Endorsement and Maintenance (E&M) Measure Developer Workshop Attendee Questions and Answers (Q&A)

Comprehensive Evaluation of Measures: A Holistic Approach (Slides 1-33)

Q: The slides focused extensively on generating value for the entity, but could you clarify how value to the patient is considered in this process? Specifically, how do you assess whether the proposed measure would be meaningful or valuable from the patient's perspective? Additionally, I noticed limited information on patient engagement. Was the community engagement component designed to address patient-level engagement directly?

A: Our measure evaluation process emphasizes the significance and value of the measure focus to patients, which is crucial for determining the measure's importance and establishing its business case. These attributes also align with our Partnership for Quality Measurement (PQM) criteria for endorsement. To ensure the inclusion of the patient voice, we actively recruit patients, caregivers, and advocates to participate on our endorsement committees. Their lived experiences and perspectives are invaluable in assessing the meaningfulness of the measures under consideration for endorsement. Additionally, we are committed to enhancing the accessibility of our materials for the patient community so patients, caregivers, and advocates can engage meaningfully in the endorsement process.

Q: In the measurement ecosystem, with advancing maturity of evidence, identifying coherent coordinated actions, pay for transformation, creating shared accountability, meaningful community engagement – where does the role of measure developers end and where does the role of measure stewards start?

A: Measure developers and measure stewards have interconnected yet distinct roles. Measure developers are generally responsible for creating the measure, defining its concept, developing methodology, and conducting initial testing to ensure the measure accurately reflects the quality of care or outcomes. The developers lay the technical and scientific groundwork, ensuring the measure is evidence based and aligns with current clinical guidelines. Measure stewards, who may also be developers, are generally responsible for maintaining, coordinating, and managing the measure; integrating it into broader health systems; aligning it with policy and payment reforms; and engaging with communities to ensure effective implementation and meaningful health outcomes. The delineation between these roles is crucial to prevent measures from becoming static and to ensure they adapt to evolving health care needs. The specific responsibilities and collaboration between developers and stewards should be clearly defined and agreed upon by both parties.

Q: Question with respect to the commonly used term "evidence-based" and statements like "When evidence is graded, the grade and the scale used should be provided verbatim." Is the content listed on CBE Strategy: Coherent Actions (Evidence) Slide 13 the model that Battelle may or will deploy as a way to standardize the evaluation of the quality of evidence and actual demonstration of clinically meaningful impact on health of

the target population through the actual use of any given quality measure? This topic very often becomes a major source of variation and uncertainty for endorsement committee members and especially for maintenance measures that have not demonstrated significant impact over time.

A: Battelle recognizes the importance of a structured approach to evaluating a measure's evidence. The table of evidence levels on slide 13 outlines a comprehensive framework that categorizes the development and validation of the measure construct itself, essentially outlining the lifecycle from initial concept through to a mature, widely applicable quality measure. This progression through the levels helps to build a strong business case for a quality measure by demonstrating its evolution, scientific acceptability, and relevance to clinical practice over time.

On the other hand, grading the quality of evidence is a complementary process that evaluates the rigor, credibility, and scientific merit of the evidence supporting these measures. It focuses on the methodological aspects, such as the design of the studies, the precision of the results, the consistency across different studies, and the direct applicability to patient care. This grading is crucial for ensuring that decisions based on this evidence are sound and can be trusted to improve health outcomes.

The distinction between the maturity of the evidence for the measure construct and evidence quality is particularly important, as it may be possible for a quality measure to advance in terms of maturity without necessarily meeting the higher standards of evidence quality, or vice versa. For example, the evidence supporting importance might be graded highly, but the measure is less mature on causality. Therefore, when evidence is graded, it is essential to provide the grade and the scale used verbatim, as recommended. This practice ensures transparency and consistency in how evidence is evaluated and communicated, facilitating better understanding and decision-making among all stakeholders involved.

While both processes aim to ensure the effectiveness and scientific acceptability of quality measures, they serve distinct but interconnected roles. Together, they provide a comprehensive framework for evaluating quality measures, ensuring that they are both well-constructed and supported by high-quality evidence.

Q: Under the Measurement Science Focus Areas Slide 17, I have not seen conformance before. Is conformance a new criterion? Is it must pass?

A: Conformance is not a new criterion; rather, it represents a holistic view of how we think about the data element or the person- or episode-level analysis. We want to make it easier for developers and stewards to be able to articulate all the thoughtfulness and analysis that has gone into the development of the measure specification, so the umbrella term we use for that is "conformance."

What Good Looks Like (Slides 1-19)

Q: Does Battelle rely on a standard definition and/or explicit criteria for the term "patient?"

A: Battelle does not have explicit criteria for the term "patient." Rather, what we look for depends on the context. The patients and caregivers serving on our committees are individuals who have

interacted closely with the health care system, and their role is to provide insights from that perspective. They do not represent a measure developer or clinician perspective.

In terms of patient engagement in the measure development process, we rely on the measure submitters to define those patient populations so that patient input accurately represents the populations impacted by the measure.

Q: How should we handle cases where no new data have been published within the last 5 years? In some of the smaller specialties we work with, published data are often limited or infrequently updated.

A: We want measure submissions to be as transparent as possible. If you know early on that this is the case, we encourage you to reach out to us at PQMsupport@battelle.org so we can discuss some strategies tailored to your measure and what data and resources are available to you.

This requirement focuses on the relevance of the measure. For maintenance measures, we expect that the measure is actively being used, which involves data collection, trend reporting, performance monitoring, and additional testing if specifications have changed based on the measure's application. Therefore, if the measure is in use, it should be generating data that can support testing for the maintenance submission.

PQM operates on a 5-year maintenance schedule; however, we work to accommodate developers and stewards who need another year or cycle to obtain testing data.

Q: Is performance stratification a "must report" among and between populations, including demographic, clinical, social, geographic, community, and practice variables?

A: While performance stratification is encouraged, we do recognize that it is not always possible depending on the availability of certain data. For maintenance measures, Table 1 (Performance Scores by Decile) in Section 2: Importance of the Full Measure Submission Form is mandatory and requires developers to provide a distribution of performance scores for the accountable entity. However, there is no requirement to examine performance across subpopulations beyond what is addressed within the Equity domain. Additionally, for maintenance measures, we require developers to complete Table 2 (Accountable Entity-Level Reliability Testing Results by Denominator-Target Population Size) in Section 4: Scientific Acceptability showing the distribution of reliability results for the accountable entity. These tables highlight the number of accountable entities and the number of patients featured in both the performance and reliability tables.

Q: Do you think that 5-year data timeline will be very challenging? Clinical guidelines on a specific topic seem to take longer to develop and disseminate.

A: When we specify the need to use data from the past 5 years, we are referring to the data used to test the measure (performance gap, trend analyses, stratification) and any data used to evaluate scientific acceptability (validity, reliability, and risk adjustment). The clinical guidelines upon which your measure is based do not necessarily need to be within the past 5 years but do need to be current and reflective of known best practices or guidelines in the field. For example, if the most current guidelines for a treatment course were issued 7 years ago, those guidelines would not need to be updated. The focus of this requirement is on the data being used to evaluate your measure, ensuring that it is recent and relevant.

Q: How are you capturing the patient experiences, especially for those as the result of suboptimal measure performance?

A: While we do not specifically collect patient experiences on suboptimal measure performance, we ensure patient representation on all our committees. To integrate the patient voice throughout the process, we have patients as members of the review committees and as one of our co-chairs. We prioritize recruiting patients who have a lot of experience with the health care system, regardless of whether they have experience with the specific condition being reviewed.

Additionally, we also encourage measure developers to invite their subject matter experts or patient partners to join the committee calls and provide additional perspectives that might be valuable.

Importance and Logic Model Guidance (Slides 1-34)

Q: Am I correct in assuming that a logic model is totally separate from the ability to efficiently capture the elements or the burden of the model?

A: It is not totally separate. The activities and outputs, including the measure focus as one of the outcomes, are interconnected components of the logic model. However, underlying these elements is a critical understanding of their feasibility—the practicality of the activities you are trying to implement, the data you are trying to generate, and your ability to provide these data back to the entities for performance improvement. As part of the Importance domain, developers establish a technical expert panel that can help advise on the feasibility and the burden associated with data collection or activities needed to achieve the outcome. Additionally, patients are strongly encouraged to weigh in on the feasibility of the approach outlined in your logic model. This involvement is vital for gaining community buy-in and establishing face validity of the measure.

Q: Is the CMS Measures Management System (MMS) Blueprint available as a whole document the way it used to be? If it is, can you please share the link. If not, can I request that Battelle think about going back to a full version. While large, it's easier to work with as a Measure and Instrument Development and Support (MIDS) contractor. For example, I'm not finding "logic model" requirements/guidance.

A: The CMS MMS Hub (https://mmshub.cms.gov) houses all the technical content previously found in the CMS MMS Blueprint as a standalone document. A separate team at Battelle manages the CMS MMS Blueprint, but we are happy to pass along your feedback regarding usability. Any further questions or feedback regarding Blueprint content and the MMS Hub can be sent to MMSsupport@battelle.org.

Q: It sounds like there is an assumption there are quality improvement (QI) programs in all settings. Per the National Association for Healthcare Quality (NAHQ), there is a nationwide problem with having QI programs in all settings. With that in mind, how are measure developers supposed to create measures that can be addressed through a QI program?

A: Given the variability in the presence of QI programs across different health care settings, measure stewards/developers can consider other strategies to ensure that the measures they create can still be effectively utilized. For example: 1) Flexibility: Design measures that are

flexible enough to be implemented in settings with varying levels of QI maturity. This means creating measures that can be adapted or scaled according to the resources and capabilities of different health care environments; 2) Simplicity and Clarity: Develop measures that are straightforward and easy to understand, minimizing the need for extensive QI infrastructure or expertise to interpret and act upon the data. This can help settings without formal QI programs to still engage in improvement efforts; and 3) Education and Support: Provide guidance and resources alongside the measures to help settings without established QI programs understand how to use the measures for improvement.

Q: Should the developer add footnotes with citations in these logic model boxes?

A: The logic model example is not intended to be overly prescriptive, but, yes, developers should summarize their logic model, which includes identifying the evidence and associated citations used to construct it. We encourage developers to provide a summary of their logic model within the logic model attachment submitted in the measure submission form. You may choose to footnote the evidence that identifies the various elements of the model, but a detailed summary should be provided in the narrative sections of the measure submission form when discussing evidence to support the measure and the anticipated impact of the measure.

Feasibility (Slides 1-17)

Q: If data element feasibility is done during initial measure development and endorsement, do you have to repeat this with measure endorsement if the data elements are the same and there were no issues the first time around?

A: If the measure specifications and associated data elements have not changed at measure maintenance, you do not need to update data-element feasibility results. However, if measure implementation challenges occurred because of the data elements, those should be described in your feasibility assessment along with a mitigation strategy or near-term path (within 1 year) to overcome any challenges.

Q: In workflow, is there a way to separate easily captured data (e.g., structured data such as vital signs) from data that requires manual or AI collection (e.g., non-structured data such as a provider note) in the feasibility review? This distinction becomes very important in future direction with electronic clinical quality measures (eCQMs).

A: When completing the feasibility scorecard, if the data are found in an unstructured field—whether due to manual extraction or use of artificial intelligence (AI)—you should still score that data element as 0. However, please be sure to include these details in the plan for readdressing the measure so reviewers are aware of additional context. As a reminder, the PQM measure evaluation rubric does not have must-pass domains, so we are collecting and considering all context when evaluating a measure holistically. We will continue to consider potential updates that may be needed for evaluating eCQMs in the future.

Q: Have you considered using the eFeasibility scorecard for non-eCQM measures?

A: The use of a feasibility scorecard is particularly important for eCQMs as it assesses potential issues with use of emerging data element standards and terminology and incorporates testing results from at least two electronic health record (EHR) vendors to account for variability in data capture. We have not considered implementing a feasibility scorecard for non-eCQMs, such as

claims-based measures, as many of the data elements used to calculate non-eCQMs rely on established data standards (e.g., Uniform Billing[UB]-04 Form) and terminologies (e.g., International Classification of Diseases [ICD] codes), and therefore are considered highly feasible (such as final action claims). However, we will continue to evaluate approaches for assessing quality data-collection burden for all measures.

Q: Is the feasibility scorecard for eCQM?

A: Yes, the feasibility scorecard is only required when submitting an eCQM.

Scientific Acceptability: Reliability, Validity, and Risk Adjustment (Slides 1-34)

Q: Given that you've defined reliability (in one way) as the "degree to which a measure repeatedly and consistently produces the same result," what is the threshold associated when looking at reliability of performance scores over time (e.g., stability of measure scores)? What statistical tests should measure developers use to establish this stability? Also, how is stability valued in the reliability assessment relative to precision (e.g., through signal-to-noise)?

A: Stability and reliability, while related, are distinct concepts. Reliability refers to the consistency of a measure's performance. It is very possible to have a reliable measure that is not stable and depends on the underlying factors that make the measure reliable. For example, a high-performing surgeon consistently delivering excellent outcomes is considered reliable because the outcomes demonstrate true performance. However, if that surgeon were to leave the practice and the measure performance declines, then the measure's reliability is not stable. Stability concerns the underlying reasons for reliability. To assess stability, we examine whether the mechanisms contributing to reliability are structural and persistent. This is typically evaluated through simple correlations over time, such as tracking performance from one year to the next to see if the results consistently align.

Q: Have you considered adding intra- and inter- "payer" reliability in the mitigation of low reliability table?

A: Historically, we have not seen anyone submit a measure that provides intra- and inter-"payer" reliability information. There's an approach to creating a hierarchy, starting with the patient entity and then borrowing strength from the variability across the entities to make inferences about reliability of individual entities. Theoretically, an additional layer could be added to that hierarchy to include a patient entity, plan, or payer way of borrowing strength and improving the reliability of the entity estimates. We have seen measures that include area as a level of that hierarchy with the same idea.

Q: Can you provide a specific example of a "known groups" validity test for an outcomes measure?

A: Typically, known groups evidence is used when there are groups for which no variation in measure performance is expected. This means that there is nothing inherent in the measure or its improvement methods that would suggest differences across populations. However, when evidence shows that there are in fact differences between the populations, one could infer that these differences are related to the quality construct of the measure. This goes back to the

approach where the best explanation for the difference across the groups is a quality difference, as there are no other explanations for the observed differences.

Q: Your reliability thresholds make sense for clinical measures (e.g., blood pressure). Have you considered setting different thresholds for self-reported measures of subjective outcomes (e.g., satisfaction with quality of life)? Reliability metrics are typically lower for those types of measures since they inherently involve personal interpretations of abstract concepts. From the point of view of person-centered practices, it is important to include such measures in QI processes.

A: The thresholds for reliability are not absolute; they are not simply a matter of meeting them or not. If a threshold is not met, to the developer or steward should provide reasoning and explanation. This approach allows for flexibility in evaluating measures that may inherently have lower reliability due to their subjective nature.

Q: How much of the validity evidence can come from the literature that may look at the same outcome but not exactly the measure that you are submitting?

A: Measure submitters often provide evidence from the literature on validity that shows an association or a specific mechanism explaining that association. When submitting literature evidence on validity, developers/stewards should make an argument about why that evidence supports the measure as specified. If you can be explicit about what the evidence demonstrates, then you can absolutely use that to support your validity argument.

Q: Under maintenance measures on Expectations for New vs. Maintenance Slide 26, can Battelle please clarify "Importance table by decile" along with estimates related to "(implementation, adoption, and effect)"—within the context of the validity criterion? Is there a specific field in the form for this? I am not familiar with this from E&M Guidebook.

A: For maintenance measures, developers are required to complete Table 1: Performance Scores by Decile in Section 2: Importance, Question 2.4 (Performance Gap) in the Full Measure Submission Form. While information about adoption, implementation, and effectiveness would be helpful to provide if available, such information is not expected or required.

Q: Related to the Blueprint, I have been wondering if there is a reason why the justification form hasn't been updated for scientific acceptability as it has for PQM (removal of exclusion testing, meaningful differences testing, revision of risk adjustment questions). At least it wasn't the last time I checked (apologies if I missed an update).

A: A separate Battelle team manages the CMS MMS Blueprint and we will pass along your feedback. For specific questions related to the Blueprint and MMSHub content, kindly send your inquiries to MMSsupport@battelle.org.

Q: Is "Better Than Nothing" a good-enough reason to use measures for public-reporting rankings and economic rewards/punishments?

A: Using the rationale "Better Than Nothing" to justify the use of certain measures for accountability purposes (e.g., public reporting, economic rewards or punishments) requires careful consideration. While the use of suboptimal measures can lead to misinformed decisions, misaligned incentives, and potentially unintended consequences, a health care landscape with no measures is not a high-quality scenario. Therefore, the use of suboptimal measures may not

necessarily worsen that landscape. In fact, the status quo may be inferior, and suboptimal measures could represent an improvement over time. That said, "Better Than Nothing" should not be the end goal. The measurement community should make continuous efforts to develop and validate more precise and meaningful measures to ensure that results truly reflect quality and drive appropriate improvements in care, and suboptimal measures could represent a critical step toward an improved measure over time.

Q: Will measure developers be asked to provide reliability and validity testing between the actual implementation use cases, with the use case constraints included in the testing?

A: Beginning with the Spring 2025 cycle, for maintenance measures, accountable entity-level reliability testing (e.g., signal-to-noise analysis) and validity testing (e.g., empirical testing of measure score, association and mechanism studies) are required. Developers should describe the data or sample used for testing in Section 4.1 (Data and Samples) of the Full Measure Submission Form, noting the number and descriptive characteristics of measure entities included in the analysis; any differences in the data used for reliability, validity, exclusion analyses, and risk adjustment; and constraints associated with the data source(s). If there are data constraints (e.g., lack of available data), these should be clearly articulated in the submission bias and it should be stated if they bias the measure testing results in any way. In addition, developers/stewards may also contact PQMsupport@battelle.org to determine what mitigation approaches, if any, might be used.

Equity Guidance (Slides 1-24)

Q: How was it determined that health disparities data for element 2 and element 3 were not needed until maintenance? With a 5-year maintenance window, improvement activities may be quite protracted and not target marginalized populations. Especially as providers practice to these measures, it would be highly recommended to include this content in new and maintenance measures.

A: Given the Equity domain will be required for the first time starting in the Spring 2025 cycle, the starting point for measure requirements needs to be feasible so that what we are asking of measure developers is not overly burdensome. By making elements 2 and 3 optional for new measures, we establish a foundational framework that allows us to build the Equity domain over time. Additionally, it is important to note that developers are not required to provide performance scores for new measure submissions but rather to explain the measure's anticipated impact on important outcomes through a business case. As Equity elements 2 and 3 involve empirical testing of differences in performance scores, making these elements optional for new measures aligns with the existing requirements for the Importance domain.

Q: Will submission forms be updated to more clearly delineate new versus maintenance requirements as described in this presentation?

A: Currently, in our submission forms, we do try to delineate what is required for maintenance measures. We indicate this by using brackets at the beginning of our questions for the four elements of equity. We will work to ensure that the questions are clear with respect to new and maintenance measures.

Q: With respect to "Pitfall: Lack of evidence to demonstrate how entities can improve underlying inequities." Why not formally request/seek quantitively evaluated field testing and use cases that demonstrate significant and meaningful impact on the measure in question up front rather than just providing suppositions on its expected potential beneficial use?

A: Equity elements 2 and 3 (optional for new measures and required for maintenance measures) asks measure submitters to describe their methodology and approach to empirical testing of differences in performance scores, provide the results, and give an interpretation, including the potential impact of these differences on the identified subpopulations.

Instrument-Based Measure Guidance (Slides 1-12)

Q: Won't this carried-over information add burden to the reviewers who have to wade through the same information multiple times?

A: The consensus-based entity (CBE) policy on instrument-based clinical quality measures states that each clinical quality measure derived from an instrument or survey is reviewed and endorsed separately. In the past, developers have submitted information for all clinical quality measures derived from the same survey or instrument in one submission and it has posed burden to reviewers who must then determine where all the relevant information might reside.

Battelle staff are working to streamline presentation of measure information to our committees and on internal efficiencies in the evaluating process itself. This includes distinguishing between measures that require detailed discussion—based on inputs from staff assessments, public comments, and Advisory Group feedback—and those with fewer questions or concerns. Additionally, we are working to identify the key discussion points or concerns that the committee should prioritize for consideration.

Q: If the developer has, for example, 19 measures, will they have to go into 19 forms for each measure? Will these be separate tabs? For instance, what if all the reliability estimates for all 19 measures exceed the criteria (e.g., above .70), so the developer would need to specify 19 times for each measure, "The measure exceeds the criteria…" rather than saying one time, "All 19 measures exceed the criteria of 0.70 for reliability ranging from .XX to .ZZ (and refer to the table to see the specifics)."

A: Beginning with the Spring 2025 cycle, if 19 clinical quality measure are derived from the same instrument or survey then 19 measure submissions will be needed. Previously, developers provided measure and testing for all 19 measures within the same submission form. Some information will be provided at the survey/instrument level (e.g., patient- or encounter-level testing) that will be entered once and "inherited" (i.e., carried over) across derived measure submissions to reduce burden. Other information (e.g., accountable entity-level testing) will need to be completed for each derived measure. We highlight that there is flexibility in considering whether a composite measure is feasible (in which case all measures included in the composite score could be included in the same submission form) or submitting measures over multiple cycles.

Q: Regarding the logic model—would there need to be 19 separate models?

A: There will be one logic model, but it should capture all the instrument-derived measures (i.e., measure focus areas). This logic model will be "inherited" across all the instrument-derived measures.

Q: Can results tables be carried over across the measures?

A: Patient- or encounter-level testing results pertain to the survey and will be "inherited" (i.e., carried over) across all instrument-derived measures. However, accountable entity-level results pertain to each individual instrument-derived measure and will need to be included in the respective submission form.

Use and Usability (Slides 1-16)

Q: Regarding "topping out," how can developers account for selection bias? Voluntarily reported measures might "top out" because entities might only report measures that will only have positive outcomes. This could negatively affect perceptions of outcomes.

A: If measures are topped out or you are seeing topping out in your own data and you are questioning whether that will be a concern for endorsement, we encourage you to reach out to us at PQMsupport@battelle.org to discuss this further on a technical assistance call. If you are thinking that measures are going to be topped out but still see value, provide a justification as to why.

If you are looking at measures being topped out as an aggregated score, consider if there are differences across subpopulations that further provide an argument that there is still value in a gap here in care. Consider if it is only certain areas of the country or certain types of systems that are reporting on the measure and think about how you can expand the use to other entities.

Q: What percentage of CBE-endorsed quality measures are not used by CMS in its various payment models? Trying to get a sense of federal vs. other entities.

A: Because this information changes year over year, we recommend reviewing the CMS Measures Inventory Tool, where you can identify all measures used in CMS programs, including filtering by those that are CBE endorsed.

Q: Can you confirm the Measures Under Consideration (MUC) submission deadline?

A: The CMS MUC submission opens in January and runs through May. Developers also have an opportunity to submit updated testing information in August. For more information, please visit https://mmshub.cms.gov/measure-lifecycle/measure-implementation/pre-rulemaking/overview or email MMSsupport@battelle.org.

Q: Prior to determining "topped out," is PQM including the review of practice and disparities data, such as performance among and between providers and populations? I suggest a more explicit set of criteria to be developed to evaluate whether or not the measure is topped out, which seems too jargony.

A: The prior CBE also considered the criteria for a "topped-out" measure and found applying a blanket criterion across measures to be challenging. When looking at the aggregated measure score, consider the clinical area and whether there is little to no room for improvement. If this is the case, the measure may be "topped out." However, a measure that appears "topped out" at

an aggregate level might have significant room for improvement when considering the performance scores across subpopulations. An argument can be made that a measure still has a gap to fill because there are disparities across that measure performance that are not topped out.

Q: Typically, some but not all accountable entities will improve. Is there a threshold for the proportion of improved entities in order to conclude that the measure has improved?

A: No, there is no universal threshold that could be applied to determine improvement. Each measure must be evaluated based on its specific context, focusing on what is actionable and achievable.

Developer Engagement: What to Expect During the Endorsement Cycle (Slides 1-18)

Q: Could you shed some light on deferring maintenance, especially those transferred from the National Quality Forum (NQF)?

A: Our general deferral policy is that developers and stewards can request an extension of up to 1 year. Each cycle is 6 months, so that is two 6-month cycles, except if it has been more than 6 years since the measure's last endorsement. We want to make sure we are reviewing measures within 6 years.

If you have questions or want to request a cycle deferral, please reach out to PQMsupport@battelle.org.

Q: How far in advance will the measure developers get meeting invites for Fall 2024? Where are the specific dates for meetings posted for the Fall 2024 cycle?

A: All Fall 2024 meeting dates and times are posted to the PQM Calendar on our website. You can click through months and weeks to view when Fall 2024 meetings take place, meeting descriptions, and links to join the meetings. Additionally, we do send out announcements and monthly newsletters. If you have not signed up for our newsletter, you can sign up through the PQM website to join our listserv and receive communications related to upcoming meetings, public comment opportunities, etc.

Developers can expect to receive invites for their respective Advisory Group meetings shortly after the Full Measure Submission deadline (November 1).

Q: Do you expect to make further adjustments to the "projects" (e.g. Primary Prevention, Initial Recognition and Management, etc.).

A: We do not anticipate making changes to the five E&M projects at this time but will continue to assess necessary changes as needed.