Proposed New Measure for HEDIS®[1] MY 2027: Follow-Up After Positive Colorectal Cancer Non-Invasive Screening Test (COF-E)

NCQA seeks comments on a proposed new measure for inclusion in HEDIS Measurement Year (MY) 2027.

Follow-Up After Positive Colorectal Cancer Non-Invasive Screening Test (COF-E): Assesses the percentage of persons 45-85 years of age who received a colonoscopy for a positive colorectal cancer non-invasive screening test within 180 days of a positive stool-based test. See measure specification for more information.

The measure is specified for reporting by commercial, Medicaid and Medicare plans, and uses the HEDIS Electronic Clinical Data Systems (ECDS) reporting standard, which uses structured information from claims, electronic health records (EHR), health information exchanges (HIEs)/registries and case management systems. The measure would be separately stratified for ages 45-75 and 76-85.

The United States Preventive Services Task Forces (USPSTF) recommends that adults aged 45 to 75 be screened for colorectal cancer through stool-based or visual-structural tests.[2] The USPSTF recommends that clinicians selectively offer screening for colorectal cancer in adults aged 76 to 85 years. If the test result of a non-invasive colorectal cancer screening test is positive, a colonoscopy test is needed to complete the screening process. Successful cancer detection relies on timely follow-up of abnormal screening results. Delays in follow-up can diminish the value of screening and postpone treatment, increasing both cancer risk and mortality. Evidence indicates that individuals who have a positive FIT stool-based test result but do not complete a follow-up colonoscopy have twice the risk of death compared to those who do.[3]

Throughout 2025, NCQA conducted a literature review, reviewed clinical guidelines, conducted field testing with three partners (one health plan and two health systems) and sought feedback from advisory panels. During field testing, partners reported that the measure specifications are feasible to report on, though one health system had difficulty accessing colonoscopy data; their system documented colonoscopies only as referrals. All partners were able to report on the Medicare and commercial product line. One partner was able to report on the Medicaid product line; however, the reported denominator results were limited in size.

Overall, partners were able to report on completed stool-based lab tests and noted that the data was easy to find, clean and navigate. Partners had slightly more difficulty reporting on stool-based test results—particularly the clinical SNOMED codes. Despite this difficulty, partners were generally able to identify events that occurred in the same record and match lab test results. The two partners that reported on numerator data noted that colonoscopies were feasible to report on. While some challenges were identified related to the current use of standardized codes, all partners were able to map their results to codes in our value sets for their eligible population. Manual abstraction also further validated that the data is stored in the patient health record.

NCQA evaluated multiple follow-up intervals during field testing, including 90, 180, 270 and 365 days. Performance rates showed the greatest improvement between 90 and 180 days. Additionally, evidence indicates increased odds of developing colorectal cancer after 180 days.[4] NCQA proposed a 180-day follow-

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[2] US Preventive Services Task Force, Davidson, K. W., Barry, M. J., Mangione, C. M., Cabana, M., Caughey, A. B., Davis, E. M., Donahue, K. E., Doubeni, C. A., Krist, A. H., Kubik, M., Li, L., Ogedegbe, G., Owens, D. K., Pbert, L., Silverstein, M., Stevermer, J., Tseng, C.-W., & Wong, J. B. (2021). Screening for Colorectal Cancer: US Preventive Services Task Force
[3] Zorzi, M., Battagello, J., Selby, K., Capodaglio, G., Baracco, S., Rizzato, S., Chinellato, E., Guzzinati, S., & Rugge, M. (2022). Non-compliance with colonoscopy after a positive faecal immunochemical test doubles the risk of dying from colorectal cancer. *Gut*, *71*(3), 561–567. https://doi.org/10.1136/gutjnl-2020-322192.
[4] Lee, Y. C., Fann, J. C., Chiang, T. H., Chuang, S. L., Chen, S. L., Chiu, H. M., Yen, A. M., Chiu, S. Y., Hsu, C. Y., Hsu, W. F., Wu, M. S., & Chen, H. H. (2019). Time to Colonoscopy and Risk of Colorectal Cancer in Patients With Positive Results From Fecal Immunochemical Tests. *Clinical gastroenterology and hepatology: the official clinical practice journal of the American Gastroenterological Association*, *17*(7), 1332–1340.e3. https://doi.org/10.1016/j.cgh.2018.10.041

up timeframe for the measure, which was supported by the various Measurement Advisory Panels. Performance rates ranged from 21.7% to 37.5% and varied by product line and age group for the 180-day follow-up timeframe. Overall, performance results suggest room for improvement.

NCQA seeks feedback on the following questions:

1. **Age Stratification.** Should NCQA include the 76-85 age stratification in the measure?
2. **Screening Tests.** Does the *Colorectal Cancer Screening Lab Test Value Set* appropriately capture stool-based tests used for screening only?
3. **Data Capture.** Do you anticipate feasibility in reporting the *Colorectal Cancer Screening Lab Test Value Set* and *Positive Colorectal Cancer Screening Lab Test Result or Finding Value Set*?
4. **Follow-Up Time Frame**. Do you support the proposed 180-day follow-up timeframe?
5. **Measure Support.** Do you support the inclusion of the measure in HEDIS MY 2027?

Supporting documents include the draft measure specification and the evidence workup.

NCQA acknowledges the contributions of the Cancer, Geriatric and Technical Measurement Advisory Panels.

Follow-Up After Positive Colorectal Cancer Non-Invasive Screening Test (COF-E)*

Measure title	Follow-Up After Positive Colorectal Cancer Non-Invasive Screening Test	**Measure ID**	COF-E
Description	The percentage of persons 45–85 years of age who received a colonoscopy for a positive colorectal cancer non-invasive screening test.		
Measurement period	January 1–December 31.		
Copyright and disclaimer notice	**This measure was supported by the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award to the Council of Medical Specialty Societies (CMSS) totaling $1,563,853 with 100 percent funded by CDC/HHS. The contents are those of the authors and do not necessarily represent the official views of nor endorsement, by CDC/HHS or the U.S. Government.* Refer to the complete copyright and disclaimer information at the front of this publication. NCQA website: www.ncqa.org. Submit policy clarification support questions via My NCQA (https://my.ncqa.org).		
Clinical recommendation statement/ rationale	The U.S. Preventive Services Task Force "recommends screening for colorectal cancer in all adults aged 50 to 75 years (A recommendation), all adults aged 45 to 49 years (B recommendation)." The taskforce also recommends that "clinicians selectively offer screening... in adults aged 76 to 85 years (C recommendation)." Potential screening methods include an annual guaiac-based fecal occult blood test (gFOBT), annual fecal immunochemical test (FIT) and multitargeted stool DNA with FIT test (sDNA FIT) every 3 years.		
Citations	U.S. Preventive Services Task Force. 2021. "Screening for Colorectal Cancer: U.S. Preventive Services Task Force Recommendation Statement." *JAMA* 325(19):1965–1977. doi:10.1001/jama.2021.6238		
Characteristics			
Scoring	Proportion.		
Type	Process.		
Product lines	• Commercial. • Medicaid. • Medicare.		
Stratifications	Age as of the index episode start date. • 45–75 years. • 76-85 years.		
Risk adjustment	None.		
Improvement notation	Increased score indicates improvement.		

Guidance	**Data collection methodology:** ECDS. Refer to *General Guideline: Data Collection Methods* for additional information. **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **Which services count?** When using claims, include all paid, suspended, pending and denied claims.
Definitions	
IESD **Intake Period**	Index episode start date. The earliest date during the intake period when a person has a positive stool-based test result. July 1 of the year prior to the measurement period to June 30 of the measurement period.
Initial Population	*Measure item count:* Person. *Attribution basis:* Enrollment. • *Benefits:* Medical. • *Continuous enrollment:* Date of the IESD through 180 days after the IESD. *Allowable gap:* No more than one gap of ≤45 days during the continuous enrollment period. No gaps on the IESD. • *Ages:* 45–85 years of age as of the IESD. *Event:* **Positive stool-based colorectal cancer screening test.** **Step 1.** Identify persons who had a fecal occult blood test or stool DNA with FIT test (Colorectal Cancer Screening Lab Test Value Set) with a positive result (Positive Colorectal Cancer Screening Lab Test Result or Finding Value Set) during the intake period. **Step 2.** Identify the IESD. For each person in step 1, determine the earliest positive stool-based test result. If the person had more than one positive test , include only the first test.
Denominator exclusions	**Persons with a date of death.** Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit. **Persons in hospice or using hospice services.** Persons who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file. **Persons receiving palliative care.** Persons receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) or who had an encounter for palliative care (ICD-10-CM code Z51.5*) any time during the intake period through the last day of the measurement period.

	Persons who are 66 years of age and older by the last day of the measurement period, with Medicare benefits, enrolled in an institutional SNP (I-SNP) or living long-term in an institution (LTI). • Enrolled in an Institutional SNP (I-SNP) any time during the intake period through the last day of the measurement period. • Living long-term in an institution any time during the intake period through the last day of the measurement period, as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the intake period through the last day of the measurement period. **Persons 66 years of age or older by the last day of the measurement period, with both frailty and advanced illness.** 1. **Frailty.** At least two indications of frailty (Frailty Device Value Set*; Frailty Diagnosis Value Set*; Frailty Encounter Value Set*; Frailty Symptom Value Set*) with different dates of service during the intake period through the last day of the measurement period. 2. **Advanced illness.** Either of the following during the measurement period or the year prior to the measurement period: • Advanced illness (Advanced Illness Value Set*) on at least two different dates of service. • Dispensed dementia medication (Dementia Medications List). **History of colorectal cancer and/or total colectomy.** Colorectal cancer (Colorectal Cancer and History of Colorectal Cancer Value Set*) or a total colectomy (Total Colectomy Value Set; SNOMEDCT code 119771000119101) any time during the person's history through the day prior to the IESD. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).
Denominator	The initial population minus denominator exclusions.
Numerator	**Follow-up colonoscopy.** Identify persons who received a follow-up colonoscopy (Colonoscopy Value Set) on the IESD or in the 180-day period after the IESD.
Summary of changes	• This is a first-year measure.

Data element tables

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table COF-E-A-1/2/3: Metadata Elements for Follow-Up After Positive Colorectal Cancer Stool-Based Test

Metric	Age	Data Element	Reporting Instructions
ColonoscopyAfterScreening	45-75	InitialPopulation	For each Stratification
	76-85	Exclusions	For each Stratification
	Total	Denominator	For each Stratification
		Numerator	For each Stratification
		Rate	(Percent)

Follow-Up After Positive Colorectal Cancer Non-Invasive Screening Test (COF-E)

Measure Workup

Topic Overview

Importance and Prevalence

Colorectal cancer (CRC) represents approximately 8% of all new cancer cases; it is the third most commonly diagnosed cancer in the United States and the leading cause of cancer deaths in men under 50 (CDC, 2024). The American Cancer Society estimates over 154,000 new cases of CRC in 2025 (*Colorectal Cancer Facts & Figures 2023-2025*, 2023). CRC is most frequently diagnosed among people 65–74 years of age; however, it is estimated that 10.5% of new CRC cases occur in adults younger than 50 (*Colorectal Cancer Statistics | How Common Is Colorectal Cancer?*, 2025). While CRC rates in older adults have dropped slightly over the past decade, rates have increased by 2.4% per year from 2012 to 2021 in adults younger than 50 (*Colorectal Cancer Statistics | How Common Is Colorectal Cancer?*, 2025).

Routine screening for CRC is an effective method for finding precancerous lesions (polyps) that could later become malignant, and for detecting early cancers that can be more easily and effectively treated. Colonoscopy and stool-based testing such as the fecal immunochemical test (FIT) and multitarget stool DNA test (sDNA) are the most commonly used CRC screening tests in the United States (Seum et al., 2025; Shaukat et al., 2021).

Precancerous polyps can be slow growing and can take up to 10–15 years to develop into CRC; most types of polyps can be identified and removed before developing into a later stage of cancer. Polyps can be removed during the screening colonoscopy or during a colonoscopy performed as follow-up to a positive screening test. For individuals diagnosed with early-stage, or localized, colon cancer between 2014 and 2020, the 5-year relative survival rate was 91% (American Cancer Society, 2026).

Health care disparities	Adherence to screening and timely follow-up has historically been identified as a major driver of racial disparities in CRC incidence and mortality. Inequitable access and persistent systemic barriers to screening, follow-up, and treatment of CRC for Black adults may contribute to the higher rate of CRC incidence and mortality in that population (Carethers, 2021). Follow-up colonoscopy rates remain substantially lower for Black adults compared to White adults (Alagoz et al., 2024). Further, positive stool-based results often do not result in a colonoscopy being ordered unless providers indicate an “urgent” request. How “urgency” for each patient is defined is unknown. Moreover, colonoscopies may be difficult for patients to access. Barriers to colonoscopy may include psychological fears such as pain, discomfort, and worry about outcomes; lack of social support; financial challenges related to insurance or cost; logistical issues like transportation and time; and gaps in provider recommendation or perceived need (Kerrison et al., 2022; Muthukrishnan et al., 2019).
Financial importance and cost-effectiveness	CRC can produce a significant financial burden on patients. Medical spending on CRC in 2020 in the United States was $24.3 billion, including medical services and prescription drugs (CDC, 2025). Primarily, the increasing price of and limited access to cancer treatment drugs have contributed to the overall costs (Leighl et al., 2021). Increased CRC screening and subsequent appropriate follow-up offer an opportunity to reduce costs (Ebner et al., 2023). Preventing later-stage CRC, through screening and timely follow-up, eliminates direct costs associated with treatment, including drugs, doctor visits and hospital stays, as well as indirect costs such as lost productivity from time away from work.

Guidelines for Colorectal Cancer Screening and Follow-Up

CRC screening is recommended by the US Preventive Services Task Force (USPSTF) for individuals 50 – 75 in the general population (US Preventive Services Task Force et al., 2021). This is an A recommendation, which means that the USPSTF found with high certainty that the net benefit is substantial. The USPSTF also recommends screening for CRC in adults 45–49. This is a B recommendation; the USPSTF found with moderate certainty that the net benefit of screening adults in this age range is moderate (US Preventive Services Task Force et al., 2021). Other national guideline organizations such as the Multi-Society Task Force on Colorectal Cancer which is a collaborative group representing the American College of Gastroenterology (ACG), the American Gastroenterological Association (AGA) and the American Society for Gastrointestinal Endoscopy (ASGE), the Centers for Disease Control and Prevention (CDC), National Comprehensive Cancer Network (NCCN) and other national organizations also recommend CRC screening in a general population.

There are several screening methods for CRC, including stool-based tests (i.e. FIT, sRNA, sDNA, sDNA FIT), blood-based biomarker tests, and visual structural tests (i.e. colonoscopy, CT colonography, flexible sigmoidoscopy); the risks and benefits of different screening methods vary. The USPSTF evaluated screening tests and their effectiveness in reducing the incidence of and mortality from CRC, or all-cause mortality, harms associated with each test, and their ability to detect adenomatous polyps, advanced adenomas and CRC. The USPSTF recommends the use of FIT, sDNA and sDNA FIT stool-based tests and visual-structural tests for screening (US Preventive Services Task Force et al., 2021). See Table 1. The USPSTF recommends that maximizing the total number of persons screened will have the greatest effect on reducing CRC deaths. Allowing various methods for early-stage screening and offering choice in screening strategies may further this goal. While individuals who have a family history of colon cancer are typically referred to a colonoscopy, rather than a stool-based screener, the type of stool-based screener ordered for average risk populations is not generally differentiated.

While the NCCN guidelines include both sRNA stool-based and blood-based tests as an option for average-risk individuals (Ness, et al., 2025) , the USPSTF and other guideline agencies, have not yet endorsed these tests in official recommendations. NCCN included these methods noting that the best screening is the one that gets completed by the patient, despite lower evidence and being less cost-effective for the patient (Ness, et al., 2025).

Table 1 summarizes recommendations from the USPSTF, outlining the screening methods that may be offered to individuals, recommended screening intervals and follow-up guidance. Notably, while most organizations agree a follow-up colonoscopy should be performed for screenings yielding a positive test result, there are no formal recommendations for time to follow-up completion. A list of CRC screening and follow-up guidelines from national organizations guidelines can be found in Appendix A.

Table 1. Summary of USPSTF Included Screening Methods and Follow-Up Guideline Recommendations

Screening Type	Screening Method	Screening Recommendation	Results	Recommended Process for Follow-Up
Stool Based Tests	Fecal occult blood test (FOBT)[1]	Annually	Negative, no blood detected	No follow up needed
			Positive, blood detected	Follow-up Colonoscopy
	Stool DNA (sDNA) with FIT test[1]	1 to 3 years	Negative, no DNA/blood detected	No follow up needed
			Positive, DNA/blood detected	Follow-up Colonoscopy
Visual-Structural Exams	Flexible sigmoidoscopy[1]	Every 5 years	Negative, no abnormalities	No follow up needed
			Positive, polyps or abnormal tissue found	Follow-up Colonoscopy
	CT Colonography[1]	Every 5 years	Negative	No follow up needed
			Positive	Follow-up Colonoscopy

	Colonoscopy[1]	Every 10 years	Negative, no polyps found	No follow-up needed
			Positive, polyps found	Follow-up Colonoscopy

[1] US Preventive Services Task Force. (2021). Screening for Colorectal Cancer: US Preventive Services Task Force Recommendation Statement. *JAMA*, *325*(19), 1965–1977. https://doi.org/10.1001/jama.2021.6238

Opportunities for Improvement and Other Considerations

Despite evidence that CRC screening can reduce both disease incidence and mortality, screening rates remain suboptimal. HEDIS measurement year 2023 performance rates indicate that 60% of commercial, 38% of Medicaid, and 70% of Medicare plan members received an appropriate screening for CRC, indicating room for improvement.

Likewise, while timely follow-up care is critical for life-saving intervention, follow-up colonoscopy completion rates have varied from 24% to 75% (Subramanian et al., 2024). Interventions targeted at increasing screening uptake should focus on timely follow-up care as well. Research demonstrates individuals who had a positive FIT result but did not have a follow-up colonoscopy were twice as likely to die as those who did have a follow-up colonoscopy (Zorzi et al., 2022).

Related measures

A review of the landscape showed two existing follow-up measures for CRC screening. One measure was developed by the American Medical Group Association and assesses the rates of adults aged 46 to 75 years who received a colonoscopy within 6 months of receiving an abnormal result from an initial stool-based CRC screening test (Ciemens et al., 2024). The other existing measure was developed by Brigham & Women's Hospital assesses the percentage of patients aged 45 to 75 years with at least one positive stool-based colorectal cancer screening test who completed a colonoscopy within 180 days (Partnership for Quality Measurement, 2025). While these measures were developed for the health system level, the use of both claims and clinical data provides a suitable comparison for a plan-level quality measure.

Measure concept risks & challenges

Despite clear guidance on routine screening for CRC and completing a colonoscopy as follow-up to a positive screening test, no guidelines indicate an appropriate time frame for follow up. Given the consequences of failure to follow up, assessing the quality of follow-up care relies on specifying a time frame. While there is limited guidance on what is considered timely follow-up care, several studies have demonstrated that odds for later developing CRC increase for follow-up colonoscopies completed at 6 – 12 months (Beshara et al., 2020; Forbes et al., 2021; Lee et al., 2019).

Digital Considerations

As part of NCQA's strategic transition to a fully digital quality measurement portfolio, we conducted a feasibility assessment to inform eventual digital measure implementation. The assessment evaluates the measure's intent and associated clinical concepts within a digital framework.

Overall, the measure's preliminary post-testing clinical concepts show medium digital feasibility. The main challenge remains utilization of available terminology standards and ensuring data availability and accessibility for stool-based test results and colonoscopies. While test sites could provide results, they had to manually map local codes to standardized codes for stool-based results. Existing standards lack full alignment for capturing stool-based test results in coded, discrete fields, highlighting an industry-wide need for standardization. Test partners aggregated stool-based results from multiple sources, encountering data issues that may affect accuracy and availability. Clinical workflows for capturing stool-based tests and colonoscopies were generally feasible but lacked integration for stool-based results. Refer to Appendix B for details.

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Appendix A: Specific Guideline Recommendations

Table 1. Clinical Practice Guidelines for Colorectal Cancer Screening and Follow Up by Screening Method and Organization

Organization or Society	Recommended Age for Screening	Screening Method	Screening Recommendation	Results	Follow Up Recommendations for Each Test Result
United States Preventive Task Force (US Preventive Services Task Force et al., 2021)	45-85	FOBT	1 year	Negative	Testing every 1-3 years
				Inconclusive	-
				Positive	Follow-up colonoscopy
		sDNA w/FIT	1-3 year	Negative	Testing every 1-3 years
				Inconclusive	-
				Positive	Follow-up colonoscopy
		Flex Sigmoidoscopy	5 year	Negative	Follow-up colonoscopy in 10 years + FIT every year
				Inconclusive	-
				Positive	Follow-Up Colonoscopy
		CT Colonography	5 year	Negative	Follow-Up in 5 years
				Inconclusive	-
				Positive	Follow-Up Colonoscopy
		Colonoscopy	5 year	Negative	Follow-Up in 10 years
				Inconclusive	-
				Positive	Follow-Up Colonoscopy
Multi-Society Task Force (Gupta et al., 2020; Patel et al., 2021; Rex et al., 2017)	45-75	FOBT	1 year	Negative	Follow-up in 1 years
				Inconclusive	-
				Positive	-
		sDNA w/FIT	1 year sDNA w/FIT, sDNA alone is every 3 years	Negative	Follow-up in 1 years
				Inconclusive	-
				Positive	-

		Flex Sigmoidoscopy	5 year	Negative	Follow-up in 5 years or every 10 years with FIT every 1 year
				Inconclusive	-
				Positive	-
		CT Colonography	5 year	Negative	Follow-up in 5 years
				Inconclusive	-
				Positive	-
		Colonoscopy	10 years	Negative	Follow-up In 10 years
				Inconclusive	-
				Positive	-
American College of Gastroenterology (Shaukat et al., 2021)	45-75	FOBT	1 year	Negative	Follow-up in 1 years
				Inconclusive	-
				Positive	-
		sDNA w/FIT	1 year	Negative	Follow-up in 1 years
				Inconclusive	-
				Positive	-
		Flex Sigmoidoscopy	5 year	Negative	Follow-up in 5 years or every 10 years with FIT every 1 year
				Inconclusive	-
				Positive	-
		CT Colonography	5 year	Negative	Follow-up in 5 years
				Inconclusive	-
				Positive	-
		Colonoscopy	10 years	Negative	Follow-up In 10 years
				Inconclusive	-
				Positive	-
Centers for Disease Control (CDC, 2024)	45-75	FOBT	1 year	Negative	Follow-up in 1 years
				Inconclusive	-
				Positive	-
		sDNA w/FIT	1 year, sDNA alone is every 1-3 years	Negative	Follow-up in 1 years
				Inconclusive	-

				Positive	-
		Flex Sigmoidoscopy	5 year	Negative	Follow-up in 5 years or every 10 years with FIT every 1 year
				Inconclusive	-
				Positive	-
		CT Colonography	5 year	Negative	Follow-up in 5 years
				Inconclusive	-
				Positive	-
		Colonoscopy	10 years	Negative	Follow-up In 10 years
				Inconclusive	-
				Positive	-
American Cancer Society (Wolf et al., 2018)	45-75	FOBT	1 year	Negative	Testing every 1-3 years
				Inconclusive	-
				Positive	Follow-up colonoscopy
		sDNA w/FIT	1-3 year	Negative	Testing every 1-3 years
				Inconclusive	-
				Positive	Follow-up colonoscopy
		Flex Sigmoidoscopy	5 year	Negative	Follow-up colonoscopy in 10 years + FIT every year
				Inconclusive	-
				Positive	Physician Follow-Up
		CT Colonography	5 year	Negative	Follow-Up in 5 years
				Inconclusive	-
				Positive	Physician Follow-Up
		Colonoscopy	5 year	Negative	Follow-Up in 10 years
				Inconclusive	-
				Positive	Physician Follow-Up
National Comprehensive Cancer Network (NCCN, 2025)	45-75	FOBT or FIT	1 year	Negative	Follow-up in 1 year
				Inconclusive	-
				Positive	Follow-up colonoscopy within 9 months

		sDNA w/FIT	3 years	Negative	Follow-up in 3 years
				Inconclusive	-
				Positive	Follow-up colonoscopy within 9 months
		sRNA	3 years	Positive	Follow-up colonoscopy within 9 months
				Inconclusive	-
				Negative	Follow-up in 3 years
		Flex Sigmoidoscopy	5 years	Negative	Follow-up in 5 years
				Inconclusive	-
				Positive	Follow-up colonoscopy within 9 months
		CT Colonography	5 years	Negative	Follow-up in 5 years
				Inconclusive	-
				Positive	Follow-up colonoscopy within 9 months
		Colonoscopy	10 years	Negative	Follow-up in 10 years
				Inconclusive	-
				Positive	Physician follow-up
		Blood-Based	3 years	Positive	Follow-up colonoscopy within 9 months
				Inconclusive	-
				Negative	Follow-up in 3 years

Appendix B: Digital Feasibility

As part of NCQA's strategic transition to a fully digital quality measurement portfolio, we conducted a feasibility assessment prior to field testing to evaluate the measure's intent and associated clinical concepts within a digital framework. The primary objectives were to determine whether the clinical concepts could be represented using standardized data models and nationally recognized terminologies, and to assess the availability of discrete, structured data necessary to support accurate and reliable digital measurement.

Data and Terminology Standards

NCQA's digital quality measures are built on the Fast Healthcare Interoperability Resources (FHIR®) standard, developed by HL7®, to support interoperable exchange of electronic health data. In the U.S., FHIR US Core profiles provide detailed implementation guidance aligned with the United States Core Data for Interoperability (USCDI), a federal standard maintained by ASTP (formerly ONC). USCDI defines essential data classes and elements, while FHIR US Core specifies how to represent and exchange them. Additionally, NCQA uses nationally recognized clinical terminologies (e.g., ICD-10, CPT, LOINC) to define value sets, ensuring standardized interpretation and representation of clinical data in quality measures.

Digital Feasibility Assessment

The digital feasibility assessment is conducted at two stages during the measure development process, pre-testing and post-testing, summarized below. This assessment examines each measure concept across three high-level categories:

- **Data Standards & Terminology**. Evaluates the alignment with national standards (FHIR, USCDI) and recognized terminology standards (i.e., LOINC, ICD).
- **Clinical Workflow & Data Accuracy**. Evaluates whether the concept aligns with standard clinical practice and the likelihood that the data will be accurate, complete and reliable.
- **Data Availability & Structure**. Assesses if the data is likely to be present, in structured fields, and accessible to health plans.

The digital feasibility assessment (shown in Figure A-1 and A-2) rate each concept from high to low. High = Feasible with no concerns, Medium = Feasible with some concerns (with a potential mitigation strategy); Low = Low feasibility with concerns (with little to no mitigation strategy for the current development cycle).

Post-Testing Feasibility Findings.

> **Summary:** Overall, the measure's preliminary post-testing clinical concepts show medium digital feasibility. The main challenge remains utilization of available terminology standards and ensuring data availability and accessibility for stool-based test results and colonoscopies. While test sites could provide results, they had to manually map local codes to standardized codes for stool-based results. Existing standards lack full alignment for capturing stool-based test results in coded, discrete fields, highlighting an industry-wide need for standardization. Test partners aggregated stool-based results from multiple sources, encountering data issues that may affect accuracy and availability. Clinical workflows for capturing stool-based tests and colonoscopies were generally feasible but lacked integration for stool-based results.

Data Standards & Terminology. All the clinical concepts used in the measure can be modeled in the FHIR data standard. Clinical concepts can be represented using nationally recognized terminologies including Logical Observation Identifiers Name and Codes (LOINC), Current Procedural Terminology (CPT), International Statistical Classification of Disease and Related health

Problems, 10th Revision (ICD-10), and Systematized Medical Nomenclature for Medicine (SNOMED). However, SNOMED codes for screening results are not consistently utilized.

Clinical Workflow & Data Accuracy. There are some workflow feasibility challenges related to capturing stool-based results in discrete data fields but generally results were available and required manual mapping for reporting which could impact the accuracy of the data.

Data Availability & Structure. There are challenges related to availability of data in structured fields for stool-based screening results to identify positive findings. Screening results data will all be found in clinical systems but health plans may not currently have access to all the data.

Figure A-2: Post-Testing Digital Concept Feasibility Assessment

Score key: H = High, M = Medium, L = Low						
	Data Standards & Terminology		**Clinical Workflow & Data Accuracy**		**Data Availability & Structure**	
Clinical Concept	**Data Standards**	**Terminology Standards**	**Workflow**	**Data Accuracy**	**Data Availability**	**Data Accessibility**
Stool-Based Test	H	H	H	H	H	H
Stool-Based Test Result	H	H	H	M	M	M
Colonoscopy	H	H	H	H	H	H
History of Colorectal Cancer	H	H	H	H	H	H
History of Total Colectomy	H	H	H	H	H	H

Pre-Testing Feasibility Findings.

> **Summary:** Overall, the clinical concepts used in the measure demonstrate medium feasibility. Stool-based tests show high feasibility, but implementation may be limited by inconsistent structured data and reliance on unstructured formats necessary to report stool-based test results. The feasibility assessment for the stool-based test concepts will be updated after current field testing.

Data Standards & Terminology. The measure demonstrates high feasibility for stool-based screening tests—such as gFOBT, FIT, and sDNA—thanks to strong alignment with existing data standards like FHIR, US Core, and HEDIS profiles. These tests and their results are well-supported by standardized terminology, including LOINC and SNOMED codes. Implementation is particularly challenging because of the absence of standard clinical terminologies needed in this measure (i.e. LOINC code and SNOMED codes), which limits interoperability and automated reporting. Overall, while most clinical concepts in the measure can be modeled using FHIR, variability in documentation and coding practices across providers and health plans continues to hinder consistent implementation and data exchange.

Clinical Workflow & Data Accuracy. Stool-based screening tests generally align well with standard clinical workflows, and when documented in structured formats, the data tends to be accurate and reliable. A significant challenge for stool-based test types is the frequent reliance on unstructured formats—such as PDFs and narrative text—which limits the reliability and usability of the data. Additionally, variability in stool-based test results (i.e.SNOMED) coding practices across systems introduces further inconsistencies, making it difficult to ensure uniform data quality and integration.

Data Availability & Structure. Stool-based screening tests generally exhibit high data availability in structured fields, making them accessible to health plans when properly coded. At the system level,

implementation feasibility is considered medium due to inconsistent use of structured data fields, needed for test results, across providers and systems. However, there are clear opportunities to enhance data structure and availability by developing and adopting standardized codes that support consistent documentation and interoperability.

Figure A-1: Pre-Testing Digital Concept Feasibility Assessment

Score key: H = High, M = Medium, L = Low						
	Data Standards & Terminology		**Clinical Workflow & Data Accuracy**		**Data Availability & Structure**	
Clinical Concept	**Data Standards**	**Terminology Standards**	**Workflow**	**Data Accuracy**	**Data Availability**	**Data Accessibility**
Stool-Based Test	H	H	H	H	H	H
Stool-Based Test Result	H	H	M	M	M	M
Colonoscopy	H	H	H	H	H	H
History of Colorectal Cancer	H	H	H	H	H	H
History of Total Colectomy	H	H	H	H	H	H