Diabetes: HbA1c Poor Control (NQF 0059/122v5)

Measure Basic Information

Name and date of specifications used: Meaningful Use 2017 electronic Clinical Quality Measure (eCQM) Specifications for Eligible Professionals, April 2016 Update and Addendum from January 2017.

URL of Specifications:
http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/eCQM_Library.html (click on files under the heading "eCQMs for Eligible Professionals and MIPS Eligible Clinicians," subheading "Addendum to eCQMs for eReporting for the 2017 Performance Period (as of January 2017)" for the specification files, including quality data model (QDM) data elements).

Note: eCQM specifications have the potential to update every six months. Once certified, electronic health records (EHRs) are not required to be recertified with the updated specifications. OHA will accept year five data submissions from previous releases of the eCQM specifications, but CCOs will need to document the date of the specifications they are using.

The eCQM specifications for CMS122 version 3 contained an error in the measure logic, as CMS described in FAQ13869 https://questions.cms.gov/faq.php?id=5005&faqId=13869. Because of that problem, OHA does not intend to accept submissions from CMS122v3 unless there are extenuating circumstances. In that case, the use of CMS122v3 should be flagged in the CCO's Data Proposal. Additional details will be included in the Year Five Guidance Document.

Measure Type:
HEDIS☐ PQI☐ Survey☐ Other■ Specify: Meaningful Use

Measure Utility:
CCO Incentive■ Core Performance☐ CMS Adult Set☐ CHIPRA Set ☐ State Performance■
Other☐ Specify:

Data Source: Electronic Health Records

Measurement Period: Calendar Year 2017

OHA anticipates publishing the Year Five Guidance Document in the summer 2017.

2013 Benchmark: n/a
2014 Benchmark: 34%, 2013 National Medicaid 75th percentile. For challenge pool only.
2015 Benchmark: 34%, 2014 national Medicaid 75th percentile.
2016 Benchmark: 19%, 2015 national Commercial 90th percentile.
2017 Benchmark: 19%, 2015 national Commercial 90th percentile.

Changes in Specifications from 2016 to 2017: Changes are documented in the 2016 Annual Update of 2014 Eligible Hospitals and Eligible Professionals eCQMs Technical Release Notes available online at

https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/eCQM_2016TechnicalReleaseNotes.pdf and the January 2017 addendum https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/eCQM_TechReleaseNotes_-ICD10only_Jan2017.pdf.

Changes since the previous release of the eCQM specifications include:

- Italicized text added to measure guidance: "Patient is numerator compliant if most recent HbA1c level >9%, the most recent HbA1c result is missing, or if there are no HbA1c tests performed and results documented during the measurement period. *If the HbA1c test result is in the medical record, the test can be used to determine numerator compliance*."
- Changes to datatypes in measure logic to conform to QDM 4.2 changes (re-specified "Diagnosis" datatype).

Value Set name	Value set OID	Status
Diabetes	2.16.840.1.113883.3.464.1003.103.12.1001	Added 11 ICD9CM codes Added 156 ICD10CM codes

Denied claims: n/a

Measure Details

Data elements required denominator: Patients 18-75 years of age who had a diagnosis of diabetes[1] during or any time prior to the measurement period and who received a qualifying outpatient service during the measurement period:

Qualifying Outpatient Service	**Grouping Value Set[2]**
Office Visit	Office Visit Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1001)
Face-to-Face Interaction	Face-to-Face Interaction Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1048)
Preventive Care Services – Established Office Visit, 18 and Up	Preventive Care Services - Established Office Visit, 18 and Up Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1025)

[1] Diabetes is identified using the Diabetes Grouping Value Set (2.16.840.1.113883.3.464.1003.103.12.1001).

[2] Grouping Value Sets are lists of specific values (terms and their codes) derived from single or multiple standard vocabularies used to define clinical concepts (e.g. patients with diabetes, clinical visit, reportable diseases) used in clinical quality measures and to support effective health information exchange. Value Sets can be accessed through the Value Set Authority Center (VSAC) at the National Library of Medicine. https://vsac.nlm.nih.gov/

Qualifying Outpatient Service	Grouping Value Set[2]
Preventive Care Services – Initial Office Visit, 18 and Up	Preventive Care Services-Initial Office Visit, 18 and Up Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1023)
Home Healthcare Services	Home Healthcare Services Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1016)
Annual Wellness Visit	Annual Wellness Visit Grouping Value Set (2.16.840.1.113883.3.526.3.1240)

Required exclusions for denominator: None.

Note: only patients with a diagnosis of Type 1 or Type 2 diabetes should be included in the denominator; patients with a diagnosis of secondary diabetes due to another condition should not be included.

Deviations from cited specifications for denominator: None.

Data elements required numerator: Patients whose most recent HbA1c level (performed during the measurement period) is >9.0%.

Patient is numerator compliant if the most recent HbA1c level >9%, if the most recent HbA1c result is missing, or if there are no HbA1c tests performed and results documented during the measurement period. If the HbA1c test result is in the medical record, the test can be used to determine numerator compliance.

Note: If there is a test result >9% recorded in the electronic health record, then the numerator criteria is satisfied. A test can be used to determine numerator compliance if the reporting provider has documentation of the test in the patient's record, regardless of who ordered or performed the test. However, this does not mean traditional chart review is required, or allowed, as part of determining numerator compliance. Numerator compliance should still be determined through the EHR-based reporting.

Required exclusions for numerator: None.

Deviations from cited specifications for numerator: None.

What are the continuous enrollment criteria:

There are no continuous enrollment criteria required for this measure. Where possible, CCOs should apply the eligibility rule of 'eligible as of the last date of the reporting period' to identify beneficiaries. OHA's preference is to receive data for Medicaid beneficiaries only, but data for the entire population may be submitted if the data is in aggregate. For any submission of patient-level data, the data must be limited to Medicaid only.

What are allowable gaps in enrollment: n/a

Define Anchor Date (if applicable): n/a

For more information:

- Value Sets can be accessed through the Value Set Authority Center (VSAC) at the National Library of Medicine . https://vsac.nlm.nih.gov/

- How to read eCQMs: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Guide_Reading_EP_Hospital_eCQMs.pdf

- CMS's eCQM Library: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/eCQM_Library.html

- Year Five guidance will be available online at: http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx

Version Control

2/10/17 -- Updates added to reflect CMS's January 2017 addendum to eCQM specifications