Diabetes: HbA1c Poor Control (NQF 0059/122v6)

Measure Basic Information

Name and date of specifications used: Eligible Professional / Eligible Clinician electronic Clinical Quality Measure (eCQM) Specifications for Performance / Reporting Year 2018.

URL of Specifications: https://ecqi.healthit.gov/eligible-professional-eligible-clinician-ecqms (select 2018 from the drop-down menu under "Select Performance/ Reporting Period" and then click the "Apply" button).

Note: eCQM specifications typically are updated at least annually. The eCQM version number changes with each annual update. Once certified, however, electronic health records (EHRs) are not required to be recertified with updated eCQM specifications, so the Certified HIT Products List may not accurately reflect the version of an eCQM that is actually supported by an EHR vendor. OHA will accept year six data (2018) submissions from previous releases of the eCQM specifications, but CCOs will need to document the version number of the specifications they are using.

As discussed in previous years, the eCQM specifications for CMS122 version 3 contained an error in the measure logic, which makes reported performance look worse than actual performance. 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.

Measure Type:

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

Measure Utility:

CCO Incentive ■ State Quality Measure ■ CMS Adult Core Set ■ CMS Child Core Set ☐
Other☐ Specify:

Data Source: Electronic Health Records

Measurement Period: Calendar Year 2018

OHA anticipates publishing the Year Six (2018) Guidance Document in summer 2018.

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.
2018 Benchmark: 22.6%, 2016 CCO 90th percentile.

2018 Improvement Targets: Minnesota method with 2 percentage point floor

Changes in Specifications from 2017 to 2018: Changes are documented in Technical Release Notes available at https://ecqi.healthit.gov/ecqm/measures/cms122v6

Changes to this measure include:

- Added exclusion for patients in hospice care.
- Under continuous enrollment criteria, removed reference to eligibility rule of "eligible as of last date of the reporting period" and added reference to alignment with CMS specifications.

Value Set name and OID	Status
Value set Diabetes (2.16.840.1.113883.3.464.1003.103.12.1001)	Added 32 SNOMEDCT codes.
Value set Encounter Inpatient (2.16.840.1.113883.3.666.5.307)	Added Encounter Inpatient
Value set Hospice care ambulatory (2.16.840.1.113762.1.4.1108.15)	Added Hospice care ambulatory
Value set Discharged to Health Care Facility for Hospice Care (2.16.840.1.113883.3.117.1.7.1.207)	Added Discharged to Health Care Facility for Hospice Care
Value set Discharged to Home for Hospice Care (2.16.840.1.113883.3.117.1.7.1.209)	Added Discharged to Home for Hospice Care
Value set Diabetes (2.16.840.1.113883.3.464.1003.103.12.1001)	Added 2 ICD10CM codes (E11.10, E11.11) Added 21 SNOMEDCT 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)
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)

[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]
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: Patients who were in hospice care during the measurement year

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. OHA's intention is to maintain alignment with CMS specifications for this measure, including specifications for reporting the supplemental data element for "Patient Characteristic Payer: Payer."

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/ ONC eCQI Resource Center: https://ecqi.healthit.gov/
- Year Six (2018) guidance will be available online at: http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx