



Uniform Data System (UDS) Clinical Tables Part 1: Screening and Preventive Care Measures

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Vision: Healthy Communities, Healthy People



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Opening Remarks

Dylan Podson
Data and Evaluation
Office of Quality Improvement
Bureau of Primary Health Care (BPHC)
Health Resources and Services Administration (HRSA)



Uniform Data System (UDS) Clinical Tables Part 1: Screening and Preventive Care Measures

AGENDA

- Discuss Uniform Data System (UDS) reporting instructions on clinical quality measures (CQMs)
- Review UDS screening and preventive care measures reporting requirements
 - **New CQM, Falls: Screening for Future Risk**
- UDS Workflow for eCQMs demonstration
- Identify reporting strategies and tips for data reporting
- Q&A

Objectives

By the end of the webinar, participants will be able to:

1

Understand reporting requirements for screening and preventive care measures.

2

Identify opportunities for quality improvement.

3

Access additional reporting support.

Poll #1

How familiar are you with the UDS CQMs?

- A. I am not familiar. The basics will be helpful to learn.
- B. I am not very familiar. Gaining a better understanding will be helpful.
- C. I am somewhat familiar. Learning about the measures in more detail will be helpful.
- D. I am very familiar with these measures. I would like to learn about any changes this year that impact UDS reporting.

UDS CQM Reporting

Key UDS Terminology in CQM Reporting

Electronic Clinical Quality Improvement (eCQI) Resource Center

Key Resources



Components of Each Clinical Measure

DENOMINATOR

- Identifies the group of patients that the measure is looking at when determining who meets the numerators.
- Equal to the initial population identified in the CQM.
- Reported in Column A (and B).

NUMERATOR

- The number of patients from the denominator who met the service, event, or outcomes requirements.
- Each patient in the denominator is assessed to determine whether they meet the numerator.
- Reported in Column C (or F).

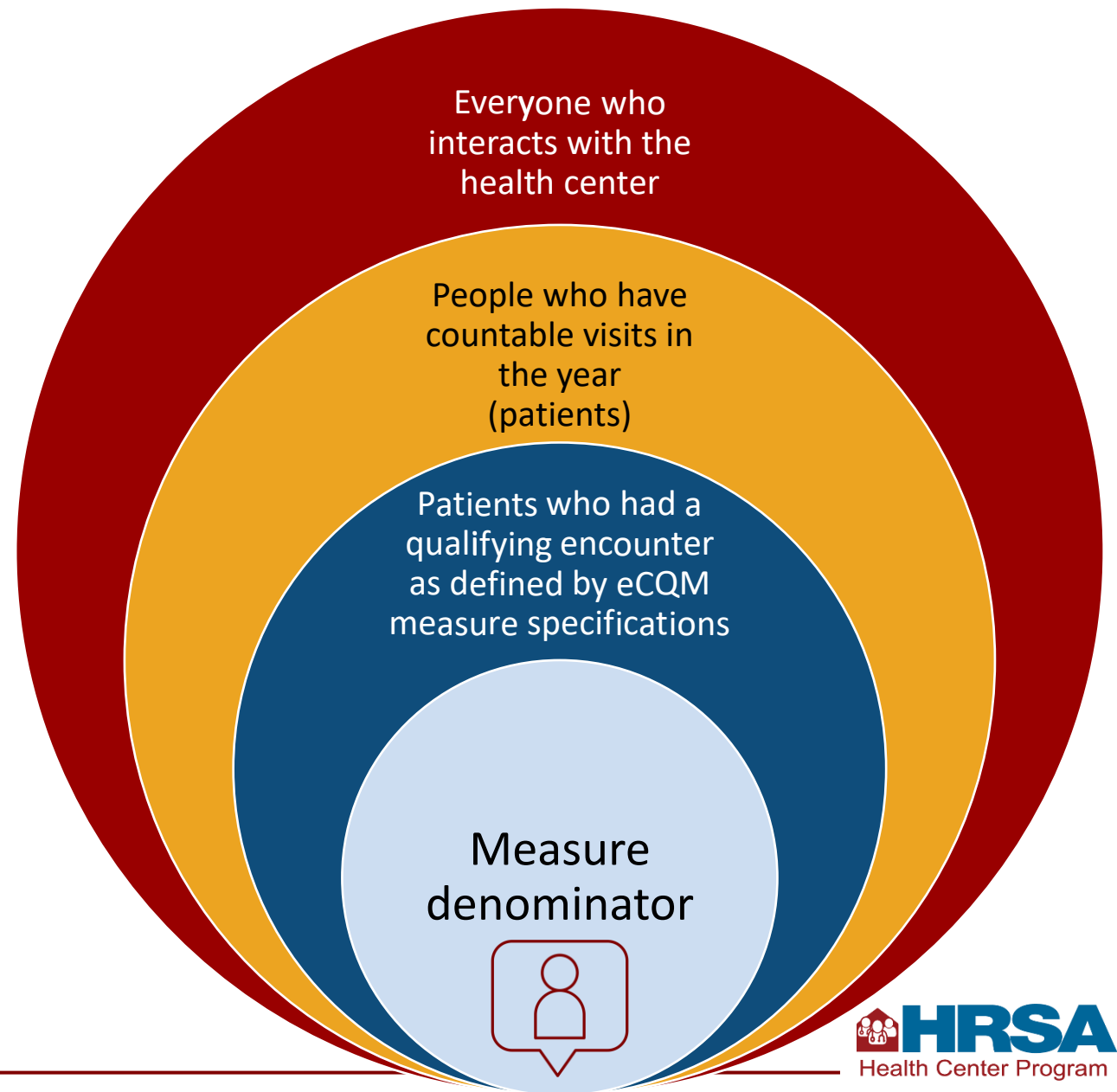
- **EXCLUSIONS** As used in clinical quality measure reporting, specific conditions or circumstances that remove certain patients from the measure's denominator because the measure criteria are not appropriate for them.
- **EXCEPTIONS** As used in clinical quality measure reporting, allowable reasons within the denominator for not meeting the measure's requirements, acknowledging valid clinical, patient-centered, or system-related factors that justify why the expected care was not provided.

Other Key Terms in UDS CQM Measurement

Specification Guidance	The Centers for Medicare & Medicaid Services (CMS) measures guidance that assists with understanding and implementing CQMs.
UDS Reporting Considerations	Additional BPHC requirements and guidance that must be applied to the specific measure and that may differ from or expand on the CQM specifications.
CQMs	A mechanism used for assessing the degree to which a clinician competently and safely delivers clinical services appropriate for the patient in an optimal time frame.
eCQMs	CQMs expressed and formatted to use data from electronic health record (EHR) and/or health information technology (Health IT) systems to measure health care quality.
Clinical Quality Language (CQL)	An open-source standard that allows a human-readable description of clinical quality logic to express clinical knowledge.
Value Sets	Lists of codes and corresponding terms from the National Library of Medicine Value Set Authority Center (VSAC)–hosted standard clinical vocabularies (such as CPT, ICD, SNOMED CT, RxNorm, and LOINC®) that define clinical concepts.
Measurement Period	Represents calendar year (CY) 2026 (January 1–December 31) unless another time frame is specifically noted in the UDS Manual or measure specifications.
Measure Steward	An individual or organization that owns a measure and is responsible for maintaining the measure. Each CQM has a measure steward.

What Is Reported in the Denominator of Each Measure?

- **Column A** and **Column B** of Table 6B are limited to the patients in the measure denominator.
- In **limited situations** where the health center doesn't have access to the full set of data needed to *assess the numerator*, health centers can report 80 percent or more of Column A in Column B.



Eligibility for Each CQM

For someone to be included in a measure denominator...

1. They must have a countable visit on Table 5.

Remember, no one is included as a patient anywhere on the UDS without having a visit counted somewhere on Table 5.

4. Then, only once someone is included in the denominator are they evaluated for the numerator.



2. They must have an encounter that meets the measure's qualifying encounter specifications.

3. They must *not* meet any of the denominator exclusions or exceptions.

CQMs: Keys to Remember



To be reported *anywhere* on the UDS, a patient must have a countable visit on Table 5 during the year.

Countable visits can be in multiple service areas (e.g., medical, dental, mental health, substance use disorder) if they meet the countable visit definition.



For CQM reporting on Table 6B, patients must meet the criteria detailed in the individual measure specifications.

Eligible visit types depend on specifications defined by the measure steward and must be assessed for each measure individually.



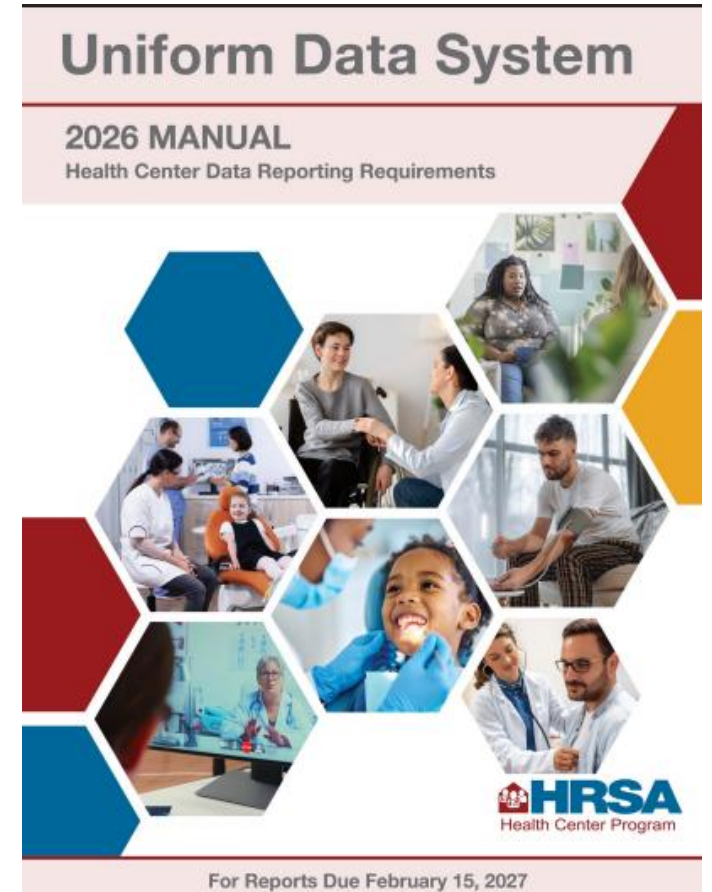
It is essential to review and use the codes listed in the CQM specifications.

Many CQMs have denominators that are limited to patients who have had at least a medical visit during the year, but in some measures, other visit types might also be included in applicable CQM value sets.

Getting Started with CQMs

Finding UDS Guidance

- Review the [2026 UDS Manual](#), which includes:
 - Definitions and instructions specific to the UDS
 - Links to all CQMs, as well as UDS-specific considerations
 - Descriptions of additional resources to support reporting
- Review year-over-year changes via:
 - [2026 Program Assistance Letter \(PAL\)](#)
 - [UDS Changes Webinar](#)
 - [Upcoming technical assistance webinars](#) and annual UDS trainings co-hosted with Primary Care Associations



Getting Started with eCQMs

eCQI Resource Center

eCQI RESOURCE CENTER

eCQMs ▾
Electronic Clinical
Quality Measures

dQMs ▾
Digital Quality
Measures

Resources ▾
Standards, Tools,
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eCQI, CDS, FAQs
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eCQM Implementation Checklist

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The Centers for Medicare & Medicaid Services (CMS) requires an [eligible clinician](#) (EC), [eligible hospital](#) (EH) or [critical access hospital](#) (CAH) to use the most current version of the [eCQMs](#) for quality reporting programs.

The [Preparation and Implementation Checklists](#) (PDF) assume that a health care practice/organization has determined which measures to report on. It provides the necessary technical steps [health information technology](#) (IT) developers, implementers and health care organizations must take to update their systems and processes with the eCQM Annual Update for the upcoming reporting and performance periods. The most recent eCQM Annual Update should be applied to your system for use in CMS electronic quality reporting.

Preparation Checklist

eCQM Implementation Checklist

- Six preparation steps and seven implementation steps.

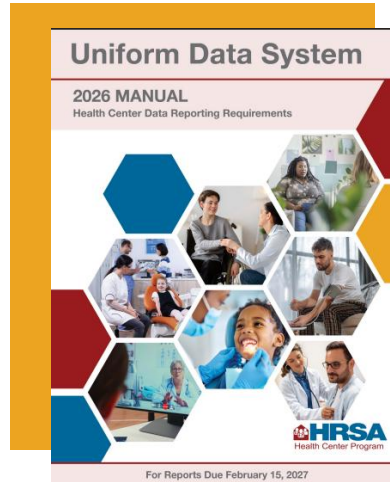
eCQM supports include:

- [eCQI Resource Center](#): For each measure, in the “Measure Information” tab, there is the option to “compare” (e.g., 2025 to 2026). **This highlights changes year over year.**
- [eCQM Flows](#): Workflows for each eCQM, updated annually; downloads as a ZIP file.
- [Technical Release Notes: 2026 Performance Period eCQMs for Eligible Clinicians](#)
- [eCQM value sets](#): The VSAC site allows you to search [value sets](#).
- Additional resources are available on the [Eligible Clinician eCQM Resources page](#).

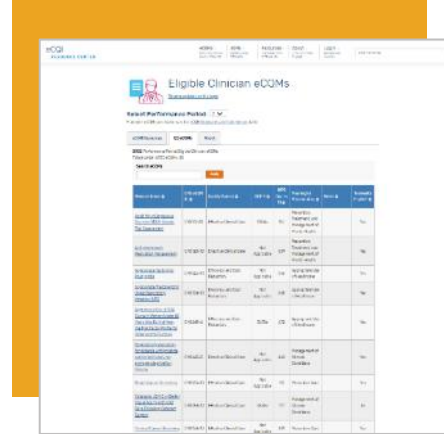


Getting Started with CQMs

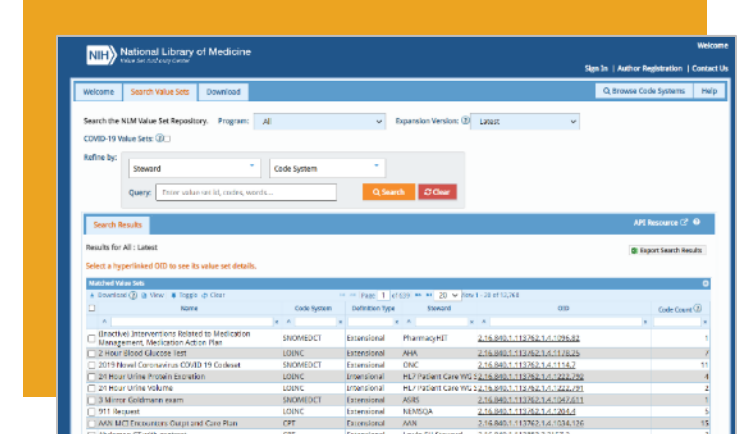
Key Resources



The [UDS Manual](#) provides specific UDS table and form reporting instructions, covers UDS-specific considerations, and links to measure specifications.



The manual links to the [eCQI Resource Center](#), where measure information, specifications, data elements, and value sets are found.



The codes that make up each value set within the measure specifications are available from the [VSAC site](#).

eCQM issues that have been identified can be reviewed in the Office of the National Coordinator for Health Information Technology (ONC) Issue Tracking System (OITS) Jira project eCQM Issue Tracker.

Responses to questions and guidance from the measure stewards can be found here.

Sign up for an [OITS account](#).

Post questions in the [eCQM Issue Tracker](#).

The screenshot displays the Jira project interface for the eCQM Issue Tracker. At the top, there are filters for 'eCQM Issue Tracker', 'Type: All', 'Status: All', 'Assignee: All', and a search bar. Below this, a list of issues is shown on the left, with 'CQM-8026' selected. The main area shows the details for issue 'CQM-8026', titled 'Self-reporting for CMS 124, 125, and 130'. The issue is marked as 'Closed' and 'Answered'. The details include the type 'EC eCQMs - Eligible Clinicians', priority 'Moderate', and the reporter 'Marta Livingstone'. The solution text states: 'Thank you for your inquiry about self-reports for CMS124v13, CMS125v13 and CMS130v13 (2025 Performance Period). Please see below each measure and their requirements regarding self-reported information. For CMS124v13, self-reported HPV test is an acceptable criterion for this measure given they are performed within the required timeframe, is documented using a code from the "HPV Test" value set (OID: 2.16.840.1.113883.3.464.1003.110.12.1059), documented'.

Knowledge Check #1

What criteria are used to determine which patients to include in a measure denominator?

- A. Only patients who had at least one medical visit during the measurement period as specified in the measure.
- B. Only patients who had a countable UDS visit **and** a visit that meets the qualifying encounter definitions for that particular CQM measure criteria and specifications during the measurement period as specified in the measure.
- C. Only patients who had at least one behavioral health visit at a health center site during the measurement period as specified in the measure.
- D. None of the above.

Knowledge Check #1 Answer

What criteria are used to determine which patients to include in a measure denominator?

- A. Only patients who had at least one medical visit during the measurement period as specified in the measure.
- B. Only patients who had a countable UDS visit and a visit that meets the qualifying encounter definitions for that particular CQM measure criteria and specifications during the measurement period as specified in the measure.**
- C. Only patients who had at least one behavioral health visit at a health center site during the measurement period as specified in the measure.
- D. None of the above.

Table 6B CQMs

Summary

Reporting Format

Key Changes

UDS CQMs

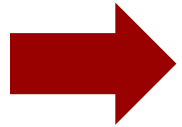


Summary of Changes to Tables 6B and 7

- **Updates:**
 - Alignment with latest electronic clinical quality measures (eCQMs).
 - Childhood Immunization Status: reporting is voluntary.
 - **Breast Cancer Screening: denominator age range changed from 50 -74 years of age to 42–74 years of age.**
 - **HIV Screening: denominator updated to patients 15–65 years of age at the start of the measurement period without an HIV diagnosis prior to the start of the measurement period.**
 - **Screening for Depression and Follow-Up: numerator has been revised to include an active depression medication overlapping the date of the qualifying encounter.**
 - Sealant Receipt on Permanent First Molars: replaced the dental sealants for children between 6–9 years measure.
- **Additions/New Lines:**
 - **Falls: Screening for Future Risk (Line 24).**



UDS CQMs



Screening and Preventive Care Measures

Today's webinar

Maternal Care and Children's Health Measures

UDS Clinical Tables Part 2: October 20, 2026, 2:00–3:30 p.m. ET

Disease Management Measures

UDS Clinical Tables Part 3: October 29, 2026, 2:00–3:30 p.m. ET



Register for future UDS webinars and [view past webinar recordings.](#)



Table 6B Reporting Format

Denominator (a)	Number of Records Reviewed (Denominator) (b)	Number of Records Meeting the Numerator Criteria (Numerator) (c)
Number of patients who fit the detailed criteria described for inclusion in the measure	Patients who fit the criteria (same as Column A), or a number equal to or greater than 80 percent of Column A	Number of records from Column B that meet the numerator criteria for the measure

Changes to Align with eCQMs

Table 6B was updated to align with the latest CMS eCQMs. The [2026 UDS CQM Criteria handout](#) is available to review for 2026 updates.

Line	Clinical Quality Care Measure	Updated eCQM
11	Cervical Cancer Screening	CMS124v14
11a	Breast Cancer Screening	CMS125v14
13	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	CMS69v14
14a	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	CMS138v14
19	Colorectal Cancer Screening	CMS130v14
20a	HIV Screening	CMS349v8
21	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	CMS2v15

General Reporting Guidelines

- Screenings and tests performed **elsewhere** may count for some measures toward performance if they are appropriately documented in the EHR and approved by a provider.
- Do not count, as meeting performance, charts that note the refusal of the patient to have the test or screening, unless otherwise noted.
- For CQMs requiring the completion of screenings, tests, or procedures to meet the numerator criteria, the findings of the screenings, tests, or procedures **must be accessible** in the patient health record.

Cervical Cancer Screening: CMS124v14

Denominator	Exclusions	Exceptions	Numerator
Women 24 through 64 years of age by the end of the measurement period with a qualifying encounter during the measurement period, as specified in the measure criteria	Women who had a hysterectomy with no residual cervix or a congenital absence of cervix Patients who were in hospice care for any part of the measurement period Patients who received palliative care for any part of the measurement period	Not applicable	Women with one or more screenings for cervical cancer. Appropriate screenings are defined by any one of the following criteria: - Cervical cytology performed during the measurement period or the 2 years prior to the measurement period for women 24–64 years of age by the end of the measurement period. - Cervical human papillomavirus (HPV) testing performed during the measurement period or the 4 years prior to the measurement period for women who are 30 years or older at the time of the test.

Cervical Cancer Screening: CMS124v14 (*cont.*)

Clarifications, Tips, and Frequently Asked Questions (FAQs)

- Evaluates whether tests were performed after a woman turned 21 years of age. The youngest age in the initial population is a patient who turned 24 years old on December 31.
- Evidence of high-risk human papillomavirus (hrHPV) testing within the last 5 years also captures patients who had cotesting; therefore, additional methods to identify cotesting are not necessary.
- The method of collection *is not* specified in the eCQM specifications. HPV tests that are documented using the codes specified in the value set meet the numerator criteria, this includes self-swab tests. This question specific to self-swab collection was captured in Jira in February 2025. See FAQ #9 on page 118 of the 2026 Manual for additional information.
- **Screening performed elsewhere?** Include documentation in the patient health record of the date the test was performed, who performed it, and the result of the finding provided by the agency that conducted the test (or a copy of the lab result). Include ***documented*** self-reported procedures as well as diagnostic studies.



Breast Cancer Screening: CMS125v14

Denominator	Exclusions	Exceptions	Numerator
Women 40* through 74 years of age by the end of the measurement period with a qualifying encounter during the measurement period, as specified in the measure criteria	Women who had a bilateral mastectomy or who have a history of a bilateral mastectomy or for whom there is evidence of a right and a left unilateral mastectomy on or before the end of the measurement period Patients who were in hospice care for any part of the measurement period Patients aged 66 or older by the end of the measurement period • Who were living long-term in a nursing home any time on or before the end of the measurement period • With an indication of frailty for any part of the measurement period who also meet any of these advanced illness criteria: – Advanced illness diagnosis during the measurement period or the year prior; or – Taking dementia medications during the measurement period or the year prior Patients who received palliative care during the measurement period	Not applicable	Women with one or more mammograms any time on or between October 1 two years prior to the measurement period and the end of the measurement period



*To report on women who received breast cancer screening on or after 40 years of age, the denominator will include patients who are at least 42 years of age on or after December 31.

Breast Cancer Screening: CMS125v14 (cont.)

Clarifications, Tips, and FAQs

- The measure only evaluates whether tests were performed after a woman turned 40 years of age. The youngest age in the initial population is 42.
- Include patients according to sex.
- **Do not** count biopsies, breast ultrasounds, or magnetic resonance imaging, because they are not appropriate methods for *primary breast cancer screening*.
- ***Mammogram performed elsewhere?*** Include documentation in the patient health record of the date the test was performed, who performed it, and the result of the finding provided by the agency that conducted the test (or a copy of the lab result). Include ***documented*** self-reported procedures as well as diagnostic studies.

Body Mass Index (BMI) Screening and Follow-Up Plan:

CMS69v14

Denominator	Exclusions	Exceptions	Numerator
Patients 18 years of age or older on the date of the visit with at least one qualifying encounter during the measurement period, as specified in the measure criteria Do not include patients who had only virtual visits during the year.	Women who are pregnant at any time during the measurement period Patients receiving palliative or hospice care at any time during the measurement period	Patients who refuse measurement of height and/or weight Patients with a documented medical reason for not documenting BMI or for not documenting a follow-up plan outside normal parameters	Patients with a documented BMI (not just height and weight) during their most recent visit or during the measurement period, and when the BMI is outside of normal parameters, a follow-up plan is documented at the visit where the BMI was outside of normal parameters or during the measurement period



Conditions linked with “and” mean that all of the conditions must be met.

Body Mass Index (BMI) Screening and Follow-Up Plan: CMS69v14 (cont.)

Clarifications, Tips, and FAQs

- Include in the numerator patients within normal parameters who had their BMI documented **and** patients with a BMI outside normal parameters with a follow-up plan.
- Normal BMI parameters are defined as BMI ≥ 18.5 and < 25 kg/m².
- If more than one BMI is reported during the measurement period and any one of the documented BMI assessments is outside of normal parameters, documentation of an appropriate follow-up plan is to be used to determine whether performance has been met.
- BMI may be documented in the patient health record at the health center or in outside patient health records obtained by the health center.
- Height and weight are not acceptable to be self-reported or reported via a telehealth visit.
- If the only visit a patient had during the year was telehealth or telephone-only, the patient should be excluded from the measure assessment. However, development of a follow-up plan for a BMI out of range is acceptable via telehealth.
- **Do not** count as meeting the numerator criteria charts or templates that display only height and weight. The fact that Health IT /EHR can calculate BMI does not replace the presence of the BMI itself.



Tobacco Use: Screening and Cessation Intervention:

CMS138v14

Denominator	Exclusions	Exceptions	Numerator
Patients aged 12 years and older at the start of the measurement period seen for at least two qualifying encounters in the measurement period or at least one preventive care qualifying encounter during the measurement period, as specified in the measure criteria	Patients who were in hospice care for any part of the measurement period	Not applicable	Patients who were: • Screened for tobacco use at least once during the measurement period and not identified as a tobacco user • Screened for tobacco use at least once during the measurement period and, if identified as a tobacco user, received tobacco cessation intervention during the measurement period or during the 6 months prior to the measurement period

Tobacco Use: Screening and Cessation Intervention:

CMS138v14 (cont.)

Clarifications, Tips, and FAQs

- The tobacco use screening and the tobacco cessation intervention **do not** need to be performed by the same provider.
- Cessation interventions include cessation counseling services, prescription or a recommendation to purchase an over-the-counter product, tobacco use cessation medication, or use of a tobacco use cessation agent.
- If a patient has multiple tobacco use screenings during the measurement period, use the most recent screening that has a documented status of tobacco user or non-user.
- Include in the numerator patients with a negative screening **and** patients with a positive screening who had cessation intervention if a tobacco user.
- If tobacco use status of a patient is unknown, the patient **does not** meet the screening component and has not met the criteria to be counted in the numerator. “Unknown” includes patients who were not screened and patients with indefinite answers.
- The measure **does** consider the use of e-cigarettes and other electronic nicotine delivery systems to be tobacco use, so patients reporting use of these devices will be included in the denominator and need to be assessed for the numerator. However, use of e-cigarettes is not considered a method of tobacco cessation for consideration of numerator compliance.



Colorectal Cancer Screening: CMS130v14

Denominator	Exclusions	Exceptions	Numerator
Patients 46 through 75 years of age by the end of the measurement period with a qualifying encounter during the measurement period, as specified in the measure criteria	Patients with a diagnosis or past history of colorectal cancer or a history of total colectomy Patients who were in palliative or hospice care for any part of the measurement period Patients aged 66 or older by the end of the measurement period: • Who were living long-term in a nursing home during any time on or before the end of the measurement period; or • With an indication of frailty for any part of the measurement period who also meet any of these advanced illness criteria: – Advanced illness diagnosis during the measurement period or the year prior; or – Taking dementia medications during the measurement period or the year prior	Not applicable	Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the following: • Fecal occult blood test (FOBT) during measurement period • Stool deoxyribonucleic acid (DNA) (sDNA) with fecal immunochemical test (FIT) during the measurement period or the two years prior to the measurement period • Flexible sigmoidoscopy during the measurement period or the four years prior • Computerized tomography (CT) during measurement period or four years prior • Colonoscopy during measurement period or nine years prior

Colorectal Cancer Screening: CMS130v14 (cont.)

Clarifications, Tips, and FAQs

- **Do not** count digital rectal exams (DREs) or fecal occult blood tests (FOBTs) performed in an office setting or performed on a sample collected via DRE.
- FOBTs can be used to document meeting the numerator criteria but are required each measurement period. There are two FOBT options: the guaiac fecal occult blood test (gFOBT) and the immunochemical-based fecal occult blood test (iFOBT).
- Lab tests (FOBT and sDNA with FIT) performed elsewhere must be confirmed by documentation in the patient's health record: either a copy of the test results or correspondence between the clinic personnel and the performing lab/provider showing the results.
- **Do not** use self-reported test results.
- Procedures and diagnostic studies are not acceptable via telehealth.
- iFOBT, gFOBT, and sDNA with FIT test kits can be mailed to patients, but receipt, processing, and documentation of the test sample is required.



HIV Screening: CMS349v8

Denominator	Exclusions	Exceptions	Numerator
Patients aged 15 through 65 years of age at the start of the measurement period without an HIV diagnosis prior to the start of the measurement period* AND who had at least one outpatient qualifying encounter during the measurement period, as specified in the measure criteria. *Without an HIV diagnosis prior to the start of the measurement period is new for 2026 reporting.	Patients diagnosed with HIV prior to the day of the start of the measurement period	Patients who died on or before the end of the last day of the measurement period	Patients with documentation of an HIV test performed on or after their 15th birthday and before their 66th birthday

HIV Screening: CMS349v8 (cont.)

Clarifications, Tips, and FAQs

- Documentation of the administration of the laboratory or point of care tests must be present in the patient's health record.
- Patient attestation or self-report of having had an HIV test, without documentation of results, is **not** permitted to meet the measurement requirements.
- HIV tests performed elsewhere must be confirmed by documentation in the chart: either a copy of the test results or correspondence between the clinic personnel and the performing lab/provider showing the results.
- The patient must have a countable visit reported on Table 5 of the UDS Report in the measurement period to be included in this measure.
- If the only visits during the year are telephone visits, exclude the patient from the denominator.



Screening for Depression and Follow-Up Plan:

CMS2v15

Denominator	Exclusions	Exceptions	Numerator
Patients aged 12 years and older at the beginning of the measurement period with at least one qualifying encounter during the measurement period, as specified in the measure criteria	Patients who have been diagnosed with bipolar disorder at any time prior to the qualifying encounter	Patients: • Who refuse to participate in or complete the depression screening • Who are in urgent or emergent situations • Who have a documented medical reason for not being screened for depression (e.g., cognitive, functional, or motivational limitations) that may impact the accuracy of results	Patients who were: • Screened for depression on the date of the visit or up to 14 days prior to the date of the visit using an age-appropriate standardized tool, and screened negative for depression • Screened for depression on the date of the visit or up to 14 days prior to the date of the visit using an age-appropriate standardized tool, and if screened positive for depression, a follow-up plan is documented on the date of or up to 2 days after the date of the qualifying encounter or an active depression medication overlaps the date of the qualifying encounter.* *Active depression medication overlaps the date of the qualifying encounter is new for 2026 reporting.

Screening for Depression and Follow-Up Plan:

CMS2v15 (cont.)

Clarifications, Tips, and FAQs

- The depression screening must be completed on the date of the visit **or** up to 14 days prior to the date of the visit and must be reviewed and addressed in the office of the provider on the date of the visit. Screening may occur outside of a countable visit.
- A follow-up plan could be additional evaluation, referral, treatment, pharmacological intervention, or other interventions.
- The denominator exclusion for patients who have ever been diagnosed with bipolar disorder at any time prior to the qualifying encounter applies regardless of whether the diagnosis is active or not.
- If a patient has had multiple screenings in the measurement period, use the most recent screening results. If screenings have been completed on the same day and one is positive, the patient is in the numerator. See this [ONC Jira ticket](#) for more information.
- Do not exclude patients seen for routine care in urgent care centers or emergency rooms from the denominator.
- A Patient Health Questionnaire (PHQ)-9 following a PHQ-2 does not meet the numerator requirements for a follow-up plan to a positive depression screening.



New—Falls: Screening for Future Risk [CMS139v14](#)

Denominator	Exclusions	Exceptions	Numerator
Patients aged 65 years and older at the start of the measurement period with a visit during the measurement period	Patients who are in hospice for any part of the measurement period	None	Patients who were screened for future risk at least once within the measurement period

NEW: Falls: Screening for Future Risk CMS139v14

Clarifications, Tips, and FAQs

- Falls risk screening can be completed via telehealth (CPT codes 99421-99423), and any documented history of falls identified during chart review should prompt the provider to follow up. See this [ONC Jira ticket](#) for more information.
- Transitional Care Management (TCM) services (CPT codes 99495 and 99496) are not included in the measure value set. TCM is not considered to be evidence of a risk assessment because such an assessment is not required to bill the code. See this [ONC Jira ticket](#) for more information.

Knowledge Check #2

What is the best way to receive clarification and guidance for eCQMs not already addressed with the measure specifications or CQL?

- A. Sign up for an ONC OITS (Issue Tracking System) account
- B. Post questions to the measure stewards and review questions others have asked
- C. Review known issues for implementation information for eCQMs
- D. All of the above

Knowledge Check #2 **Answer**

What is the best way to receive clarification and guidance for eCQMs not already addressed with the measure specifications or CQL?

- A. Sign up for an ONC OITS (Issue Tracking System) account
- B. Post questions to the measure stewards and review questions others have asked
- C. Review known issues for implementation information for eCQMs
- D. All of the above**

UDS Workflow for eCQMs Demonstration

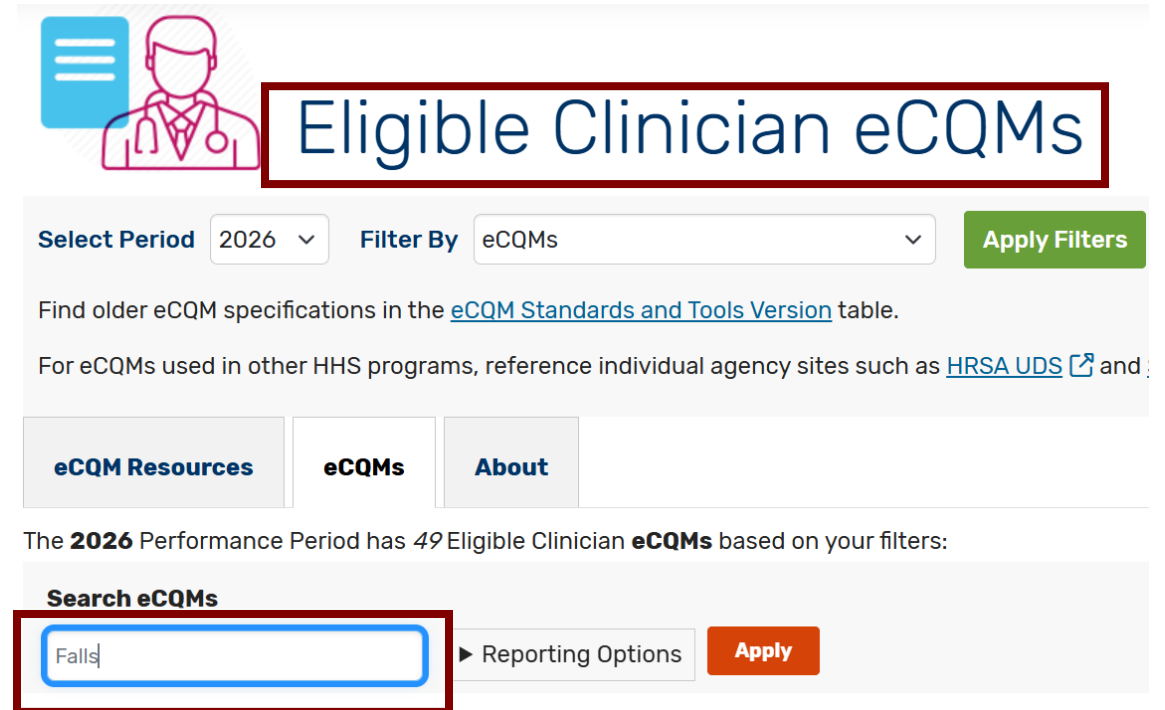
Goal: Learn how to access the measure specifications and value sets for UDS eCQMs
Live demonstration of accessing the eCQI Resource Center and VSAC



Deep Dive: Falls Risk

Step 1: Access the eCQI Resource Center. From the eCQMs dropdown on the top left, select “EC eCQMs” (EC = eligible clinicians).

Step 2: On the EC eCQMs page, use the search bar to find the measure of interest. In this case, that’s the Falls: Screening for Future Risk measure. Select the measure from the search results.



The screenshot shows the 'Eligible Clinician eCQMs' page. At the top, there is a header with a menu icon and a title 'Eligible Clinician eCQMs' enclosed in a red box. Below the header, there are filters for 'Select Period' (set to 2026) and 'Filter By' (set to eCQMs), with an 'Apply Filters' button. A text block provides information about finding older eCQM specifications and references to HRSA UDS. Below this is a navigation bar with 'eCQM Resources', 'eCQMs', and 'About' tabs. A summary line states: 'The 2026 Performance Period has 49 Eligible Clinician eCQMs based on your filters:'. At the bottom, there is a 'Search eCQMs' section with a search bar containing the text 'Falls' (highlighted with a red box), a 'Reporting Options' button, and an 'Apply' button.

Falls: Screening for Future Fall Risk

Measure Information

Specifications and Data Elements

Release Notes

Compare Versions of: "Falls: Screening for Future Fall Risk"

The Compare function compares two years of the measure specifications found in the header of the measure's HTML. It does not include a comparison of any information in the body of the HTML, e.g., population criteria, Clinical Quality Language, or value sets.

Strikethrough text highlighted in red indicates information changed from the previous version. Text highlighted in green indicates information updated in the new eCQM version.

COMPARE **2026** VERSION TO

2025 ▼

Compare >

Reset

TABLE OPTIONS

Expand All Rows

DOWNLOAD

Download ▼

Step 3: Select Specification and Data Elements tab.

Note: The Measure Information tab allows you to read all about the measure and compare the current year's guidance to prior and future years' guidance. Since this measure is new for 2026, this functionality is not as important, but in future years be sure to review any changes to the measure guidance using the Compare feature.

Falls: Screening for Future Fall Risk

Measure Information

Specifications and Data Elements

Release Notes

Specifications

- [CMS139-v14.0.000-QDM.html](#)
- [CMS139-v14.0.000-QDM.zip](#) (ZIP)

Additional Resources for CMS139v14

- [Value Sets](#) 
- [Data Elements](#)
- [eCQM Flow](#) (PDF)
- [Technical Release Notes](#) (Excel)
- [Jira Issue Tracker tickets](#) 

Step 4: Select the html link under “Specifications”

Note: Under “Additional Resources” there are several helpful links.

- Value Sets directs to the VSAC webpage, which we will explore further in subsequent steps.
- Data Elements directs to a page on the eCQI Resource Center with more detailed information about the elements of the measure.
- eCQM Flow directs to a PDF walk-through of the measure. This is a helpful visual for clinical care teams.
- Technical Release Notes downloads a spreadsheet of the updates and changes to this version of the measure.
- And finally, the Jira Issue Tracker links directly to tickets about this specific measure.

Step 5: Use the control find function to search for “Qualifying Encounter”

Note: This page contains a lot of information about every component of the measure. For this example, we are looking for the qualifying encounter value sets—specifically, “Virtual Encounter”

Step 6: Under the Terminology section, find “Virtual Encounter” and the associated Value Set OID. We will use this in the next step.

Qualifying Encounter

```
( ["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"]
union ["Encounter, Performed": "Ophthalmological Services"]
union ["Encounter, Performed": "Preventive Care Services Individual Counseling"]
union ["Encounter, Performed": "Discharge Services Nursing Facility"]
union ["Encounter, Performed": "Nursing Facility Visit"]
union ["Encounter, Performed": "Care Services in Long Term Residential Facility"]
union ["Encounter, Performed": "Audiology Visit"]
union ["Encounter, Performed": "Telephone Visits"]
union ["Encounter, Performed": "Virtual Encounter"]
union ["Encounter, Performed": "Physical Therapy Evaluation"]
union ["Encounter, Performed": "Occupational Therapy Evaluation"] ) ValidEncounters
where ValidEncounters.relevantPeriod during day of "Measurement Period"
```

Terminology

- valueset "Office Visit" (2.16.840.1.113883.3.464.1003.101.12.1001)
- valueset "Ophthalmological Services" (2.16.840.1.113883.3.526.3.1285)
- valueset "Payer Type" (2.16.840.1.114222.4.11.3591)
- valueset "Physical Therapy Evaluation" (2.16.840.1.113883.3.526.3.1022)
- 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 Individual Counseling" (2.16.840.1.113883.3.464.1003.101.12.1026)
- 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" (2.16.840.1.113883.3.464.1003.101.12.1088)
- valueset "Virtual Encounter" (2.16.840.1.113883.3.464.1003.101.12.1089)



Welcome

Search Value Sets

Download

 Comparison Tool

 Browse Code Systems

 Help

Search the NLM Value Set Repository.

Search By:

Program ▾

Program:

CMS eCQM and Hybrid Measure ▾

Release:

eCQM Update 2025-05-08 ▾



Compare Releases

Refine by:

Steward ▾

Code System ▾

CMS eCQM ID

Quality Data Model Category ▾

Query:

Enter value set id, codes, words...

 Search

 Clear

Include Retired Value Sets: ☐

Step 7: Head to the [Value Set Authority Center \(VSAC\) webpage](#). In the Query bar, paste the OID for Virtual Encounters, then hit Search.

Note: You will need to make an account on the VSAC webpage. It is free and easy to do!

Step 8: Select the search results, then click “Download” and select “Excel” as the Download Type (in the pop-up window).

The spreadsheet will show all the codes within the selected Value Set.

Search Results

Results for CMS eQCM and Hybrid Measure : eQCM Update 2025-05-08 : "2.16.840.1.113883.3.464.1003.101.12.1089"

Select a hyperlinked OID to see its value set expansion detail.

Matched Value Sets

Download

View

Toggle

Clear

Columns

Reset Columns

Page 1 of 1

20

View 1 - 1 of 1

☐	Name	Code System	Definition Type	Steward	OID
☐	~	~		~	~
☒	Virtual Encounter	CPT HCPCS	Grouping	NCQA	2.16.840.1.113883.3.464.1003.101.12.1089

View

Download

Page 1 of 1

20

View 1 - 1 of 1

99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
99422	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes
99423	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes

Pictured above is a screenshot from the Value Set spreadsheet for Virtual Encounters. This shows CPT codes 99421-99423 in the Value Set, meaning patients with these visits have a qualifying encounter for the Falls Screening measure. If the patient meets the other measure criteria, they would be included in the measure denominator.

VSAC Downloadable Resources

This page contains groups of value sets designated for a particular program usage. You can search the entire repository of published VSAC value sets in the [Search Value Sets](#) tab.

CMS eCQM & Hybrid Measure Value Sets

CMS dQM Value Sets

C-CDA Value Sets

eCQMs will not be eligible for reporting to CMS unless and until they are proposed and finalized through notice, public comment, and rulemaking for each applicable program. For more information about eCQMs please visit the [eCQI Resource Center](#).

2027 Reporting/Performance Period of eCQM & Hybrid Measure Value Sets

2026 Reporting/Performance Period of eCQM & Hybrid Measure Value Sets

May 2025 Release eCQM & Hybrid Measure Value Sets Publication Date: May 08, 2025

Expansion Version: eCQM Update 2025-05-08

The Eligible Hospital (EH) measures have been renamed to [Hospital Inpatient](#) and [Hospital Outpatient](#). All program candidate measures, including Hospital Outpatient measures CMS1244 and CMS1264 and Eligible Clinician measures CMS1154 and CMS1173, are located here in the CMS eCQM & Hybrid Measure Value Sets.

Available Downloads	Sorted by CMS ID*	Sorted by Value Set Name*	Sorted by Quality Data Model Category*
eCQM Value Sets for Hospital Inpatient Published May 08, 2025	Excel (xlsx) SVS (xml)	Excel (xlsx) SVS (xml) SVS (text)	Excel (xlsx)
eCQM Value Sets for Eligible Clinicians Published May 08, 2025	Excel (xlsx) SVS (xml)	Excel (xlsx) SVS (xml) SVS (text)	Excel (xlsx)

Select the “Download” tab on the top left of the screen. From the list of years, select the current reporting year (2026), then the May 2025 Release.

For the UDS measures, select Eligible Clinician.

There are three options:
Sorted by CMS ID
Sorted by Value Set Name
Sorted by Quality Data Model Category

By CMS ID groups value sets by measure.



Strategies for Successful Reporting

Quality Improvement, UDS Guidance and Resources, Data Accuracy, and Teamwork



QI for Screening and Prevention Measures

Consider re-visiting (or developing new) workflows for the screening and prevention measure when:

- Rates of completion are not improving year to year (or month to month)
- There is greater variation in completion among sub-populations
- Your health center's rate of completion varies significantly from state/regional/national averages

Not all screening and prevention workflows are the same:

- Breast, Colon, and Cervical Cancer Screenings are often done by standing order (with differing time intervals)
- HIV and Tobacco Screenings often require clinician involvement
- Falls Risk is a new process



QI for Screening and Prevention Measures (*cont.*)

Workflows ideally intersect, rather than compete, with one another. For example, calling one patient multiple times for different cancer screening measures is inefficient, likely ineffective, and potentially irritating to the patient.

- Consider workflows that look across types of care gaps and services.

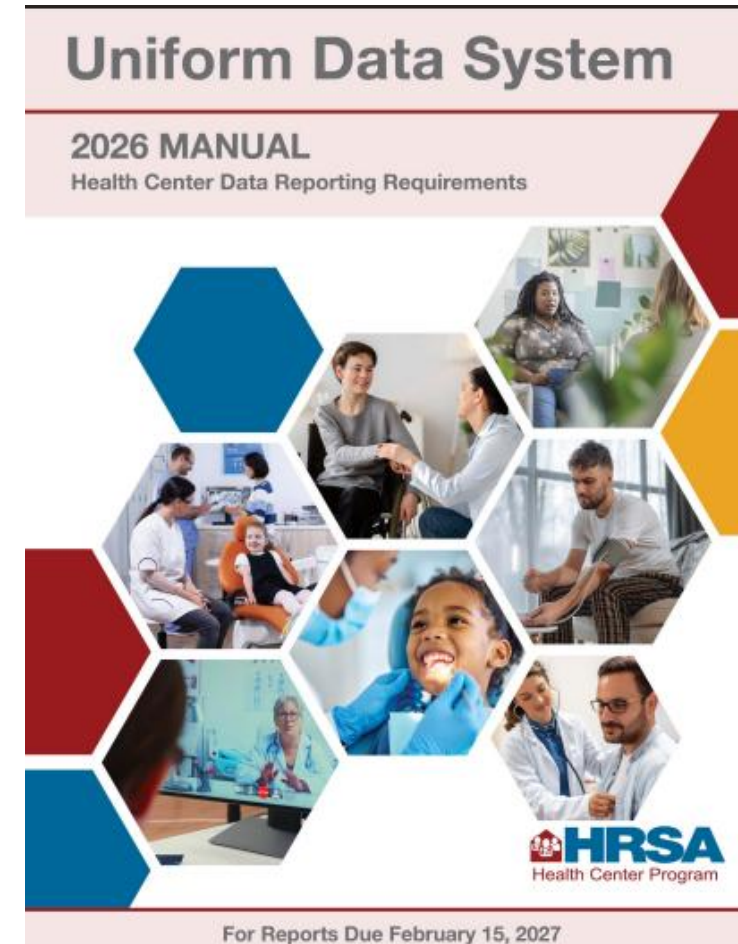
Workflows should not sit on the shelf; they should be used as tools of discovery to provide clues as to why intended outcomes aren't realized.

- An opportunity for an update would be modifying the Cervical Cancer Screening workflow to reflect self-swab collection

New to workflows: See [here](#) for Agency for Healthcare Research and Quality's (AHRQ's) compilation of workflow tools

Follow UDS Guidance

- Thoroughly read definitions and instructions in the [2026 UDS Manual](#).
- See other available guidance:
 - [PAL](#)
 - [eCQI Resource Center](#)
 - [VSAC](#)
- The UDS Support Center offers help with UDS measures and requirements.
 - Call 866-UDS-HELP (available year-round from 8:30 a.m. to 5 p.m. ET).
 - Email udshelp330@bphcdata.net
 - Submit a ticket via the [BPHC Contact Form](#) (select UDS Reporting).



Check Data for Accuracy

- Vendor-developed reports and other reporting advancements will not replace the need for data governance and validation in your health center!
- Educate health center staff involved with UDS reporting on 2026 UDS changes.
- Work with your EHR and/or community health system vendor to validate data workflows and output and to verify that CY updates have been programmed.

[Reporting Guidance](#) resources are available on the UDS Technical Assistance site.

Work as a Team

Tables are interrelated

- Communicate early and throughout the process with your internal UDS data preparation team.
 - Identify appropriate team members responsible for submitting UDS data, including contingency/succession planning.
- Review data across tables to ensure data are consistent and reasonable.

Use available tools

- Preliminary Reporting Environment (PRE) will be available in November 2026.
- Use the reporting features—Excel file, offline HTML file, comparison tool, and Excel mapping document—to help you prepare for UDS data reporting.
- Review changes in performance to validate accuracy and identify potential areas for improvement.

Available Assistance

- Technical assistance materials, including local trainings, are available online:
 - [UDS Technical Assistance](#)
- UDS Support Center for assistance with UDS reporting questions:
 - udshelp330@bphcddata.net
 - 866-UDS-HELP (866-837-4357)
 - [BPHC Contact Form](#), select UDS Reporting
- For EHBs help and account access/roles questions:
 - 877-464-4772
 - [BPHC Contact Form](#), select Technical Support/EHBs Tasks/EHBs Technical Issues
- Office of the National Coordinator for Health Information Technology (ONC) Issue Tracking System (OITS) Jira project eCQM Issue Tracker:
 - Sign up for an [OITS account](#)
 - Post questions in the [eCQM Issue Tracker](#)



For more information, visit the [Technical Assistance Contacts](#) webpage.

UDS Webinars



- Additional technical assistance webinars will occur in the fall, covering topics such as:
 - Counting visits and patients on the UDS
 - UDS clinical tables
 - UDS financial and operational tables
- Register [here!](#)

Q&A

What questions do you have for us?



Thank You!

Sarah Cruthirds, MS, Training and Technical Assistance Specialist



udshelp330@bphcdata.net **or** [BPHC Contact Form](#)



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