ELIGIBLE CLINICIAN eCQM WEBINAR SERIES #3:

TRENDS AND HIGH USE eCQMs

April 28, 2022

PRESENTATION OVERVIEW

- How to submit inquiries about eCQMs
  - Via the Office of the National Coordinator for Health Information Technology (ONC) Project Tracking System (Jira) eCQM Issue Tracker
- Review three high-use measures:
  - CMS165v10—Controlling High Blood Pressure
  - CMS122v10—Diabetes, Hemoglobin A1c (HBA1c) Poor Control (>9%)
  - CMS130v10—Colorectal Cancer Screening

USE JIRA TO SUBMIT QUESTIONS ABOUT eCQMs

ONC Jira Platform – eCQM Issue Tracker

- Submit eCQM inquiries through the Office of the National Coordinator for Health Information Technology (ONC) Project Tracking System (Jira) at https://oncprojectracking.healthit.gov/
- Inquiries about eligible clinician eCQM specifications are managed in the **eCQM Issue Tracker** (https://oncprojectracking.healthit.gov/support/projects/CQM/issues)

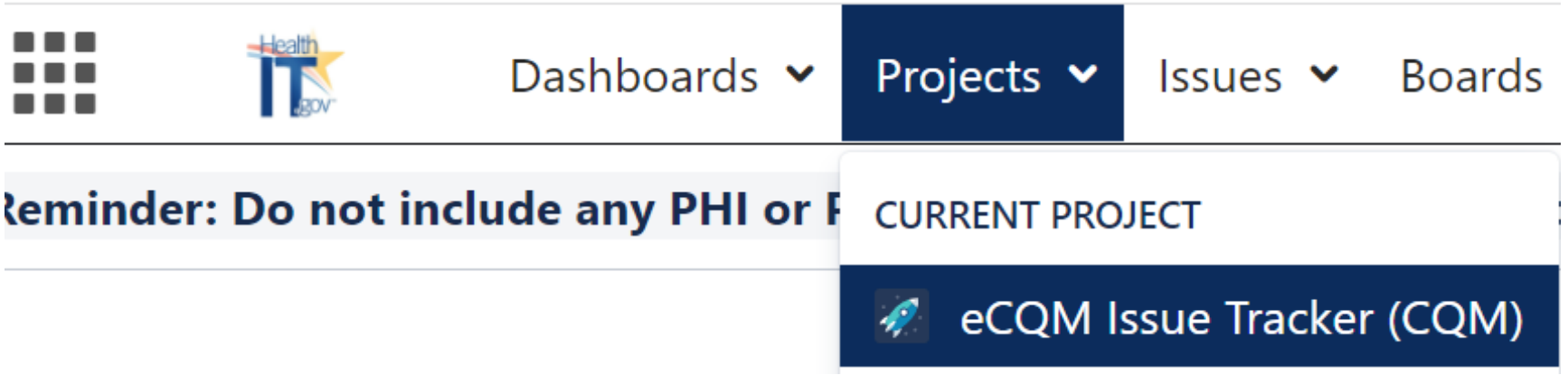
Create an account

- New users must create an account via the ONC Project Tracking System website

HOW TO SUBMIT QUESTIONS ABOUT eCQMs
(cont'd.)

Navigate to the [eCQM Issue Tracker]

- Select the "Projects" pull-down in the top ribbon and select "eCQM Issue Tracker (CQM)"

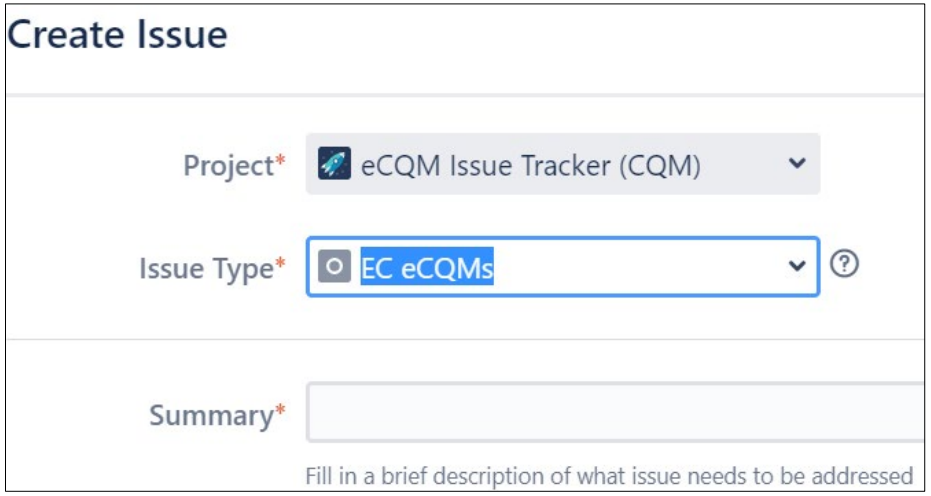


HOW TO SUBMIT QUESTIONS ABOUT eCQMs
(cont'd.)

Submit a question

- On the eCQM Issue Tracker project home page, select "Create" in the top ribbon

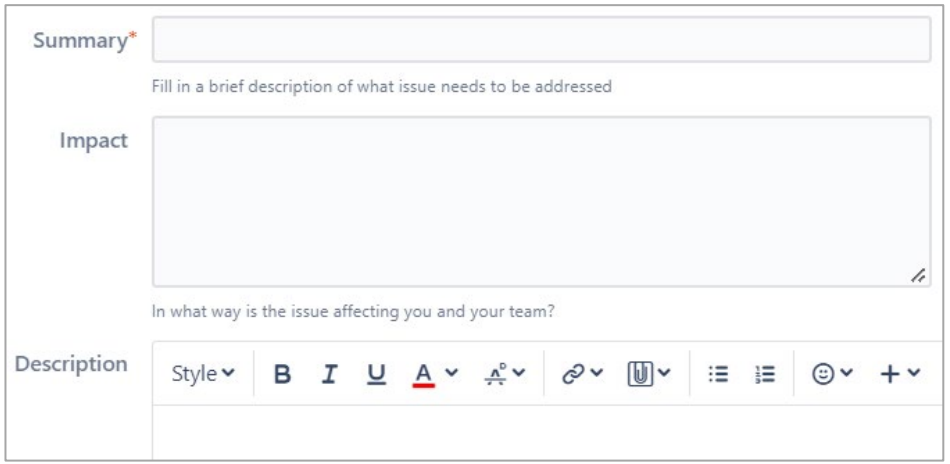
- On the "Create Issue" screen, select "EC eCQMs" from the pull-down menu



HOW TO SUBMIT QUESTIONS ABOUT eCQMs *(cont'd.)*

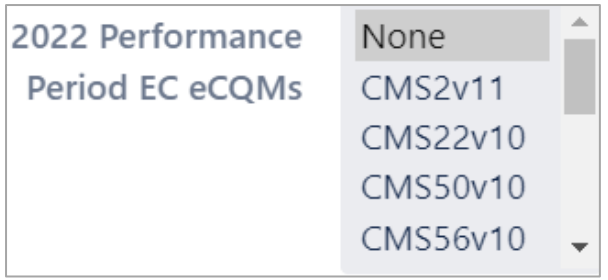
Complete the following fields

- Summary
- Impact
- Description



Identify affected eligible clinician eCQMs

- Select one or more eCQMs corresponding to both the current and two prior reporting periods



Add attachments (if necessary)

Contact Information

TIPS FOR SUBMITTING QUESTIONS ABOUT eCQMs

Use clear and concise language, including complete sentences, to convey the issue(s)

- Review inquiries for clarity prior to submitting. Be as specific as possible.

Reference the correct eCQM number(s) and version(s)

- Jira eCQM selection fields: select the correct performance period(s) of the affected eCQM(s)
- Jira text fields: reference the appropriate eCQM number/version

Document QDM Datatypes, CQL logic, and value sets, if applicable

- CQL logic – Include screenshots of affected measure logic
- Value sets – Include specific value set OID and codes
- QDM datatypes – include specific QDM datatypes, such as “Encounter, Performed”

DO NOT include text in the “Solution” field

- Subject matter experts will document the response to your inquiry in the “Solution” field

MONITORING eCQMs

eCQM stakeholder input is used by CMS to inform future measure annual update cycles

CMS evaluates trends over time to conduct process improvement and analyses

- Examples of ticket trends:
  - Which eCQMs consistently receive the most Jira inquiries across reporting periods
  - Rise in Jira ticket volume in June, July, and August, corresponding to implementors reviewing new measure specifications after the May publication

WEBINAR PART 2

OVERVIEW OF HIGH USE eCQMs IN 2022

CMS165V10—Controlling High Blood Pressure

CMS122v10—Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)

CMS130v10—Colorectal Cancer Screening

MEASURE OVERVIEW

CMS165V10—CONTROLLING HIGH BLOOD PRESSURE

eCQM title	Controlling High Blood Pressure
Description	Percentage of patients 18–85 years of age who had a diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period, and whose most recent blood pressure was adequately controlled (<140/90mmHg) during the measurement period
Measure steward	National Committee for Quality Assurance (NCQA)
Domain	Effective clinical care
Measure scoring	Proportion measure
Measure type	Intermediate outcome measure
Improvement notation	Higher score indicates better quality

MEASURE OVERVIEW

CMS165V10—CONTROLLING HIGH BLOOD PRESSURE

CMS165v10	Performance period 2022
Clinical recommendation statement (summarized)	The **U.S. Preventive Services Task Force (2015) recommends screening for high blood pressure in adults age 18 years and older**. This is a grade A recommendation. American College of Cardiology/American Heart Association (2017) For **adults with confirmed hypertension and known CVD or 10-year ASCVD event risk of 10% or higher, a blood pressure target of less than 130/80 mmHg is recommended** (Level of evidence: B-R (for systolic blood pressures), Level of evidence: C-EO (for diastolic blood pressure)) For **adults with confirmed hypertension, without additional markers of increased CVD risk, a blood pressure target of less than 130/80 mmHg may be reasonable** (Note: clinical trial evidence is strongest for a target blood pressure of 140/90 mmHg in this population. However, observational studies suggest that these individuals often have a high lifetime risk and would benefit from blood pressure control earlier in life) (Level of evidence: B-NR (for systolic blood pressure), Level of evidence: C-EO (for diastolic blood pressure))

MEASURE OVERVIEW

CMS165V10—CONTROLLING HIGH BLOOD PRESSURE

CMS165v10	Performance period 2022
Guidance	In reference to the numerator element**, only blood pressure readings performed by a clinician, or a remote monitoring device are acceptable for numerator compliance with this measure**. This includes blood pressures taken in person by a clinician and blood pressures measured remotely by electronic monitoring devices capable of transmitting the blood pressure data to the clinician. Blood pressure readings taken by a remote monitoring device and conveyed by the patient to the clinician are also acceptable. **It is the clinician's responsibility and discretion to confirm the remote monitoring device used to obtain the blood pressure is considered acceptable and reliable and whether the blood pressure reading is considered accurate** before documenting it in the patient's medical record. **Do not include BP readings:** • Taken during an acute inpatient stay or an ED visit • Taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or change in medication on or one day before the day of the test or procedure, with the exception of fasting blood tests. • Taken by the patient using a non-digital device such as with a manual blood pressure cuff and a stethoscope. If no blood pressure is recorded during the measurement period, the patient's blood pressure is assumed "not controlled." **If there are multiple blood pressure readings on the same day**, use the lowest systolic and the lowest diastolic reading as the most recent blood pressure reading. **This eCQM is a patient-based measure.** **This version of the eCQM uses QDM version 5.5**. Please refer to the eCQI resource center (https://ecqi.healthit.gov/qdm) for more information on the QDM.

MEASURE OVERVIEW

CMS165V10—CONTROLLING HIGH BLOOD PRESSURE

CMS165v10	Performance period 2022
Initial population	Patients 18–85 years of age who had a visit and diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of, the measurement period.
Denominator	Equals initial population

MEASURE OVERVIEW

CMS165V10—CONTROLLING HIGH BLOOD PRESSURE

CMS165v10	Performance period 2022
Denominator exclusions	Patients with evidence of end stage renal disease (ESRD), dialysis or renal transplant before or during the measurement period. Also exclude patients with a diagnosis of pregnancy during the measurement period. Exclude patients who are in hospice care for any part of the measurement period. Exclude patients 66 and older who are living long term in an institution for more than 90 consecutive days during the measurement period. Exclude patients 66 and older with an indication of frailty for any part of the measurement period who meet any of the following criteria: • Advanced illness with two outpatient encounters during the measurement period or the year prior • OR advanced illness with one inpatient encounter during the measurement period or the year prior • OR taking dementia medications during the measurement period or the year prior Exclude patients 81 and older with an indication of frailty for any part of the measurement period. Exclude patients receiving palliative care during the measurement period.

MEASURE OVERVIEW

CMS165V10—CONTROLLING HIGH BLOOD PRESSURE

CMS165v10	Performance period 2022
Numerator	Patients whose most recent blood pressure is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period
Numerator exclusions	Not applicable
Denominator exceptions	None

KEY LOGIC STATEMENTS

CMS165V10—CONTROLLING HIGH BLOOD PRESSURE

Initial Population

```
exists ["Patient Characteristic Birthdate": "Birth date"] BirthDate
  where Global."CalendarAgeInYearsAt" ( BirthDate.birthDatetime, start of "Measurement Period" ) in Interval[18, 85 )
    and exists "Essential Hypertension Diagnosis"
    and ( exists AdultOutpatientEncounters."Qualifying Encounters"
        or exists ( ( ["Encounter, Performed": "Telephone Visits"]
            union ["Encounter, Performed": "Online Assessments"] ) Telehealth
            where Telehealth.relevantPeriod during "Measurement Period"
        )
    )
```

Essential Hypertension Diagnosis

```
["Diagnosis": "Essential Hypertension"] Hypertension
  where Hypertension.prevalencePeriod overlaps Interval[start of "Measurement Period", start of "Measurement Period" + 6 months )
```

KEY LOGIC STATEMENTS

CMS165V10—CONTROLLING HIGH BLOOD PRESSURE

Denominator Exclusions

```
Hospice."Has Hospice"
  or exists ( "Pregnancy Or Renal Diagnosis Exclusions" )
  or exists ( "End Stage Renal Disease Procedures" )
  or exists ( "End Stage Renal Disease Encounter" )
  or ( exists ( ["Patient Characteristic Birthdate": "Birth date"] BirthDate
       where Global."CalendarAgeInYearsAt" ( BirthDate.birthDatetime, start of "Measurement Period" ) >= 65
    )
     and ( FrailtyLTI."Has Long Term Care Periods Longer Than 90 Consecutive Days" )
  )
  or FrailtyLTI."Advanced Illness and Frailty Exclusion Including Over Age 80"
  or PalliativeCare."Palliative Care in the Measurement Period"
```

KEY LOGIC STATEMENTS

CMS165V10—CONTROLLING HIGH BLOOD PRESSURE

Numerator

"Has Diastolic Blood Pressure Less Than 90"
and "Has Systolic Blood Pressure Less Than 140"

Has Diastolic Blood Pressure Less Than 90

"Lowest Diastolic Reading on Most Recent Blood Pressure Day".result < 90 'mm[Hg]'

Has Systolic Blood Pressure Less Than 140

"Lowest Systolic Reading on Most Recent Blood Pressure Day".result < 140 'mm[Hg]'

Lowest Diastolic Reading on Most Recent Blood Pressure Day

First("Qualifying Diastolic Blood Pressure Reading" DBPReading
where Global."LatestOf"(DBPReading.relevantDatetime, DBPReading.relevantPeriod)same day as "Most Recent Blood Pressure Day"
sort by(result as Quantity)

Lowest Systolic Reading on Most Recent Blood Pressure Day

First("Qualifying Systolic Blood Pressure Reading" SBPReading
where Global."LatestOf"(SBPReading.relevantDatetime, SBPReading.relevantPeriod)same day as "Most Recent Blood Pressure Day"
sort by(result as Quantity)

VALUE SETS AND CODES (SUMMARIZED)

CMS165V10—CONTROLLING HIGH BLOOD PRESSURE

Terminology

- code "Birth date" ("LOINC Code (21112-8)")
- code "Diastolic blood pressure" ("LOINC Code (8462-4)")
- code "Discharge to healthcare facility for hospice care (procedure)" ("SNOMEDCT Code (428371000124100)")
- code "Discharge to home for hospice care (procedure)" ("SNOMEDCT Code (428361000124107)")
- code "Functional Assessment of Chronic Illness Therapy - Palliative Care Questionnaire (FACIT-Pal)" ("LOINC Code (71007-9)")
- code "Systolic blood pressure" ("LOINC Code (8480-6)")
- valueset "Acute Inpatient" (2.16.840.1.113883.3.464.1003.101.12.1083)
- valueset "Advanced Illness" (2.16.840.1.113883.3.464.1003.110.12.1082)
- valueset "Annual Wellness Visit" (2.16.840.1.113883.3.526.3.1240)
- valueset "Care Services in Long-Term Residential Facility" (2.16.840.1.113883.3.464.1003.101.12.1014)
- valueset "Chronic Kidney Disease, Stage 5" (2.16.840.1.113883.3.526.3.1002)
- valueset "Dementia Medications" (2.16.840.1.113883.3.464.1003.196.12.1510)
- valueset "Dialysis Services" (2.16.840.1.113883.3.464.1003.109.12.1013)
- valueset "Emergency Department Visit" (2.16.840.1.113883.3.464.1003.101.12.1010)
- valueset "Encounter Inpatient" (2.16.840.1.113883.3.666.5.307)
- valueset "End Stage Renal Disease" (2.16.840.1.113883.3.526.3.353)
- valueset "ESRD Monthly Outpatient Services" (2.16.840.1.113883.3.464.1003.109.12.1014)
- valueset "Essential Hypertension" (2.16.840.1.113883.3.464.1003.104.12.1011)
- valueset "Ethnicity" (2.16.840.1.114222.4.11.837)
- valueset "Frailty Device" (2.16.840.1.113883.3.464.1003.118.12.1300)
- valueset "Frailty Diagnosis" (2.16.840.1.113883.3.464.1003.113.12.1074)
- valueset "Frailty Encounter" (2.16.840.1.113883.3.464.1003.101.12.1088)
- valueset "Frailty Symptom" (2.16.840.1.113883.3.464.1003.113.12.1075)
- valueset "Home Healthcare Services" (2.16.840.1.113883.3.464.1003.101.12.1016)

Value Set Authority Center

MEASURE OVERVIEW

CMS122V10—DIABETES: HEMOGLOBIN A1C (HBA1C) POOR CONTROL (>9%)

eCQM title	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)
Description	Percentage of patients 18–75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period
Measure steward	National Committee for Quality Assurance (NCQA)
Domain	Effective clinical care
Measure scoring	Proportion measure
Measure type	Intermediate outcome measure
Improvement notation	Lower score indicates better quality

MEASURE OVERVIEW

CMS122V10—DIABETES: HEMOGLOBIN A1C (HBA1C) POOR CONTROL (>9%)

CMS122v10	Performance period 2022
Clinical recommendation statement	• An A1C goal for many nonpregnant adults of <7% (53 mmol/mol) is appropriate. (Level of evidence: A) • On the basis of provider judgement and patient preference, achievement of lower A1C goals (such as <6.5%) may be acceptable if this can be achieved safely without significant hypoglycemia or other adverse effects of treatment. (Level of evidence: C) • Less stringent A1C goals (such as <8% [64 mmol/mol]) may be appropriate for patients with a history of severe hypoglycemia, limited life expectancy, advanced microvascular or macrovascular complications, extensive comorbid conditions, or long-standing diabetes in whom the goal is difficult to achieve despite diabetes self-management education, appropriate glucose monitoring, and effective doses of multiple glucose-lowering agents including insulin. (Level of evidence: B)

MEASURE OVERVIEW

CMS122V10—DIABETES: HEMOGLOBIN A1C (HBA1C) POOR CONTROL (>9%)

CMS122v10	Performance period 2022
Guidance	If the HbA1c test result is in the medical record, the test can be used to determine numerator compliance. Only patients with a diagnosis of Type 1 or Type 2 diabetes should be included in the denominator of this measure; patients with a diagnosis of secondary diabetes due to another condition should not be included. This eCQM is a patient-based measure. This version of the eCQM uses QDM version 5.5. Please refer to the eCQI resource center (https://ecqi.healthit.gov/qdm) for more information on the QDM.

MEASURE OVERVIEW

CMS122V10—DIABETES: HEMOGLOBIN A1C (HBA1C) POOR CONTROL (>9%)

CMS122v10	Performance period 2022
Initial population	Patients 18–75 years of age with diabetes with a visit during the measurement period
Denominator	Equals initial population

MEASURE OVERVIEW

CMS122V10—DIABETES: HEMOGLOBIN A1C (HBA1C) POOR CONTROL (>9%)

CMS122v10	Performance period 2022
Denominator exclusions	Exclude patients who are in hospice care for any part of the measurement period. Exclude patients 66 and older who are living long term in an institution for more than 90 consecutive days during the measurement period. Exclude patients 66 and older with an indication of frailty for any part of the measurement period who meet any of the following criteria: • Advanced illness with two outpatient encounters during the measurement period or the year prior • OR advanced illness with one inpatient encounter during the measurement period or the year prior • OR taking dementia medications during the measurement period or the year prior Exclude patients receiving palliative care during the measurement period.

MEASURE OVERVIEW

CMS122V10—DIABETES: HEMOGLOBIN A1C (HBA1C) POOR CONTROL (>9%)

CMS122v10	Performance period 2022
Numerator	Patients whose most recent HbA1c level (performed during the measurement period) is >9.0% or is missing, or was not performed during the measurement period.
Numerator exclusions	Not applicable
Denominator exceptions	None

KEY LOGIC STATEMENTS

CMS122V10—DIABETES: HEMOGLOBIN A1C (HBA1C) POOR CONTROL (>9%)

Initial Population

```
exists ( ["Patient Characteristic Birthdate": "Birth date"] BirthDate
    where Global."CalendarAgeInYearsAt" ( BirthDate.birthDatetime, start of "Measurement Period" ) in Interval[18, 75 )
)
  and exists ( AdultOutpatientEncounters."Qualifying Encounters"
      union "Telehealth Services"
  )
  and exists ( ["Diagnosis": "Diabetes"] Diabetes
      where Diabetes.prevalencePeriod overlaps "Measurement Period"
  )
```

AdultOutpatientEncounters.Qualifying Encounters

```
( ["Encounter, Performed": "Office Visit"]
  union ["Encounter, Performed": "Annual Wellness Visit"]
  union ["Encounter, Performed": "Preventive Care Services - Established Office Visit, 18 and Up"]
  union ["Encounter, Performed": "Preventive Care Services-Initial Office Visit, 18 and Up"]
  union ["Encounter, Performed": "Home Healthcare Services"] ) ValidEncounter
  where ValidEncounter.relevantPeriod during "Measurement Period"
```

Telehealth Services

```
["Encounter, Performed": "Telephone Visits"] TelehealthEncounter
  where TelehealthEncounter.relevantPeriod during "Measurement Period"
```

KEY LOGIC STATEMENTS

CMS122V10—DIABETES: HEMOGLOBIN A1C (HBA1C) POOR CONTROL (>9%)

Denominator Exclusions

```
Hospice."Has Hospice"
  or FrailtyLTI."Advanced Illness and Frailty Exclusion Not Including Over Age 80"
  or ( exists ["Patient Characteristic Birthdate": "Birth date"] BirthDate
     where ( Global."CalendarAgeInYearsAt" ( BirthDate.birthDatetime, start of "Measurement Period" ) >= 65 )
       and FrailtyLTI."Has Long Term Care Periods Longer Than 90 Consecutive Days"
       or PalliativeCare."Palliative Care in the Measurement Period"
  )
```

KEY LOGIC STATEMENTS

CMS122V10—DIABETES: HEMOGLOBIN A1C (HBA1C) POOR CONTROL (>9%)

Numerator

```
"Has Most Recent HbA1c Without Result"
  or "Has Most Recent Elevated HbA1c"
  or "Has No Record Of HbA1c"
```

Has Most Recent Elevated HbA1c

```
"Most Recent HbA1c".result > 9 '%'
```

Has Most Recent HbA1c Without Result

```
"Most Recent HbA1c" is not null
  and "Most Recent HbA1c".result is null
```

Has No Record Of HbA1c

```
not exists ( ["Laboratory Test, Performed": "HbA1c Laboratory Test"] NoHbA1c
    where Global."LatestOf" ( NoHbA1c.relevantDatetime, NoHbA1c.relevantPeriod ) during "Measurement Period"
)
```

VALUE SETS AND CODES

CMS122V10—DIABETES: HEMOGLOBIN A1C (HBA1C) POOR CONTROL (>9%)

Terminology

- code "Birth date" ("LOINC Code (21112-8)")
- code "Discharge to healthcare facility for hospice care (procedure)" ("SNOMEDCT Code (428371000124100)")
- code "Discharge to home for hospice care (procedure)" ("SNOMEDCT Code (428361000124107)")
- code "Functional Assessment of Chronic Illness Therapy - Palliative Care Questionnaire (FACIT-Pal)" ("LOINC Code (71007-9)")
- valueset "Acute Inpatient" (2.16.840.1.113883.3.464.1003.101.12.1083)
- valueset "Advanced Illness" (2.16.840.1.113883.3.464.1003.110.12.1082)
- valueset "Annual Wellness Visit" (2.16.840.1.113883.3.526.3.1240)
- valueset "Care Services in Long-Term Residential Facility" (2.16.840.1.113883.3.464.1003.101.12.1014)
- valueset "Dementia Medications" (2.16.840.1.113883.3.464.1003.196.12.1510)
- valueset "Diabetes" (2.16.840.1.113883.3.464.1003.103.12.1001)
- valueset "Emergency Department Visit" (2.16.840.1.113883.3.464.1003.101.12.1010)
- valueset "Encounter Inpatient" (2.16.840.1.113883.3.666.5.307)
- valueset "Ethnicity" (2.16.840.1.114222.4.11.837)
- valueset "Frailty Device" (2.16.840.1.113883.3.464.1003.118.12.1300)
- valueset "Frailty Diagnosis" (2.16.840.1.113883.3.464.1003.113.12.1074)
- valueset "Frailty Encounter" (2.16.840.1.113883.3.464.1003.101.12.1088)
- valueset "Frailty Symptom" (2.16.840.1.113883.3.464.1003.113.12.1075)
- valueset "HbA1c Laboratory Test" (2.16.840.1.113883.3.464.1003.198.12.1013)
- valueset "Home Healthcare Services" (2.16.840.1.113883.3.464.1003.101.12.1016)
- valueset "Hospice care ambulatory" (2.16.840.1.113762.1.4.1108.15)
- valueset "Nonacute Inpatient" (2.16.840.1.113883.3.464.1003.101.12.1084)
- valueset "Nursing Facility Visit" (2.16.840.1.113883.3.464.1003.101.12.1012)
- valueset "Observation" (2.16.840.1.113883.3.464.1003.101.12.1086)
- valueset "Office Visit" (2.16.840.1.113883.3.464.1003.101.12.1001)
- valueset "ONC Administrative Sex" (2.16.840.1.113762.1.4.1)
- valueset "Outpatient" (2.16.840.1.113883.3.464.1003.101.12.1087)
- valueset "Palliative Care Encounter" (2.16.840.1.113883.3.464.1003.101.12.1090)
- valueset "Palliative Care Intervention" (2.16.840.1.113883.3.464.1003.198.12.1135)
- valueset "Payer" (2.16.840.1.114222.4.11.3591)
- valueset "Preventive Care Services - Established Office Visit, 18 and Up" (2.16.840.1.113883.3.464.1003.101.12.1025)
- valueset "Preventive Care Services-Initial Office Visit, 18 and Up" (2.16.840.1.113883.3.464.1003.101.12.1023)
- valueset "Race" (2.16.840.1.114222.4.11.836)
- valueset "Telephone Visits" (2.16.840.1.113883.3.464.1003.101.12.1080)

Value Set Authority Center

MEASURE OVERVIEW

CMS130V10—COLORECTAL CANCER SCREENING

eCQM title	Colorectal Cancer Screening
Description	Percentage of adults 50–75 years of age who had appropriate screening for colorectal cancer
Measure steward	National Committee for Quality Assurance (NCQA)
Domain	Effective clinical care
Measure scoring	Proportion measure
Measure type	Process measure
Improvement notation	Higher score indicates better quality

MEASURE OVERVIEW

CMS130V10—COLORECTAL CANCER SCREENING

CMS130v10	Performance period 2022
Clinical recommendation statement	The U.S. Preventive Services Task Force (2016) recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years. This is a Grade A recommendation (U.S. Preventive Services Task Force, 2016). Appropriate screenings are defined by any one of the following: • Colonoscopy (every 10 years) • Flexible sigmoidoscopy (every 5 years) • Fecal occult blood test (annually) • FIT-DNA (every 3 years) • Computed tomographic colonography (every 5 years)

MEASURE OVERVIEW

CMS130V10—COLORECTAL CANCER SCREENING

CMS130v10	Performance period 2022
Guidance	Do not count digital rectal exams (DRE), fecal occult blood tests (FOBTs) performed in an office setting or performed on a sample collected via DRE. This eCQM is a patient-based measure. This version of the eCQM uses QDM version 5.5. Please refer to the eCQI resource center (https://ecqi.healthit.gov/qdm) for more information on the QDM.

MEASURE OVERVIEW

CMS130V10—COLORECTAL CANCER SCREENING

CMS130v10	Performance period 2022
Initial population	Patients 50–75 years of age with a visit during the measurement period
Denominator	Equals initial population

MEASURE OVERVIEW

CMS130V10—COLORECTAL CANCER SCREENING

CMS130v10	Performance period 2022
Denominator exclusions	Exclude patients who are in hospice care for any part of the measurement period. Exclude patients with a diagnosis or past history of total colectomy or colorectal cancer. Exclude patients 66 and older who are living long term in an institution for more than 90 consecutive days during the measurement period. Exclude patients 66 and older with an indication of frailty for any part of the measurement period who meet any of the following criteria: • Advanced illness with two outpatient encounters during the measurement period or the year prior • OR advanced illness with one inpatient encounter during the measurement period or the year prior • OR taking dementia medications during the measurement period or the year prior • Exclude patients receiving palliative care during the measurement period.

MEASURE OVERVIEW

CMS130V10—COLORECTAL CANCER SCREENING

CMS130v10	Performance period 2022
Numerator	Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the following criteria: • Fecal occult blood test (FOBT) during the measurement period • Flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period • Colonoscopy during the measurement period or the nine years prior to the measurement period • FIT-DNA during the measurement period or the two years prior to the measurement period • CT Colonography during the measurement period or the four years prior to the measurement period
Numerator exclusions	Not applicable
Denominator exceptions	None

KEY LOGIC STATEMENTS

CMS130V10—COLORECTAL CANCER SCREENING

Initial Population

```
exists ( ["Patient Characteristic Birthdate": "Birth date"] BirthDate
    where Global."CalendarAgeInYearsAt" ( BirthDate.birthDatetime, start of "Measurement Period" ) in Interval[50, 75 )
      and exists ( AdultOutpatientEncounters."Qualifying Encounters"
          union "Telehealth Services"
      )
)
```

AdultOutpatientEncounters.Qualifying Encounters

```
( ["Encounter, Performed": "Office Visit"]
  union ["Encounter, Performed": "Annual Wellness Visit"]
  union ["Encounter, Performed": "Preventive Care Services - Established Office Visit, 18 and Up"]
  union ["Encounter, Performed": "Preventive Care Services-Initial Office Visit, 18 and Up"]
  union ["Encounter, Performed": "Home Healthcare Services"] ) ValidEncounter
  where ValidEncounter.relevantPeriod during "Measurement Period"
```

Telehealth Services

```
( ["Encounter, Performed": "Online Assessments"]
  union ["Encounter, Performed": "Telephone Visits"] ) TelehealthEncounter
  where TelehealthEncounter.relevantPeriod during "Measurement Period"
```

KEY LOGIC STATEMENTS

CMS130V10—COLORECTAL CANCER SCREENING

Denominator Exclusions

```
Hospice."Has Hospice"
  or exists "Malignant Neoplasm"
  or exists "Total Colectomy Performed"
  or FrailtyLTI."Advanced Illness and Frailty Exclusion Not Including Over Age 80"
  or ( exists ["Patient Characteristic Birthdate": "Birth date"] BirthDate
      where ( Global."CalendarAgeInYearsAt" ( BirthDate.birthDatetime, start of "Measurement Period" ) >= 65 )
        and FrailtyLTI."Has Long Term Care Periods Longer Than 90 Consecutive Days"
  )
  or PalliativeCare."Palliative Care in the Measurement Period"
```

KEY LOGIC STATEMENTS

CMS130V10—COLORECTAL CANCER SCREENING

Numerator

```
exists "Colonoscopy Performed"
  or exists "Fecal Occult Blood Test Performed"
  or exists "Flexible Sigmoidoscopy Performed"
  or exists "Fecal Immunochemical Test DNA Performed"
  or exists "CT Colonography Performed"
```

Colonoscopy Performed

```
["Procedure, Performed": "Colonoscopy"] Colonoscopy
  where Global."NormalizeInterval" ( Colonoscopy.relevantDatetime, Colonoscopy.relevantPeriod ) ends 10 years or less on or before
  end of "Measurement Period"
```

Fecal Occult Blood Test Performed

```
["Laboratory Test, Performed": "Fecal Occult Blood Test (FOBT)"] FecalOccultResult
  where FecalOccultResult.result is not null
    and Global."LatestOf" ( FecalOccultResult.relevantDatetime, FecalOccultResult.relevantPeriod ) during "Measurement Period"
```

KEY LOGIC STATEMENTS

CMS130V10—COLORECTAL CANCER SCREENING

Flexible Sigmoidoscopy Performed

```
["Procedure, Performed": "Flexible Sigmoidoscopy"] FlexibleSigmoidoscopy
  where Global."NormalizeInterval" ( FlexibleSigmoidoscopy.relevantDatetime, FlexibleSigmoidoscopy.relevantPeriod ) ends 5 years or less on or before
  end of "Measurement Period"
```

Fecal Immunochemical Test DNA Performed

```
["Laboratory Test, Performed": "FIT DNA"] FitDNA
  where FitDNA.result is not null
    and Global."LatestOf" ( FitDNA.relevantDatetime, FitDNA.relevantPeriod ) 3 years or less on or before
    end of "Measurement Period"
```

CT Colonography Performed

```
["Diagnostic Study, Performed": "CT Colonography"] Colonography
  where Global."NormalizeInterval" ( Colonography.relevantDatetime, Colonography.relevantPeriod ) ends 5 years or less on or before
  end of "Measurement Period"
```

VALUE SETS AND CODES (SUMMARIZED)

CMS130V10—COLORECTAL CANCER SCREENING

Terminology

- code "Birth date" ("LOINC Code (21112-8)")
- code "Discharge to healthcare facility for hospice care (procedure)" ("SNOMEDCT Code (428371000124100)")
- code "Discharge to home for hospice care (procedure)" ("SNOMEDCT Code (428361000124107)")
- code "Functional Assessment of Chronic Illness Therapy - Palliative Care Questionnaire (FACIT-Pal)" ("LOINC Code (71007-9)")
- valueset "Acute Inpatient" (2.16.840.1.113883.3.464.1003.101.12.1083)
- valueset "Advanced Illness" (2.16.840.1.113883.3.464.1003.110.12.1082)
- valueset "Annual Wellness Visit" (2.16.840.1.113883.3.526.3.1240)
- valueset "Care Services in Long-Term Residential Facility" (2.16.840.1.113883.3.464.1003.101.12.1014)
- valueset "Colonoscopy" (2.16.840.1.113883.3.464.1003.108.12.1020)
- valueset "CT Colonography" (2.16.840.1.113883.3.464.1003.108.12.1038)
- valueset "Dementia Medications" (2.16.840.1.113883.3.464.1003.196.12.1510)
- valueset "Emergency Department Visit" (2.16.840.1.113883.3.464.1003.101.12.1010)
- valueset "Encounter Inpatient" (2.16.840.1.113883.3.666.5.307)
- valueset "Ethnicity" (2.16.840.1.114222.4.11.837)
- valueset "Fecal Occult Blood Test (FOBT)" (2.16.840.1.113883.3.464.1003.198.12.1011)
- valueset "FIT DNA" (2.16.840.1.113883.3.464.1003.108.12.1039)
- valueset "Flexible Sigmoidoscopy" (2.16.840.1.113883.3.464.1003.198.12.1010)
- valueset "Frailty Device" (2.16.840.1.113883.3.464.1003.118.12.1300)
- valueset "Frailty Diagnosis" (2.16.840.1.113883.3.464.1003.113.12.1074)
- valueset "Frailty Encounter" (2.16.840.1.113883.3.464.1003.101.12.1088)
- valueset "Frailty Symptom" (2.16.840.1.113883.3.464.1003.113.12.1075)
- valueset "Home Healthcare Services" (2.16.840.1.113883.3.464.1003.101.12.1016)
- valueset "Hospice care ambulatory" (2.16.840.1.113762.1.4.1108.15)
- valueset "Malignant Neoplasm of Colon" (2.16.840.1.113883.3.464.1003.108.12.1001)
- valueset "Nonacute Inpatient" (2.16.840.1.113883.3.464.1003.101.12.1084)
- valueset "Nursing Facility Visit" (2.16.840.1.113883.3.464.1003.101.12.1012)
- valueset "Observation" (2.16.840.1.113883.3.464.1003.101.12.1086)

Value Set Authority Center

eCQM RESOURCES AND STANDARDS

Key standards for electronic transmission of health information used to support eCQMs are:

- CQL – Clinical Quality Language – is the expression language used to explicitly communicate the specific data to be retrieved along with the logic needed to evaluate eCQMs. Essential to the operationalization of CQL is the Expression Logical Model (ELM) file. The ELM file is the machine-readable representation of the CQL designed for sharing and implementation applications.
- HQMF – Health Quality Measure Format – is a standard format to describe eCQM metadata, such as numerator, denominator, exclusions, and exceptions, as an XML document.
- CQL-based Health Quality Measure Format (HQMF) – is a standard implementation guide that describes how to use the HQMF base standard using the QDM and CQL to author eCQMs.
- QDM – Quality Data Model – is a standard information model that describes the data to represent information necessary for electronic quality assessment.
- QRDA – Quality Reporting Document Architecture – is a standard format for reporting eCQM data in a structured, consistent representation. There are two forms of QRDA in use, QRDA I for individual patient data and QRDA III for aggregate patient data.

QUESTIONS?

eCQM RESOURCES

eCQI Resource Center	• The one-stop shop for the most current resources to support electronic clinical quality improvement • The eCQI Resource Center will include CRP announcements • Contact Us if you have questions on locating, downloading, and comparing eCQM specifications.
Office of National Coordinator Project Tracking System (ONC Jira) eCQM Issue Tracker	• CMS receives questions on eCQMs through ONC Jira, which is used as a collaborative platform for logging, tracking, and discussing issues related to program eCQMs • Jira uses platforms, known as trackers or projects. The Jira eCQM Issue Tracker addresses questions specific to eCQM specifications, from questions on measure intent, logic implementation, and value set coding, to eCQM reporting and recommendations for updates to specifications. • Measure developers use the eCQM Issue Tracker as a source for gathering new requirements for the eCQM Annual Update and are included as Change Review Process (CRP) tickets on the eCQM Issue Tracker summary page.

ADDITIONAL RESOURCES

Guide for Reading eCQMs

- To help providers, quality analysts, implementers, and health information technology vendors understand eCQMs and their related documents
- https://ecqi.healthit.gov/sites/default/files/Guide-for-Reading-eCQMs-v7.pdf

eCQM Logic and Implementation Guide

- Provides general implementation guidance, including defining how specific logic and data elements should be conceptualized and addressed during eCQM implementation
- https://ecqi.healthit.gov/sites/default/files/eCQM-Logic-and-Guidance-v5.pdf

Value Set Authority Center

- A repository for value sets across authors and stewards, with downloadable access to all official versions of value sets in the eCQMs
- https://vsac.nlm.nih.gov/download/ecqm?rel=2022

Pioneers in Quality Video Short—CQL Basics

- https://ecqi.healthit.gov/cql?qt-tabs_cql=2

CMS Measures Management System Blueprint

- A standardized approach to developing and maintaining quality measures used in quality initiatives and programs
- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/MMS-Blueprint