists, the majority of individuals with mental health and substance use conditions are treated in primary care and general medical settings. They highlighted ongoing challenges related to silos between behavioral health and primary care, suggesting that deferring responsibility between specialty-focused workgroups undermines efforts to support integration of care.

  In contrast, a co-chair shared additional workgroup concerns, including questions whether the IET measure belongs in the ACO/PCMH/PC core set and the presence of significant confounding factors that affect whether patients initiate or engage in treatment after identification. These factors include availability of services and other external barriers beyond provider control, which complicate interpretation of the measure's results.

  Ballot Decision: The measure will not be added to the ballot.

Potential Removals:

- **Measure Title:** CBE #1800 Asthma Medication Ratio

[1] This measure is not included in the Behavioral Health core set.

Endorsement/Use: The measure is endorsed and is currently in use in the Medicaid: Adult Core Set, Marketplace Quality Rating System, and Medicaid: Child Core Set.

Rationale for Potential Removal and Written Member Feedback: NCQA will be retiring this measure in 2026 because it no longer aligns with current asthma treatment recommendations. Two workgroup members agreed with the recommendation to remove the measure.

Discussion: There was no discussion on the measure.

Ballot Decision: The measure will be added to the ballot.

- **Measure Title:** CBE #0005 CAHPS Clinician & Group Surveys (CG-CAHPS) Version 3.1

  Endorsement/Use: The measure is endorsed and is currently in use in MIPS, Medicare Shared Savings Program, ACO REACH, MDTCOC Model, and the PCF Model.

  Rationale for Potential Removal and Written Member Feedback: Two workgroup members proposed the measure for removal. One member was concerned about how measure scores are presented. The other member had concerns about CAHPS being outdated, low reliability, and the survey being ill-suited to measuring primary care quality.

  Discussion: A workgroup member noted that there are medical societies who try to eliminate CAHPS each year but the member did not know the rationale behind the decision.

  Ballot Decision: The measure will be added to the ballot.

- **Measure Title:** CBE #0058 Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)

  Endorsement/Use: The measure is endorsed and is currently used in MIPS, Marketplace Quality Rating System, Medicaid: Adult Core Set, and the Medicaid: Child Core Set.

  Rationale for Potential Removal: A workgroup member noted that the measure is not validated at the clinician level and holds primary care providers accountable for care they did not provide.

  Discussion: There was no discussion on the measure.

  Ballot Decision: The measure will be added to the ballot.

- **Measure Title:** CMIT #729 Transitions of Care (TRC)

  Endorsement/Use: The measure has not been submitted for endorsement and is currently used in the Medicare Part C Star Rating.

Rationale for Potential Removal: A workgroup member noted that the measure is burdensome for small practices, lacks CBE endorsement, and is not validated for use at the clinician level.

Discussion: There was no discussion on the measure.

Ballot Decision: The measure will be added to the ballot.

- **Measure Title:** Use of Imaging Studies for Low Back Pain

  Endorsement/Use: The measure's endorsement has been removed, and the measure is currently in use in the Marketplace Quality Rating System.

  Rationale for Potential Removal: A workgroup member noted that the measure lacks CBE endorsement, is not validated for clinician-level use, and that there are higher priority measures for a primary care core set.

  Discussion: There was no discussion on the measure.

  Ballot Decision: The measure will be added to the ballot.

- **Measure Title:** CBE #0421/0421e Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

  Endorsement/Use: Endorsement was removed from both versions of the measure. The measure is currently in use in the Medicare Shared Savings Program, MIPS, and the MDTCOC Model.

  Rationale for Potential Removal: A workgroup member recommended the measure for removal because the measure's specifications do not align with the HEDIS version and because the measure is a process measure. Additionally differing versions of the measure creates unnecessary burden and misaligned priorities. The member also noted the measure lost CBE endorsement.

  Discussion: There was no discussion on the measure.

  Ballot Decision: The measure will be added to the ballot.

Gaps Discussion

The workgroup did not discuss gap areas, but Ms. Buchanan noted that when the ballot is sent, Battelle will ask for feedback on gap areas.

Priority gap areas to consider for this core set are:

- Patient-reported measures
- Stratification of existing measures to identify differences in outcomes
- Unnecessary services and waste/overuse
- Misdiagnosis/delayed diagnoses
- Integration across settings/specialties and populations

Additional gap areas identified by the workgroup are:

- Appropriate pain management
- Behavioral health and substance use
- Advanced illness, hospice care, and palliative care
- Health-related quality of life
- Composite measures
- Goals of care and patient education
- Contraceptive care measures tested at the clinician level
- Medication adherence
- Shared decision-making
- Supplementing core set with population-based outcome measures to address social needs that impact health and development of measures to address differences in outcomes

Next Steps

Ms. Buchanan provided an overview of voting procedures. Battelle will send the voting link from CQMC@battelle.org. Ms. Buchanan reminded the group of supermajority voting rules and provided an overview of the Full Collaborative approval process. Ms. Buchanan and the co-chairs gave closing remarks before adjourning the meeting.