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National Consensus Development and Strategic Planning for Health Care Quality Measurement

2025-2026 Pre-Rulemaking Measure Review (PRMR) Recommendation Group Final Meeting Summary

CLINICIAN COMMITTEE

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Pre-Rulemaking Measure Review (PRMR)

Battelle staff convened the PRMR Recommendation Group for the Clinician Committee on January 14, 2026, for discussion on the 2025 Measures Under Consideration (MUC).

The goal of this meeting was to discuss the proposed additions to Centers for Medicare & Medicaid Services (CMS) programs through the perspective of interested parties impacted by the programs. This meeting summary provides an overview of the meeting and outcomes and will be followed by a comprehensive PRMR Meeting Recommendations Report and Recommendations Spreadsheet. For reference, a list of acronyms can be found on the Partnership for Quality Measurement (PQM) glossary page.

Figure 1. PRMR Meeting Attendance

Meeting participants joined virtually through the Zoom meeting platform. Figure 1 outlines overall meeting attendance. From the Clinician Committee, 28 active Recommendation Group members and 25 Advisory Group members attended and engaged in the measure discussion. Only members of the Recommendation Group voted on recommendations. Representatives from the interested parties shown in Figure 1 attended the meeting. CMS, partners at other federal agencies, and Battelle's PQM representatives also attended the meeting. Twenty members of the public joined the call in "listen only" mode.

Overview and Purposes

Brenna Rabel, MPH, technical director of the PQM welcomed the attendees to the meeting and introduced her co-facilitators Dr. Meridith Eastman, PhD, MSPH, PRMR/Measure Set Review (MSR) task lead and Kate Buchanan, MPH, PRMR/MSR deputy task lead. After a brief overview of the day's objectives and agenda, Ms. Buchanan conducted roll call, and Recommendation Group members disclosed any conflicts of interest regarding the measures under review. No members were recused from voting. Recommendation Group co-chairs Christa Starkey, patient co-chair, and Dr. Deepak Gopal, MD, technical co-chair, shared their relevant perspectives and motivation for serving in this role.

Several attendees represented CMS including Dr. Michelle Schreiber, MD, the deputy director of the Center for Clinical Standards and Quality (CCSQ) and the director of the Quality

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Measurement and Value-Based Incentives Group (QMVIG) at CMS. Dr. Schreiber welcomed participants and expressed appreciation to Battelle, CMS staff, measure developers, and the co-chairs. She noted that stakeholder input from the Advisory and Recommendation groups is carefully considered and helps shape CMS policy and rulemaking.

Dr. Schreiber noted that, in addition to the three measures under consideration for the Merit-based Incentive Payment System (MIPS), there is another measure to be discussed. The Advance Care Planning measure is for patients 18 years and older and assesses whether they have an advanced directive or a designated decision-maker for end-of-life care. She explained that, although this measure is not currently being considered for MIPS and therefore will not be voted on, CMS is gathering input whether this measure is appropriate for clinician programs.

PRMR Clinician Committee Measure Discussion

After opening remarks, Battelle facilitators outlined the procedures for discussing and voting on measures. The discussion quorum required the attendance of at least 60% of the Recommendation Group members during roll call at the beginning of the meeting. The voting quorum required at least 80% of active Recommendation Group members who have not recused themselves from the vote. During the meeting, some members stepped away temporarily, so Battelle collected voting counts for each measure to ensure the meeting retained quorum. To reach consensus on a recommendation, a majority of at least 75% of voting members must agree. At the beginning of each measure discussion, a CMS representative gave an overview of the measure and rationale for inclusion in CMS programs.

Table 1 shows the vote counts by measure. PRMR Recommendation Group members had the option of voting to recommend or do not recommend for each of the 2025 MUC List measures for MIPS. Figure 2 shows the committees' voting choices, voting tabulations (percentages), and the reporting language for vote tabulation. Recommendation Group members could provide considerations if they voted to recommend a measure; if they voted not to recommend, a rationale was required. Members provided considerations in the chat and rationales were captured via the Poll Everywhere platform. Battelle summarized committee member voting considerations, where provided, and rationales in the Voting Narrative section for each measure. Battelle's reflections on committee discussion and feedback are summarized in the Future Directions section for each measure.

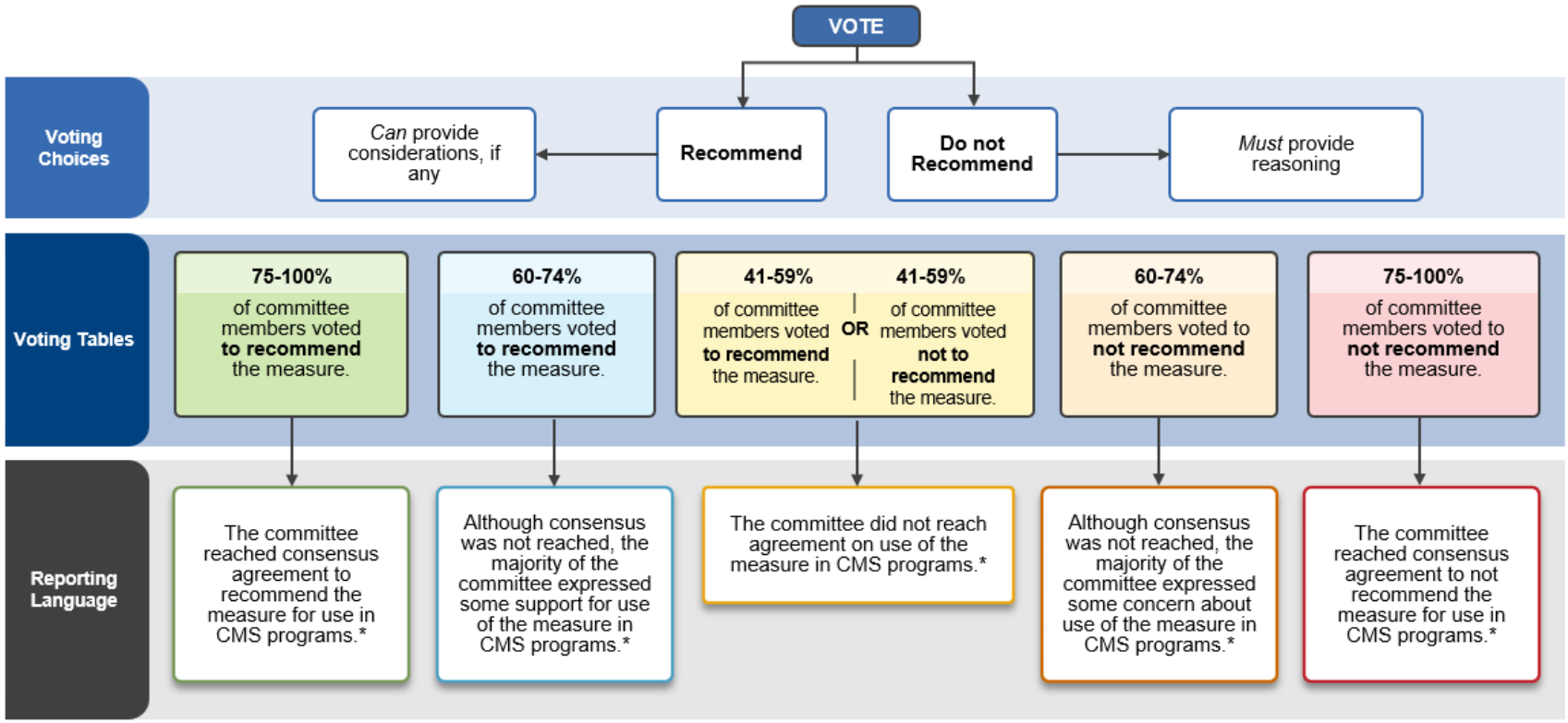

Figure 2. PRMR Voting Process

Table 1. PRMR Recommendation Group Vote Counts per Measure (Clinician Committee, MUC 2025)

MUC ID	Measure Title	Program	Vote Result	Recommend n (%)	Do Not Recommend n (%)	Recusals
MUC2025-034	Low Density Lipoprotein Cholesterol (LDL-C) Monitoring and Management	Merit-based Incentive Payment System (MIPS)	**The committee reached consensus agreement to recommend the measure for use in the Merit-based Incentive Payment System.**	21 (78%)	6 (22%)	0
MUC2025-042	Rate of Timely Follow-up on Abnormal Screening Mammograms for Breast Cancer Detection	Merit-based Incentive Payment System (MIPS)	Although consensus was not reached, the majority of the committee expressed some support for use of the measure in the Merit-based Incentive Payment System.	20 (71%)	8 (29%)	0
MUC2025-043	Rate of Timely Follow-up on Positive Stool-based Tests for Colorectal Cancer Detection	Merit-based Incentive Payment System (MIPS)	The committee did not reach agreement on use of the measure in the Merit-based Incentive Payment System.	16 (57%)	12 (43%)	0

MUC2025-034 Low Density Lipoprotein Cholesterol (LDL-C) Monitoring and Management [American Heart Association]

Description: Percentage of patients aged 18 years and older with clinical atherosclerotic cardiovascular disease (ASCVD) who received a low-density lipoprotein cholesterol (LDL-C) test via lipid panel and achieved an LDL-C of <70mg/dL on the most recent test during the measurement period.

Program: Merit-based Incentive Payment System (MIPS)

Committee Final Vote: The committee reached consensus agreement to recommend the measure for use in MIPS.

Vote Count: Recommend, (21 votes; 78%); Do Not Recommend, (6 votes; 22%); No Recusals.

Measure Discussion:

CMS Opening Remarks: CMS introduced the LDL-C measure, explaining the measure has two numerators: the share of patients who receive LDL-C testing and the share of ASCVD patients who achieve LDL-C <70 mg/dL. The measure uses an outcome-focused approach to evaluate whether patients are managed to a clinically recommended lipid target. The measure aligns with Meaningful Measures 2.0 and the chronic conditions priority and could fit within a primary care MIPS Value Pathway (MVP). CMS cited performance gaps (about 65% tested; 47% at target) and contrasted it with the current MIPS statin therapy measure, which assesses prescribing rather than outcomes. CMS expects this new measure to drive quality improvement and better patient management.

Battelle Summary of Public Comment: Battelle received 26 written comments, two spoken comments, and a congressional support letter about this measure. Commenters noted strong evidence that lowering LDL-C reduces ASCVD risk, highlighted recent reversals in cardiovascular mortality trends, and noted uncontrolled LDL-C levels require enhanced clinical management, particularly for those with chronic kidney disease (CKD), where ASCVD is a leading cause of mortality. Commenters noted alignment with Kidney Disease: Improving Global Outcomes (KDIGO) recommendations to assess and treat LDL-C in CKD, and with American Heart Association (AHA) and American College of Cardiology (ACC) guidelines that target LDL-C <70 mg/dL for ASCVD patients. Commenters also highlighted the measure's focus on outcomes rather than prescribing practices and noted that patients view LDL-C values as clear, actionable indicators of risk and treatment progress.

Commenters recommended refinements to enhance interpretability and feasibility, including considering a <55 mg/dL target for very high-risk patients; allowing exceptions for multimorbidity; incorporating shared decision making; reporting LDL-C monitoring and goal attainment separately, particularly in multiplayer or low integration settings; permitting a 50% LDL-C reduction as an alternative metric when baseline values are unavailable; and monitoring subgroups (e.g., women and racial/ethnic minority groups) to avoid widening disparities in testing and control. One professional society raised feasibility concerns for older adults and suggested refining the specifications before advancing the measure in MIPS.

Closing Gaps of Care Considerations: The literature review on closing gaps of care identified persistent gaps in LDL-C management driven by patient complexity, access, and communication. Older adults encounter significant challenges related to multimorbidity, frailty,

cognitive impairment, and polypharmacy, all of which complicate clinical decision-making and impede effective management of their conditions. Urban patients undergo lipid testing more often than rural patients, and uninsured individuals—despite similar disease prevalence as insured patients—are far less likely to receive treatment or achieve control. Language and health literacy barriers further limit effective management; many patients do not know their LDL-C targets or grasp the seriousness of high cholesterol. The review underscores the need to improve testing, treatment access, and patient education.[1]

Committee Discussion:

Measure design and scoring: Several committee members expressed support for the measure but cautioned against a 100% performance target. They recommended awarding full MIPS credit for high performance (e.g., around 90%) to signal that complete compliance is neither feasible nor clinically advisable. A committee member emphasized the importance of closing care gaps associated with age, multimorbidity, and polypharmacy. They underscored the need for shared decision making to ensure that patients understand and agree to the treatment plan, noting that meaningful patient engagement is critical for sustained treatment adherence. Committee members noted the measure demonstrates advantages over existing statin-dispensing metrics by supporting a broader set of interventions, including lifestyle modification, increased physical activity, and dietary changes, especially for patients who cannot tolerate statin therapy. This outcome-driven design also addresses the limitations of claims-based measures that capture dispensing but do not assess adherence or treatment effectiveness. A patient committee member added that the measure supports prevention and ongoing management but stressed the importance of acknowledging access challenges related to medications, laboratory testing, follow-up care, and comprehensive treatment needs.

Members requested clarity on denominator requirements, specifically whether the measure requires completion of a lipid panel during the measurement year and how cases without testing should be handled. The measure developer said that the denominator was drafted to require a lipid panel within the calendar year. Another committee member requested confirmation that the patient would not be considered to have met the standard if LDL-C is not measured within the 12-month period, consistent with Healthcare Effectiveness Data and Information Set (HEDIS) approaches used for A1C and blood pressure control. Members discussed whether the measure should retain two separate scores, one for testing and one for goal attainment, or use a single composite score. Several members observed that analogous measures for diabetes and hypertension rely on a single unified score in which missing data are treated as noncompliant, which can negatively impact performance score. Others raised concerns that limiting the denominator to ASCVD patients may reduce incentives for broader screening across the population and asked whether infrequent LDL-C testing (e.g., outside a 12-month period) might further reduce opportunities for timely monitoring.

LDL-C target: One committee member expressed concern about the LDL-C target, noting that anti-inflammatory and anti-thrombotic actions of statins contribute to cardiovascular disease (CVD) risk reduction independent of LDL-C levels and pointed to recent literature[2] that cites a paradoxical association between higher LDL-C levels and longevity in elderly populations,

[1] For complete information on the closing gaps of care literature review for this measure, including references cited, please refer to the Clinician Recommendation Group Meeting slide deck.

[2] Bruggen, F.H.v.; Diamond, D.M. Is Targeting LDL-C Levels Below 70 mg/dL Beneficial for Cardiovascular and Overall Health? A Critical Examination of the Evidence. J. Clin. Med. 2025, 14, 3569. https://doi.org/10.3390/jcm14103569

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suggesting equivocal evidence for the benefits of setting the measure's threshold LDL-C level at <70 mg/dL.

Locus of accountability: Several committee members noted that achieving an LDL-C level <70 mg/dL often requires multiple therapies beyond statins, which can be costly and administratively complex under current coverage policies. Members cautioned that the absence of parallel accountability for payers and pharmaceutical manufacturers may limit access to non-statin medications and diminish the measure's overall impact. They further emphasized that socioeconomic status, medical complexity, and rural practice settings could disproportionately influence clinicians' performance scores, urging CMS to anticipate and mitigate these differences.

Another committee member recommended system-level or care team-level accountability rather than individual clinician attribution since lipid management commonly involves multiple clinicians. They noted that for high-risk patients, achieving LDL-C <70 mg/dL often requires therapies beyond statins, yet these medications can be difficult to obtain and manage, increasing cost and administrative burden. They suggested focusing on primary prevention in high-risk populations may offer greater impact.

Measure exceptions: One committee member asked how to document patient exceptions when care team members deliver care that is not billed and does not generate CPT codes, and whether a patient planning to, or could become, pregnant is considered an exception.

The measure developer explained the focus is on the ASCVD population because that is where evidence is strongest and where 50–70% have uncontrolled LDL-C, noting that a specific goal can also drive routine LDL-C testing and help close gaps among older adults, rural communities, women, and underrepresented minorities. The measure developer explained that exceptions align with those used in other CMS measures, including medical exceptions like pregnancy-related circumstances. and may be documented using ICD or Healthcare Common Procedure Coding System (HCPCS) codes, while acknowledging challenges when documentation occurs outside structured encounters or across diverse reporting systems.

Inclusion in MVP: CMS stated that, if adopted, the measure would likely appear within an MVP, and clinicians would retain choice among multiple measures within an MVP. However, several committee members noted that in some MVPs, measure selection may be limited or effectively constrained by scoring requirements, reducing flexibility for clinicians.

Endorsement: Several committee members noted that the measure is not endorsed by a consensus-based entity (CBE). They said that endorsement is a strong indicator of a measure's validity and reliability. CMS replied that endorsement is a separate and resource-intensive process, and the absence of endorsement should not be interpreted negatively against the measure. Battelle indicated that the committee should rely on the test results submitted by the measure developer when assessing whether the measure is ready for implementation.

Overall, the committee expressed strong support for the LDL-C outcome measure focused on the ASCVD population, citing its alignment with evidence, emphasis on effectiveness over prescribing, and potential to promote routine testing. Committee members also underscored implementation risks and gaps in care concerns, including access and affordability of non-statin medications, documentation feasibility (especially outside billed encounters), rural and resource-limited settings, and potential scoring bias due to data fragmentation.

Voting Narrative:

The committee noted several considerations supporting a vote to recommend. Committee members urged CMS to clarify the rationale for the narrow ASCVD definition, the LDL-C threshold of 70, the appropriateness of a 100 percent benchmark, and the potential impact of medication costs. Those who voted "do not recommend" noted that documenting denominator exceptions places undue burden on billing clinicians and recommended additional pathways for capturing exceptions. They noted that the measure may require refinement—potentially splitting it into monitoring and management components—and suggested allowing a 50 percent LDL-C reduction option for patients without a baseline value. Committee members also indicated the specific LDL-C goal lacked a strong evidence base, highlighted the need for more research on the broader physiologic effects of statins, and raised concerns about medication affordability. A committee member added that they preferred expanding this measure to include a more comprehensive lipid-management approach rather than focusing on a single LDL-C target.

Considerations provided with recommend vote:

- There is support for adoption of the measure, but CMS should address why it defines ASCVD so narrowly, why it sets the threshold at 70, concerns about targeting a 100% benchmark, and how medication costs may affect performance.

Rationales for do not recommend vote:

- Billing physicians carry the primary burden of documenting denominator exceptions, even though other care team members often identify these exceptions during non-billable encounters. Additional mechanisms should support documenting these exceptions.
- The measure requires refinement and potentially separation into two components—monitoring and managing. The committee member noted the need to consider offering a 50% LDL-C reduction option for patients without a baseline value, as well as addressing concerns about medication cost and access.
- The initial measurement component functions appropriately; however, the second component, which requires achieving a specific LDL-C goal, lacks sufficient detail and will need further development.
- Statins have anti-inflammatory and anti-thrombotic effects independent of LDL-C reduction and affect multiple body systems, which underscores the need for more research to ensure patient safety and prevent unintended harm.
- Committee members expressed concern about medication costs for patients and the implications of endorsing the measure.
- Committee member preferred expanding the measure into a broader lipid-management treatment plan rather than focusing on a specific LDL-C target.

Future Directions:

Committee members recommended setting realistic performance targets to avoid pressure for 100% compliance and reduce measure complexity. Members stressed the need to clarify denominator specifications, testing intervals, and treatment of missing data to ensure consistent scoring. They also advised maintaining separate reporting for LDL-C testing and goal attainment. Additionally, committee members encouraged CMS to reinforce system-level

accountability, promote team-based care, and address access barriers, including policy options to improve availability of combination therapies when clinically indicated. They also recommended attainment of CBE endorsement.

MUC2025-042 Rate of Timely Follow-up on Abnormal Screening Mammograms for Breast Cancer Detection [Brigham and Women's Hospital]

Description: This electronic Clinical Quality Measure (eCQM) reports the percentage of female patients aged 40 to 75 years with at least one abnormal screening (BI-RADS 0) or screening-to-diagnostic (BI-RADS 4, 5) mammogram during the measurement period (i.e., calendar year) who received timely diagnostic resolution defined as either follow-up imaging with negative/benign/probably benign results or a breast biopsy within 60 days after their index (i.e., first) abnormal screening mammogram.

Negative/benign/probably benign follow-up imaging was defined as diagnostic mammography, breast ultrasound or magnetic resonance imaging (MRI) with BI-RADS ratings of 1, 2, or 3. Relevant diagnostic breast biopsy procedures were defined as core needle biopsy, fine needle aspiration, and surgical excision.

Breast Imaging – Reporting and Data System (BI-RADS) ratings: 0-incomplete, 1-negative, 2-benign, 3-probably benign, 4-suspicious, 5-highly suggestive of malignancy.

Program: Merit-based Incentive Payment System (MIPS)

Committee Final Vote: Although consensus was not reached, the majority of the committee expressed some support for use of the measure in MIPS.

Vote Count: Recommend, (20 votes; 71%); Do Not Recommend, (8 votes; 29%); No Recusals.

Measure Discussion:

CMS Opening Remarks: CMS explained that the measure focuses on ensuring prompt action after an abnormal mammogram result, a process essential to maintaining high-quality patient care and supporting early identification of breast cancer. CMS noted that no other existing measures in MIPS assess timely follow-up for abnormal mammograms. The measure aligns with CMS's Meaningful Measures 2.0 Framework, reinforcing national healthcare priorities, particularly around wellness and prevention.

The measure is under consideration for inclusion in the Diagnostic Radiology MVP. CMS noted that performance results currently range from 70% to 98% depending on the groups or locations, reflecting both variability in practice and opportunities for improvement.

CMS emphasized the urgency of addressing timely follow-up, given the significant emotional burden on patients and the critical role of early detection in improving breast cancer outcomes.

Battelle Summary of Public Comment: Battelle received 11 written comments and four spoken comments about this measure. Commenters supported the measure's potential to strengthen breast cancer care, noting that breast cancer is the second leading cause of cancer-related death among U.S. women and that delays in follow-up after abnormal screening results drive disease progression and poorer outcomes. Commenters said the measure could close quality gaps by tracking both the timeliness and completeness of follow-up, thereby improving screening and diagnostic processes.

Commenters identified technical challenges, because imaging reports and BI-RADS assessments often reside in unstructured EHR fields, and they noted the risk of penalizing clinicians for delays outside their control, including scheduling constraints, patient navigation barriers, and patient-driven postponements. They also observed that clinicians may practice in smaller or rural facilities that lack sufficient information technology (IT) infrastructure, creating a disproportionate resource burden to satisfy the measure.

Closing Gaps of Care Considerations: The literature review on closing gaps of care indicated individuals over 70 are more likely to experience delayed follow-up, underscoring the need for targeted interventions for older populations. Women in rural areas face higher false positive rates, longer delays before biopsy, and reduced access to core needle biopsy procedures, reflecting systemic limitations in rural healthcare capacity. Insurance status further influences timely care. Patients with Medicaid or without insurance are more likely to delay breast imaging or diagnostic procedures due to out-of-pocket costs, compared to those with employer-sponsored coverage. Non-English-speaking Latina patients experience markedly longer care pathways than English-speaking Latina or white patients.[3]

Committee Discussion:

Clinical rationale and threshold: Committee members affirmed that timely diagnostic follow-up after an abnormal screening mammogram is a high-priority quality gap in current programs and emphasized the emotional impact of waiting for follow-up after an abnormal mammogram. The committee recognized that such results are highly distressing for patients, and a two-month wait for further testing or biopsy may heighten anxiety.

Committee members said that timeliness of follow-up is dependent on many factors including technologist availability, imaging unit capacity, scheduling workflows, patient navigation, and cross-system care, which raises concern that providers might be penalized for factors beyond their control. CMS noted that radiologists and radiology practices retain meaningful influence over scheduling and operational prioritization (e.g., adding late-day slots, advocating within hospital operations), and therefore share responsibility for timely follow-up. Several committee members suggested that reporting the measure at the clinician group level could mitigate attribution challenges.

The committee broadly supported the clinical value of a follow-up threshold, with 60 days recognized as meaningful for patient outcomes and anxiety reduction. Committee members cited precedent (e.g., National Breast and Cervical Cancer Early Detection Program [NBCCEDP] program expectations), and evidence associating longer waits (particularly beyond 12 weeks) with larger tumor size and nodal metastases, noting aggressive subtypes (e.g., triple-negative) can double in under 60 days. At the same time, members raised operational concerns: resource-limited and non-suburban settings may struggle to meet 60 days consistently, suggesting the need for additional data analysis, sensitivity testing by site type, and stakeholder input to optimize achievability and fairness.

Multiple committee members urged the measure to explicitly include younger, high-risk individuals (e.g., significant family history, genetic predisposition) for whom a mammogram at earlier ages is clinically indicated.

[3] For complete information on the closing gaps of care literature review for this measure, including references cited, please refer to the Clinician Recommendation Group Meeting slide deck.

Testing and attribution: The committee had concerns that the testing results submitted for the measure's endorsement review were at the facility/integrated delivery system levels, not the individual or group practice levels. They questioned whether the breadth of testing sites is sufficient to establish feasibility across diverse environments (urban, rural, resource-constrained). Some committee members called for expanded testing that captures a wider spectrum of operational realities and validates data quality, attribution, and compliance at scale. The measure developer clarified that they performed feasibility, reliability, and validity testing at the individual clinician (radiologist) level for MIPS. They explained that attribution will align with the chosen reporting level, with individual attribution when reported by an individual clinician and group attribution when reported at the group level. A committee member from the radiology community noted that individual clinician-level reliability has sufficient case volume, though reliability improves at the Taxpayer Identification Number (TIN)/group level.

Committee members and CMS also discussed harmonization with the existing breast cancer screening measure. The current screening metric primarily reflects primary care ordering patterns; however, primary care clinicians have limited control over diagnostic scheduling. Radiologists and radiology practices are better positioned to influence follow-up timeliness. Some committee members recommended pairing the screening and follow-up measures to close the loop—screen all eligible patients and, if abnormal, ensure timely diagnostic resolution—thereby enhancing continuity and reducing fragmentation.

The committee advised CMS to focus near-term decision making on whether inclusion in MIPS, at what level(s) of attribution, and with what guardrails, yields a favorable balance of impact, feasibility, and fairness.

Data capture and interoperability: Committee members noted that BI-RADS ratings are not consistently stored in discrete fields across sites, complicating automated extraction. Battelle clarified major EHRs (e.g., Epic, Cerner) do contain discrete fields and that, during multi-site testing, string-search/natural language processing (NLP) methods achieved accurate extraction where structured fields were not consistently used. Members requested clarification on whether such extraction approaches meet eCQM reporting requirements and whether any manual manipulation would be permissible. Committee members noted that data should be sourced from discrete fields or integrated workflow solutions rather than ad hoc string searches. Committee members agreed that CMS guidance on compliance pathways (e.g., acceptable extraction methods, attestation requirements, and validation expectations) is essential.

Several committee members noted that claims-based signals and EHR-bound data may be incomplete for patients receiving follow-up care in other systems (e.g., Department of Defense, Veterans Health Administration, Indian Health Services, Tribal facilities), potentially undercounting timely resolution. Committee members requested clarity on cross-system data reconciliation, acceptable data sources, and strategies to ensure measure accuracy when care fragments across networks.

The committee strongly supported the clinical importance of ensuring timely diagnostic follow-up after abnormal screening mammograms and recognized the measure as a meaningful program gap closer. The discussion highlighted three decisive implementation pillars for CMS: (1) clear attribution policy that balances individual and system responsibility, (2) technical clarity on eCQM compliance and BI-RADS data capture (discrete vs. NLP-enabled), and (3) feasibility supports (pilot testing breadth, data linkage for cross-system care, and harmonization with the screening measure).

Voting Narrative:

The committee noted several considerations supporting a vote to recommend. Committee members stated the importance of timely follow-up and encouraged CMS to strengthen methods for capturing follow-up that occurs outside the reporting practice. They also raised concerns about attribution validity at the clinician level and noted that clinicians operating across multiple systems, such as IHS, DoD, VA, and Tribal facilities, may be inaccurately attributed due to technical implementation challenges.

Those who voted do not recommend cited persistent issues with attribution, reliability, and seamless reporting. They questioned the feasibility of the measure, noting that available data may not accurately reflect radiologists' actions and therefore may not drive meaningful process improvements. Additional concerns included inconsistent BI-RADS data capture, unresolved questions about use at the individual clinician level, varying feasibility across care settings, and insufficient testing to support the required follow-up timeframes. Collectively, members indicated that feasibility and attribution challenges—particularly for radiologists—remain substantial barriers to implementation.

Considerations provided with recommend vote:

- The measure supports the follow-up intent, and CMS should establish methods to capture timely follow-up that occurs outside the practice, as well as address concerns about validity at the clinician level.
- The measure receives support but raises concerns about technical implementation challenges, including the risk of inaccurate attribution for clinicians who care for patients across multiple systems (e.g., IHS, DoD, VA, Tribal facilities).

Rationale for do not recommend vote:

- Attribution, seamless reporting, and reliability remain a concern at certain levels of analysis; inconsistent discrete capture of BI-RADS data further undermines reliability.
- Feasibility remains uncertain because available data may not consistently reflect radiologists' actions or support meaningful process improvements.
- Testing challenges persist, with feasibility differing widely across care settings. Ongoing concerns include attribution to radiologists and follow-up timelines.

Future Directions:

Committee members called for a clear attribution policy with default group or TIN reporting and clinician-level reporting only when volumes support reliable estimates. They supported exploring dual attribution and adopting defined exclusions and site-based adjustments to promote fairness. Members backed the 60-day follow-up standard while allowing flexibility through site type stratification, improvement scoring, or tiered 30/45/60-day benchmarks, and recommended piloting time to first diagnostic contact. They endorsed retaining age 40 for average risk screening and explicitly including high-risk patients under 40 using clear criteria.

Members urged CMS to issue clear guidance on eCQMs, including expectations for NLP or text search methods when BI-RADS results are not discrete. They encouraged developing a validation toolkit and aligning with BI-RADS fields and Fast Healthcare Interoperability

Resources (FHIR) standards. To address fragmented care, they emphasized strengthening data linkage and defining acceptable evidence of follow-up. The committee also recommended piloting the measure across diverse settings, using phased implementation with technical assistance, and harmonizing the follow-up and screening measures while supporting public reporting of related timeliness indicators.

MUC2025-043 Rate of Timely Follow-up on Positive Stool-based Tests for Colorectal Cancer Detection [Brigham and Women's Hospital]

Description: This electronic Clinical Quality Measure (eCQM) reports the percentage of patients aged 45 to 75 years with at least one positive stool-based colorectal cancer screening test (i.e., high-sensitivity guaiac fecal occult blood test, fecal immunochemical test, or Cologuard) during the measurement period (i.e., calendar year) who completed a colonoscopy within 180 days after their index (i.e., first) positive stool-based test result date.

Program: Merit-based Incentive Payment System (MIPS)

Committee Final Vote: The committee did not reach agreement on use of the measure in MIPS.

Vote Count: Recommend, (16 votes; 57%); Do Not Recommend, (12 votes; 43%); No Recusals.

Measure Discussion:

CMS Opening Remarks: CMS highlighted that the measure addresses a significant gap in CMS's existing performance metrics, as there is currently no measure that evaluates the timeliness of follow-up after a positive stool-based colorectal cancer screening test. The measure directly targets this gap and supports CMS's efforts to strengthen oversight of timely diagnostic follow-up for colorectal cancer detection. CMS explained that the measure aligns with the Meaningful Measures 2.0 Framework, particularly within the priority area of wellness and prevention, which focuses on advancing early detection and reducing disease burden through evidence-based interventions. Within CMS programs, the measure could potentially be incorporated into the Gastroenterology MVP, allowing gastroenterologists to report performance on timely follow-up care and supporting broader quality-improvement efforts.

CMS reviewed performance data associated with the measure. The median performance score was 57.5%, with observed performance ranging from 45% to 78% across reporting organizations. This wide variation indicates significant differences in clinician performance and highlights the importance of implementing targeted quality-improvement strategies to reduce delays in diagnostic follow-up. CMS acknowledged areas requiring further evaluation before the measure can be fully implemented within MIPS. A primary concern involves the measure's current 180-day follow-up window for completing a diagnostic colonoscopy after a positive stool-based screening. CMS believes this timeframe may be too long to ensure high-quality, timely patient care. However, because the measure has not yet undergone testing with a shorter follow-up interval, the committee will consider the measure as is presented. CMS will consider future refinements, including additional testing at the clinician level and pilot work to determine a more clinically appropriate and evidence-based follow-up period.

Battelle Summary of Public Comment: Battelle received 21 written comments and 4 verbal comments about this measure. Commenters overwhelmingly supported the measure's intent

and design, consistently emphasizing its importance in promoting timely follow-up after positive stool-based colorectal cancer screening tests. One patient commenter noted that timely access to a diagnostic colonoscopy could have altered their clinical trajectory and as such supported the measure's use of a 180-day timeframe, citing the realities of financial planning, time off work, and workforce shortages that can impede rapid access.

Strong support also came from a physician commenter who emphasized that the measure reinforces accountability for completing diagnostic colonoscopies and would incentivize health systems to improve timely access. One commenter advocated for including the measure in MIPS, stating that adoption would meaningfully address persistent gaps in colorectal cancer screening and follow-up. Similarly, a commenter described the measure as an important acknowledgment of the critical role of colonoscopy within the screening continuum. Another expressed strong support as well and endorsed the 180-day follow-up timeframe.

Commenters encouraged CMS to grant credit for documented patient outreach and navigation activities, especially in cases where delays stem from circumstances outside clinicians' control, such as payer-driven prior authorization processes. This recommendation aimed at ensuring clinicians are not penalized for system-level delays. Second, commenters recommended expanding future iterations of the measure to include all non-invasive colorectal cancer screening modalities rather than limiting it to stool-based tests. They also encouraged CMS to explore shortening the follow-up interval to 90 days to further promote timely diagnostic evaluation.

Closing Gaps of Care Considerations: The literature review on closing gaps of care indicated that patient- and system-level factors intersect with implementation of the measure. Age strongly influences colonoscopy decision-making, as older adults face higher procedural risks (e.g., perforation) and more comorbidities, requiring individualized care while maintaining timely follow-up. Geographic barriers reduce follow-up rates, with rural and remote patients experiencing limited access to gastroenterology specialists and longer travel to endoscopy facilities; a longer follow-up interval may help some patients navigate these constraints. Insurance coverage is a critical determinant of timely follow-up: federal requirements ensure private insurance coverage for diagnostic colonoscopy after a positive stool-based test, but uninsured patients continue to face financial barriers. Language proficiency also affects screening and follow-up, as individuals with limited English proficiency are less likely to be up to date and may have difficulty understanding results and the need for prompt diagnostic colonoscopy.[4]

Committee Discussion:

Reliability and feasibility at the clinician-level: Committee members expressed strong support for the measure's intent to improve timely diagnostic colonoscopy after a positive stool-based screening test. Members examined the measure's reliability and feasibility across accountability levels and noted that it was originally endorsed using facility and integrated system data. CMS is now considering use at the clinician and group levels, which raised concerns due to small denominators, year-to-year variation in positive stool-based test results, and low signal- to- noise ratios that undermine clinician level reliability. Members also cautioned

[4] For complete information on the closing gaps of care literature review for this measure, including references cited, please refer to the Clinician Recommendation Group Meeting slide deck.

that most practices may struggle to meet the case minimums required for reliable MIPS benchmarking.

Attribution and level of accountability: Committee members also raised significant concerns about attribution. They explained that health plans and third-party vendors frequently send at-home stool-based tests directly to patients without clinician involvement, leaving clinicians unaware that testing occurred yet still accountable for arranging timely colonoscopy. Committee members emphasized that many practices—particularly in rural settings, but also in some urban areas—face limited specialist availability, prior authorization delays, and fragmented referral pathways that lie outside the clinician's control. They agreed that integrated delivery systems with coordinated navigation are better positioned to meet the measure's expectations and cautioned that holding individual clinicians accountable for processes they do not oversee raises equity and fairness concerns.

Follow-up and care workflow: The committee also discussed the appropriate follow-up interval. A member noted that a 180-day window may feel too long for patients and could be perceived as a lapse in communication or care, reflecting broader patient experience feedback. Some members supported a 90-day interval to reduce the risk of delayed diagnoses, while others endorsed a 180-day timeframe due to workforce shortages, limited endoscopy capacity, prior authorization challenges, transportation barriers, and socioeconomic factors that commonly prolong completion times. Members emphasized that the 180-day interval is intended to drive meaningful improvement for patients facing systemic barriers without suggesting that earlier completion is unnecessary. They agreed that the measure aims to strengthen system-level accountability for reaching patients at risk of falling behind, rather than redefining the standard for those able to complete follow-up sooner. Committee members also stressed the importance of clinical triage and encouraged systems to prioritize patients with positive stool-based results ahead of routine screening appointments. They noted that explicit triage protocols, common in open access models and recognized as a patient safety practice, can help manage capacity constraints and align workflows with the measure's intent.

Measure scope and exclusions: In response to the committee's questions, the measure developer noted that the measure intentionally focuses on patients with positive stool-based test results who need short term diagnostic colonoscopy and excludes other noninvasive modalities, such as computed tomography colonography, because they follow different workflows under the Colorectal Imaging Reporting and Data System. The measure excludes patients in hospice care and may evolve to incorporate newer modalities—such as stool based ribonucleic acid tests and blood-based biomarker tests—as evidence and standards mature.

Voting Narrative:

A committee member who recommended the measure urged CMS to transition to a more appropriately timed metric, such as a 90-day follow-up, at the earliest opportunity.

Committee members who voted do not recommend cited concerns raised by multiple professional societies regarding its suitability for use in MIPS. They noted that while a 180-day timeframe may be reasonable, the measure must clearly apply at the group or health-system level because individual clinicians often lack control over the follow-up process. Committee members emphasized that the measure should not be used at the clinician level, consistent with direction from the measure steward and American Society for Gastrointestinal Endoscopy (ASGE) and stressed the need for a reliable method to capture follow-up performed outside the attributed organization. Additional concerns centered on attribution, accountability, and

reliability, particularly when health plans distribute test kits directly to patients. Members requested confirmation that the denominator excludes patients assigned solely based on panel assignment and noted that insufficient analysis exists for individual-level reporting. They also raised feasibility and reliability concerns, especially since the measure excludes blood-based Colorectal Cancer (CRC) screening and CT colonography, potentially missing at-risk populations. Reliability challenges persist even at the group level, and explicit exclusions are needed. Members further highlighted colonoscopy access issues that fall outside clinicians' control. While committee members strongly supported timely follow-up, they concluded that current testing results do not demonstrate adequate reliability or readiness for clinician- or group-level implementation.

Considerations provided with recommend vote:

- The recommendation calls for adopting the measure and transitioning to a timelier metric, such as a 90-day follow-up, as soon as possible.

Rationale for do not recommend vote:

- There are concerns with attributing responsibility to ordering clinicians, given ongoing colonoscopy access challenges outside their control. Additionally, the exclusion of blood-based tests and CT colonography presents feasibility challenges at the clinician level and may not capture at-risk populations.
- The measure is not supported because the steward and ASGE advised that it should not be used at the clinician level. If CMS revisits this in the future, it will need to determine how to capture timely follow-up when patients receive care outside the attributed organization and when health plans send kits directly to patients.
- Current reliability results do not support readiness for individual-level implementation. Reliability concerns also persist at the group level. The denominator must be confirmed to exclude patients based solely on primary-care panel assignment.

Future Directions:

The committee's concerns about measure reliability could be addressed by limiting the measure to group-level reporting within MVPs, where larger case volumes produce more stable results, and by phased implementation at integrated systems before expanding to individual clinicians. The committee emphasized that clear attribution rules are essential, particularly when health plans or vendors send stool-based tests directly to patients, to ensure accountability aligns with the clinicians responsible for follow-up. The committee encouraged CMS and the measure developer to explore different follow-up windows. Retaining a 180-day follow-up window would support comprehensive capture, while a 90-day view could promote timelier care. As clinical practice evolves, the committee encourages CMS and the measure developer to expand the measure to include emerging noninvasive modalities and refine exclusions, such as refusals or contraindications, to better reflect real world care. Recognizing documented outreach, navigation support, and patient level barriers—such as transportation, language needs, or prior authorization—would help ensure fair assessment.

MUC2025-020 Advance Care Planning (ACP) [CMS]

Description: Percentage of patients aged 18 years and older at the start of the measurement period with one or more inpatient encounters during the measurement period who have an advance care planning document or documentation of an advance care planning discussion resulting in a documented decision in the electronic health record (EHR) by the time of hospital discharge for at least one hospital encounter during the measurement period.

Voting:

CMS excluded the measure from voting because it is not specified for or tested at the clinician level. The committee discussed it but did not vote.

Measure Discussion:

CMS Opening Remarks: CMS stated that an ACP measure already exists in MIPS and explained that the measure under discussion differs as it expands to adults starting at age 18 and is designed as a digital measure. CMS stated they are exploring whether MIPS is appropriate for encouraging earlier ACP conversations and asked the committee for feedback regarding its alignment with program goals. CMS is also evaluating whether the hospital ACP measure should be re-specified for use in other programs, including MIPS and post-acute care, to standardize or expand ACP expectations and improve patient engagement. They underscored a commitment to gathering informed feedback to guide future policy decisions.

Battelle Summary of Public Comment: Battelle noted that the measure received 100 written comments and 10 spoken comments. Commenters encouraged taking every opportunity to engage patients in conversations about their end-of-life wishes, as ACP is vital for documenting values and preferences to ensure care aligns with what matters most to individuals. Commenters noted that systematic ACP discussions across all care settings can improve quality of care, reduce unnecessary interventions, and conserve resources. They stressed that ACP should occur early and often throughout serious or chronic conditions, not just at end-of-life, and that better data collection and reporting can enhance care for older adults and those with serious illnesses. However, commenters raised concerns about clarifying what constitutes a "documented decision," especially when patients defer decisions, and about the risk of excessive ACP discussions causing fatigue or confusion. Some public commenters also expressed concerns about interoperability of the measure across settings, the measure's focus on documentation rather than conversation quality, and the need for staff training to ensure meaningful discussions. Some commenters questioned applicability in short-stay rehabilitation settings, suggesting denominator exclusions for patients with quick transfers.

Closing Gaps of Care Considerations: The literature review on Closing Gaps of Care found that people living in rural areas have fewer opportunities for ACP; patients eligible for both Medicare and Medicaid face fragmented care, which can impact the completion and efficacy of ACP; and that people with limited English proficiency experience barriers in end-of-life decision-making and care planning, which may lead to more aggressive interventions at end of life and lower rates of comfort measures and do-not-resuscitate orders. The review also noted that Medicare patients are more likely to have preoperative ACP documentation in the EHR than those with other insurance types.

Committee Discussion:

Measure intent: Several committee members supported adding the measure to MIPS, citing that ACP conversations often occur too late during hospital or emergency department encounters, limiting clinicians' ability to honor patient preferences. Supporters also viewed the broader age range as appropriate, noting that ACP discussions can be relevant for young adults. Other members supported ambulatory use of an ACP measure but opposed mandating it for all adults. They warned that a universal requirement could burden clinicians, particularly for younger and healthier populations, and might encourage checkbox documentation instead of meaningful, patient-centered dialogue.

Population and clinical criteria concerns: Committee members emphasized the need to consider cultural and religious differences and to avoid exacerbating disparities for rural and underserved populations. They also questioned whether age alone should determine the denominator and suggested exploring chronic condition criteria or alignment with existing MIPS clinical quality measures. In response, CMS noted that specifying chronic conditions in claims or electronic health record data is challenging due to documentation variability.

Early ACP Rationale: Committee members who supported earlier ACP engagement highlighted that the measure does not require Medical Orders for Life-Sustaining Treatment (MOLST) or Physician Orders for Life-Sustaining Treatment (POLST) forms but instead focuses on identifying a health care proxy. CMS reiterated that starting discussions earlier in adulthood may reduce stigma around end-of-life care decisions.

Operational burden: Some committee members raised concerns about operational burden in high-volume outpatient settings and recommended more targeted approaches and clearer population definitions. Committee members also expressed interest in ongoing re-specification for ambulatory use.

Future Directions:

Committee members emphasized the need to balance earlier ACP engagement with practical implementation in ambulatory settings. They noted that expanding the age range may support earlier conversations but questioned whether age alone should determine eligibility, encouraging CMS to explore alternative denominator populations and measure harmonization. Committee members stressed the importance of meaningful, patient-centered discussions rather than administrative checkboxes, especially in high volume practices. Committee members highlighted the need for the measure to reflect cultural, religious, and community needs and to avoid widening disparities in rural or underserved areas.

Next Steps

Ms. Buchanan thanked all attendees for their active and enthusiastic participation, and reviewed the next steps for the committee and shared important dates, including:

- January 30, 2026: Final MUC Recommendations Spreadsheet published on PQM website
- February 2-16, 2026: Final MUC Recommendations Spreadsheet public comment period
- February 12, 2026: Final PRMR Clinician Recommendation Group Meeting Summary and Recording published on PQM website
- February 25, 2026: Final MUC Recommendations Report published on PQM website

She added that the public comment period for the MUC Recommendations Spreadsheet is an opportunity for additional feedback on measures but does not alter the voting results from the meetings.

Closing Acknowledgements

Acknowledging the committee's diverse perspectives and heartfelt personal stories, Dr. Schreiber thanked members for their dedication to improving health care quality, and thanked Battelle for excellent facilitation. She emphasized that CMS values and listens closely to the committee's input and adjourned the meeting.

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