The CMS EHR Incentive Programs: Small-Practice Providers and Clinical Quality Measures

October 25, 2011

1:00 p.m. ET

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Schedule

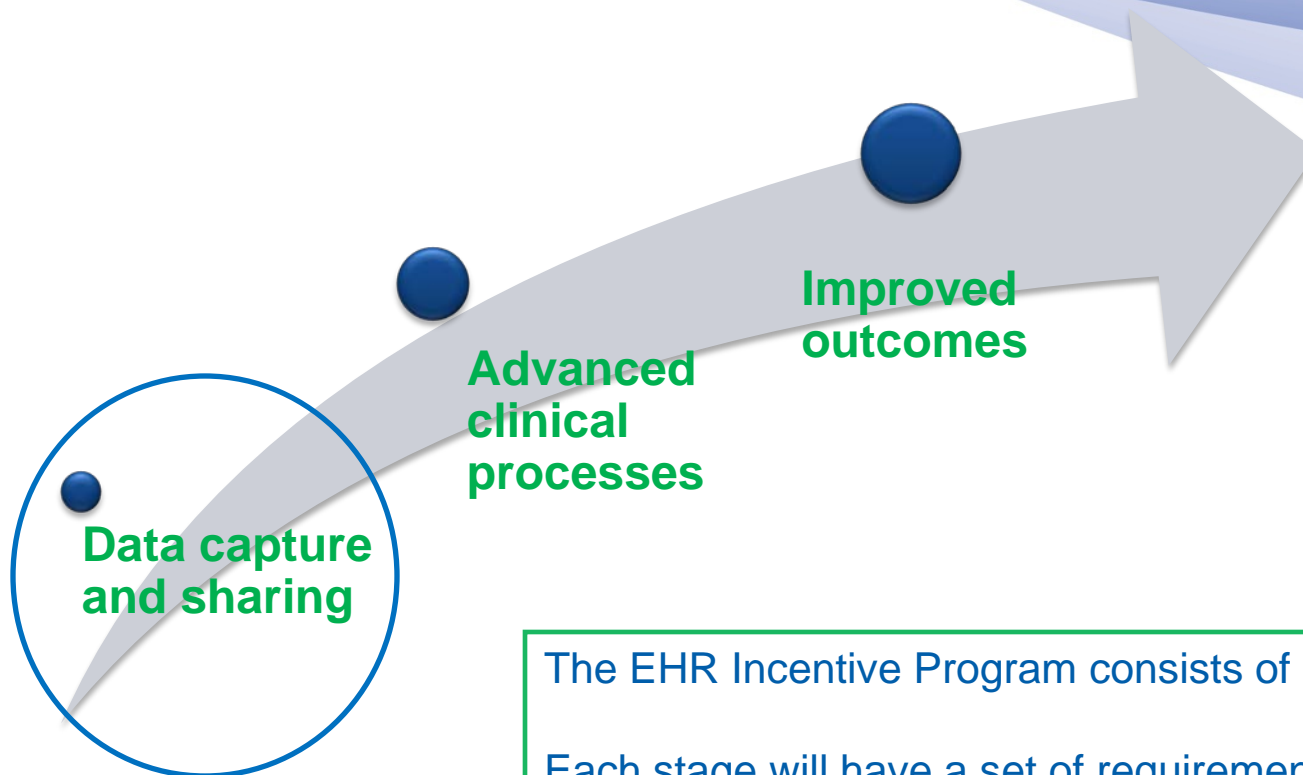| Agenda	Time
Introduction and Welcome	1:00 to 1:10

Presentation by CMS Experts
    - Overview of the CMS EHR Incentive Programs
         • Meaningful Use Overview
         • Certified EHR Technology
    - Description of CQMs
         • What is a CQM?
         • Who Develops CQMs?
         • Anatomy of a CQM
    - CQMs and the Attestation Process
	1:10 to 2:20

Incentive Programs Overview

- The American Recovery and Reinvestment Act of 2009 authorizes CMS to provide incentive payments to eligible professionals (EPs) and hospitals who adopt, implement, upgrade or demonstrate meaningful use of certified electronic health record (EHR) technology.

- Providers have to meet specific requirements in order to receive incentive payments:
  - Meaningful Use Objectives
  - Clinical Quality Measures
  - Other Program Requirements

http://www.cms.gov/EHRIncentivePrograms/

How Does the Program Work?

Data capture and sharing

Advanced clinical processes

Improved outcomes

The EHR Incentive Program consists of 3 stages.

Each stage will have a set of requirements to meet in order to demonstrate meaningful use.

We are currently in **Stage 1**. The requirements in **Stage 1** are focused on providers capturing patient data and sharing that data either with the patient or with other healthcare professionals.

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Certified EHR Technology

- You do not need certified technology to register for the EHR Incentive Program

- However, to meet meaningful use, providers must attest to the use of EHR technology that is certified by the Office of the National Coordinator Authorized Testing and Certification Body (ONC-ATCB)

- A list of the latest certified technology can be found on the ONC website
    - http://onc-chpl.force.com/ehrcert

EHR Certification Number

http://www.cms.gov/EHRIncentivePrograms/

Certification of CQMs

http://healthcare.nist.gov/use_testing/finalized_requirements.html

- §170.304 (j) **Calculate and submit clinical quality measures**

Evaluates the capability to electronically calculate -
    EPs:
        1. all six of the *core clinical measures specified by CMS* and
        2. at a minimum, three clinical quality measures specified by CMS, excluding the six *core clinical quality measures*
    Eligible Hospitals and CAHs:
        1. all 15 clinical quality measures

Submit calculated clinical quality measures – evaluates the capability to electronically submit calculated quality measures in accordance with the standard and implementation specifications

Reporting Meaningful Use

- Providers participating in the Medicare Incentive Program must attest to using certified EHR technology in a meaningful way starting in the first year of program participation

- During the first year of participation in the Medicare program, EPs and eligible hospitals must report their data for a continuous 90-day period. For subsequent years, EPs and hospitals have to report their data for the entire program year

- Providers participating in the Medicaid Incentive Program **do not need** to attest to demonstrating meaningful use in the first year of program participation. During the second year, EPs and hospitals have to report their data for 90 days. During the third and subsequent years, data needs to be reported for the entire program year

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Meaningful Use Requirements: EPs

Stage 1 - Objectives and Associated Measures

- **§ 495.6(d) -** Eligible professionals must complete 15 core objectives, including:

  - Report ambulatory clinical quality measures to CMS or, in the case of Medicaid EPs, the States

  - **Six total Clinical Quality Measures**

    - **(3 core or alternate core, and 3 out of 38 from additional set)**

- **§ 495.6(e)** Complete five objectives out of 10 from menu set

Meaningful Use Requirements: Hospitals

Stage 1 - Objectives and Associated Measures

- **§ 495.6(f)** - Eligible hospitals must complete 14 core objectives, including:
    – Report hospital clinical quality measures to CMS or, in the case of Medicaid eligible hospitals, the states
    – **15 Clinical Quality Measures**
- **§ 495.6(g)** - Five objectives out of 10 from menu set

Exclusions

- Some core and menu objectives are not applicable to every provider's clinical practice (e.g., not all dentists perform immunizations, chiropractors do not e-prescribe)

- Some CQMs cannot be met during the reporting period chosen by the provider. For example, many eligible professional CQMs require a minimum of 2 visits for a patient to meet the denominator criteria

- Exclusions do not count against a provider's attestation requirements

- Reporting "zeros" is acceptable for CQMs if that is what has been calculated by your certified EHR technology.

What is a CQM?

- A 'quality measure' means a standard for measuring the performance and improvement of population health or of health plans, providers of services, and other clinicians in the delivery of health care services

- A 'clinical quality measure' is a mechanism used for assessing the degree to which a provider competently and safely delivers clinical services that are appropriate for the patient in an optimal timeframe

Why are Measures Important to CMS?

- Measuring the quality of patient care helps to drive improvements in health care

- CQMs help identify areas that require improvement in care delivery, identify differences in care among various populations, and may improve care coordination between health care providers.

Who Develops CQMs?

- Any person or entity can develop a CQM

- Typically CMS CQMs require consensus endorsement by a national endorsement organization and must meet certain criteria such as:
    - Important to Measure and Report
    - Scientific Acceptability of Measure Properties
    - Usability
    - Feasibility

http://www.qualityforum.org/docs/measure_evaluation_criteria.aspx

Electronic Specifications and eMeasures

- HITECH CQMs:
  - To report CQMs from an EHR, **electronic specifications** must be developed that include all of the measure data elements and computer logic that can be captured and stored in the EHR and transmitted to CMS in a standardized format
  - An eMeasure is a health quality measure encoded in a health quality measure format (HQMF)
  - HQMF is a standards based representation of quality measures

- Each measure has a human readable portion and an associated code list for the eMeasure. For the EP measures this is a separate excel spreadsheet. For the eligible hospital measures this is contained within the HITSP documentation

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eMeasure Example

Hypertension: Blood Pressure Measurement (NQF 0013) ← Title

EMeasure Name	Hypertension: Blood Pressure Measurement	EMeasure Id	Pending
Version Number	1	Set Id	Pending
Available Date	No information	Measurement Period	January 1, 20xx through December 31, 20xx
Measure Steward	American Medical Association – Physician Consortium for Performance Improvement		
Endorsed by	National Quality Forum		
Description	Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure (BP) recorded.		
Measure scoring	Proportion		
Measure type	Process		
Rationale	Effective management of blood pressure in patients with hypertension can help prevent cardiovascular events, including myocardial infarction, stroke, and the development of heart failure.		
Clinical Recommendation Statement	Treating SBP and DBP to targets that are <140/90 mm Hg is associated with a decrease in CVD risk complications. In patients with hypertension and diabetes or renal disease, the BP goal is <130/80 mm Hg. (JNC VII, 2004).		
Improvement notation	Higher score indicates better quality		
Measurement duration	12 months		
References			
Definitions			

← Steward (Measure Steward row)

← Description (Description row)

http://www.cms.gov/EHRIncentivePrograms/

Anatomy of a CQM

- There are 4-5 components of CQMs:

  1. Initial patient population (may not be specified in non-EHR based measures)
  2. Denominator
  3. Numerator
  4. Exclusions

Initial Patient Population

The initial patient population is defined as the group of patients the performance measure is designed to address:

Patients >= 18yrs of age with an active dx of hypertension who have been seen for at least 2 or more visits by their provider

eMeasure:

Initial Patient Population =

o AND: "Patient characteristic: birth date" (age) >= 18 years";

o AND: "Diagnosis active: hypertension";

o AND: >=2 count(s) of:

- OR: "Encounter: encounter outpatient" to determine the physician has a relationship with the patient;

- OR: "Encounter: encounter nursing facility" to determine the physician has a relationship with the patient to determine the physician has a relationship with the patient;

Denominator

▸ Denominator- is a subset of the initial patient population – In some eMeasures the denominator may be the same as the initial patient population.

Patients >= 18yrs of age with an active dx of hypertension who have been seen for at least 2 or more visits by their provider (same as initial patient population)

eMeasure:
   o AND: "All patients in the initial patient population";

Numerator

▸ Numerator is a subset of the denominator for whom a process or outcome of care occurs

> **Patients >= 18yrs of age with an active dx of hypertension who have been seen for at least 2 or more visits by their provider (same as initial patient population) and have a recorded blood pressure**

eMeasure:

Numerator =

o AND: "Physical exam finding: systolic blood pressure";

o AND: "Physical exam finding: diastolic blood pressure";

Exclusions

▶ Denominator Exclusions are:

…" The mechanism used to exclude patients from the denominator of a performance measure when a therapy or service would not be appropriate in instances for which the patient otherwise meets the denominator criteria"

No exclusions for this measure

eMeasure:

Exclusions =

o AND: None;

http://www.ama-assn.org/resources/doc/cqi/exclusions053008.pdf

Clinical Quality Measure Notation

- For reporting purposes, this measure would look like:
  - Initial population = 200
  - Denominator = 200
  - Numerator = 100
  - Exclusions = 0

- The measure is typically expressed as a fraction:

  $$\frac{100\ (N)}{200\ (D)}$$

EP Example

- Eligible professionals must report a total of six (6) CQMs
  - *CQM <u>Core</u> Requirement: 3 core or alternate core CQMs*
  - *CQM <u>Additional</u> Requirement: 3 from a list of 38 additional CQMs*

- Eligible professionals must report Additional CQMs even if 0 is the result displayed for the core/alternate core CQMs

EP Example Scenarios – Core

- Every EP MUST report on the 3 core measures:
  - *NQF0013 – Hypertension: Blood Pressure Measurement*
  - *NQF0028 – Preventive Care Screening Measure Pair a. Tobacco Use Assessment b. Tobacco Cessation Intervention*
  - *NQF0421 – Adult Weight Screening and Follow-up*

- There are 3 scenarios for reporting these core measures.

Core Scenario #1

1) Have > or = 1 reported for the denominators from your certified EHR Technology for each core measure

Next Step –

- Report measure results for core set

NQF 0013	Numerator: 0	Denominator: 25
NQF 0028	Numerator 1: 20 Denominator 1: 20	Numerator 2: 20 Denominator 2: 20
NQF 0421	Numerator 1: 0 Denominator 1: 5	Numerator 2: 0 Denominator 2: 5

- Core Requirement Complete. Go to Additional Measures

http://www.cms.gov/EHRIncentivePrograms/

Core Scenario #2

2) Don't have > or = 1 for one or more core measures from your certified EHR Technology

Next Step –

- Report measure results for core set:

NQF 0013	Numerator: 0	Denominator: 25
NQF 0028	Numerator 1: 0 Denominator 1: 0	Numerator 2: 0 Denominator 2: 0
NQF 0421	Numerator 1: 0 Denominator 1: 5	Numerator 2: 0 Denominator 2: 5

Core Scenario #2 (cont.)

- Select 1 or more Alternate Core measure(s) for each Core measure result of 0:

- In example above, NQF#0028 has a value of 0. Must select 1 Alternate Core measure.

NQF 0041	Numerator: 43 Denominator: 100

- If all Alternate Core Measures are 0, must report on all 3 (NQF 0024, 0041, 0038.)

- Go to Additional Measures

Core Scenario #3

3) Don't have > = 1 for any core measures from your certified EHR Technology

Next Step –

- Report measure results for core set (all 0s)
- Report measure results for Alternate Core measures (all 0s)
- Go to Additional Measures

EP Example Scenario – Additional Measures

Next step:

Report 3 additional measures

- Select 3 additional measures from the menu list of 38 measures that have one or more patients in the denominator

- If all measures are reported having a value of 0 from your certified EHR, then report any of the 3 additional measures

- If your certified EHR only contains a subset of the 38 measures, you must still report 3 additional measures

Which CQMs Apply to the EHR Incentive Programs?

- EPs and eligible hospitals have different criteria for the CQMs

- Where to find the measures selected:
  - Final Rule
  - CMS electronic CQM Website:
    http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp#TopOfPage

- Note: In the first participation year, participants in the Medicaid EHR Incentive Program *do not need* to attest to meaningful use, and therefore, do not need to report CQMs.
  - They will need to do so in subsequent participation years

Eligible Professionals: CQMs

Eligible professionals must report a total of six (6) CQMs:

First: Report 3 <u>Core</u>

↓

If any Core Denominators are "0"

↓

Then report Alternate Core

#alternate core reported = # Core with "0" in denominator

↓

Second: Report 3 <u>Additional</u> Measures

http://www.cms.gov/EHRIncentivePrograms/

Eligible Hospitals: CQMs

- Eligible hospitals must all meet the same 15 CQMs
  - Two measures target emergency department throughput processes
  - Seven address the care of patients with stroke
  - Six address the care of patients with venous thromboembolism

How to Report CQMs for Attestation

- In 2011: EPs and eligible hospitals attesting to the Medicare EHR Incentive Program are required to enter data for:
  - Numerator
  - Denominator
  - Exclusion (if applicable)

- In 2012: Proposed attestation or pilot options

EP Reporting for Attestation

- Numerator, denominator, and exclusion data are entered into CMS' web-based attestation system

http://www.cms.gov/EHRIncentivePrograms/

Eligible Hospital Reporting for Attestation

- Numerator, denominator, and exclusion data are entered into CMS' web-based attestation system

http://www.cms.gov/EHRIncentivePrograms/

Common CQM Questions Related to Reporting

- No patients in the measure population
  - It is acceptable to report zero in the denominator, even for 1 or more measure, as long as that is the value displayed & calculated by your certified EHR.
  - This is a reporting requirement not a performance measurement.

- Is sampling allowed?
  - No. Sampling is not allowed in the EHR Incentive Program.

Common CQM Questions

- Reporting for other federal initiatives
  - Are there any crossovers?
    - Reporting is separate at this point in time
    - EPs and hospitals/CAHs must report for each initiative for which they qualify and choose to participate

- All Patient Data
  - Reporting in the EHR Incentive Program Stage 1 is for all patients, not Medicare only

http://www.cms.gov/EHRIncentivePrograms/

Common CQM Questions

- EHR Incentive Program Reporting Period:
  - 1st Payment Year: Any continuous 90 day period
    - Although the measure specifications assume a full calendar year, you should only calculate the denominator and numerator from the first day of the 90 day reporting period to the last day of the 90 day reporting period

  - 2nd Payment Year: Report for the entire year
    - January 1-December 31 for EPs
    - October 1-September 30 for eligible hospitals

Resources to Help You

- Get information, tip sheets and more at CMS' official website for the EHR incentive programs
  - www.cms.gov/EHRIncentivePrograms

- Find electronic specifications information at:
  - http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp#TopOfPage

- Learn about certification and identify certified EHRs:
  - http://healthit.gov

Thank You