



The CMS EHR Incentive Programs: What You Need to Know about the Clinical Quality Measures

August 30, 2011
1:00 p.m. ET





Schedule

Agenda	Time
Introduction and Welcome	1:00 to 1:10
Presentation by CMS Experts <ul style="list-style-type: none">- Overview of the CMS EHR Incentive Programs<ul style="list-style-type: none">• Eligibility• Differences between the two Incentive Programs• Certified EHR Technology• Meaningful Use Overview- Description of CQMs<ul style="list-style-type: none">• What is a CQM?• Who Develops CQMs?• Anatomy of a CQM- CQMs and the Attestation Process	1:10 to 2:10
Online Q&A	2:10 to 3:00



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



About the Two Incentive Programs

Medicare EHR Incentive Program	Medicaid EHR Incentive Program
Managed by CMS	Each state manages its own program
EPs can receive a maximum incentive amount of \$44,000 (over 5 successive years of program participation)	EPs can receive a maximum incentive amount is \$63,750 (over 6 years of program participation)
Incentive payments for eligible hospitals are based on a number of factors, beginning with a \$2 million base payment	Incentive payments for eligible hospitals are based on a number of factors, beginning with a \$2 million base payment
Payment reductions begin in 2015 for providers who are eligible but choose not to participate	No Medicaid payment reductions if providers choose not to participate
In the first year and all remaining years, providers have MU objectives and associated measures they must meet to get incentive payments	In the first year, providers can receive an incentive payment for adopting, implementing, or upgrading a certified EHR
	In all remaining years, providers must meet the same MU objectives and associated measures as in Medicare



Which Professionals are Eligible?

Medicare-only Eligible Professionals (EPs)

Medicaid-only Eligible Professionals (EPs)

**Doctors of Optometry
Doctors of Podiatric Medicine
Chiropractor**

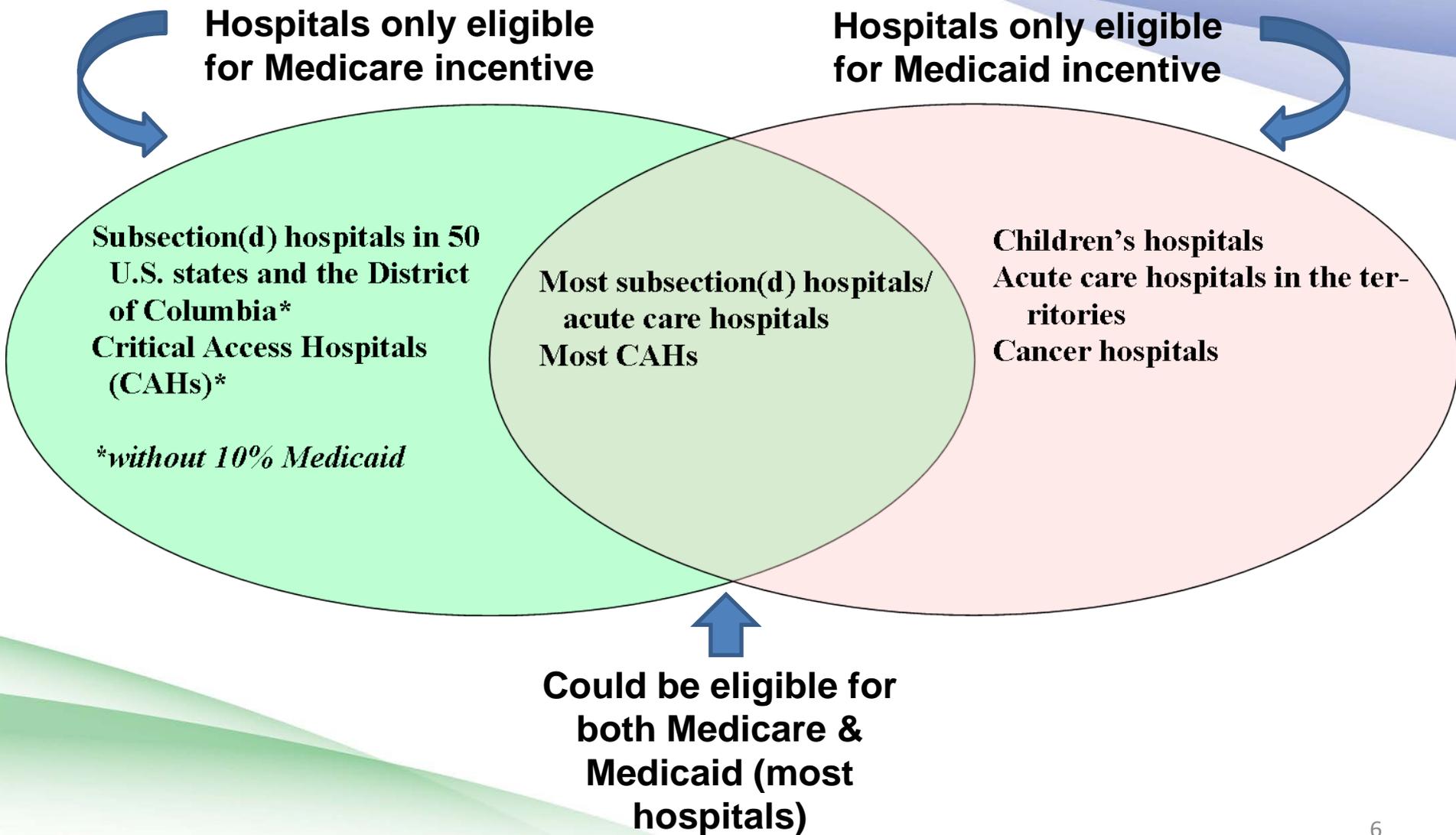
**Doctors of Medicine
Doctors of Osteopathy
Doctors of Dental Medicine
or Surgery**

**Nurse practitioners
Certified nurse midwives
Physician assistants (PAs)
when working at an FQHC
or RHC that is so led by a
PA**

**Could be eligible for
either Medicare &
Medicaid incentives**



Which Hospitals are Eligible?





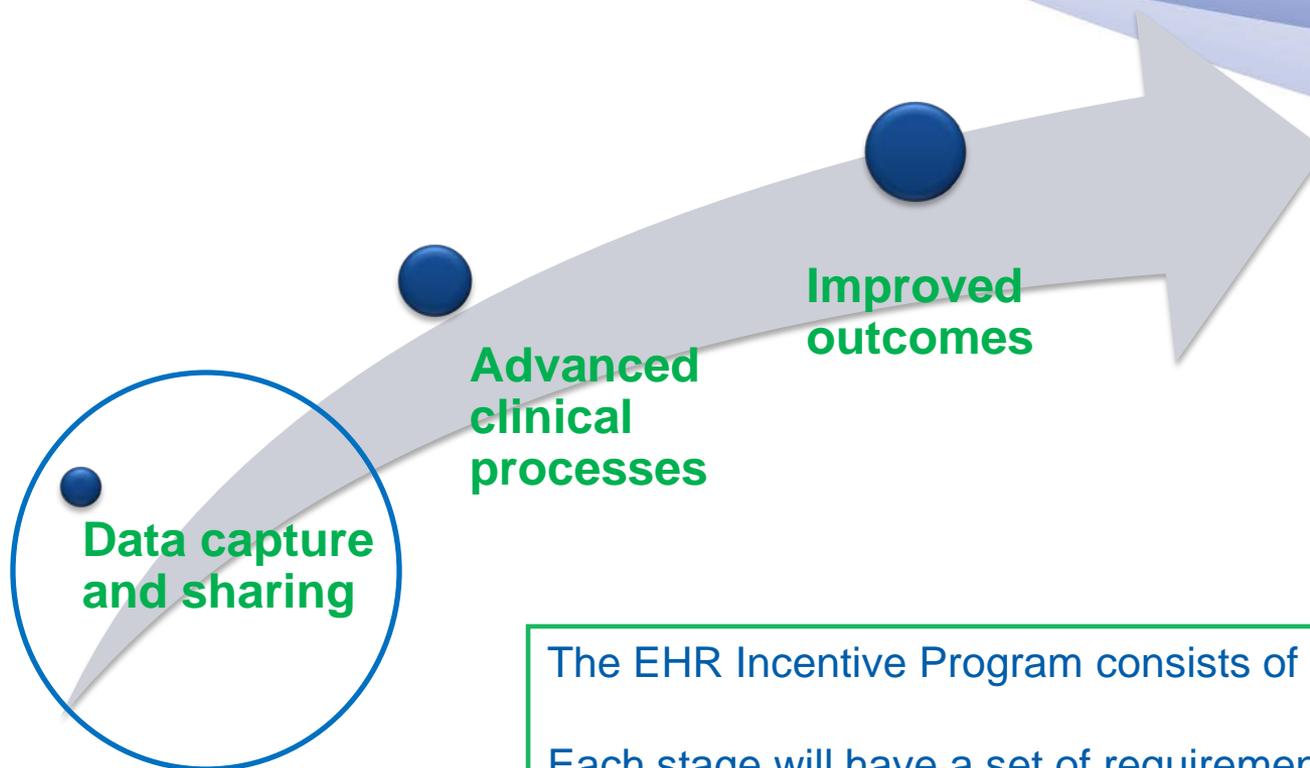
Eligibility Widget

- CMS has developed a web tool to help providers determine which EHR Incentive Program they are eligible to participate.
- The tool can be found on the CMS EHR Incentive Programs website:
<http://www.cms.gov/EHRIncentivePrograms>





How Does the Program Work?



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.



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

Certified Health IT Product List
The Office of the National Coordinator for Health Information Technology
HealthIT.HHS.Gov

The Certified HIT Product List (CHPL) provides the authoritative, comprehensive listing of Complete EHRs and EHR Modules that have been tested and certified under the Temporary Certification Program maintained by the Office of the National Coordinator for Health IT (ONC). Each Complete EHR and EHR Module listed below has been certified by an ONC-Authorized Testing and Certification Body (ONC-ATCB) and reported to ONC. Only the product versions that are included on the CHPL are certified under the ONC Temporary Certification Program.

Please send suggestions and comments regarding the Certified Health IT Product List (CHPL) to ONC.certification@hhs.gov, with "CHPL" in the subject line.

Vendors or developers with questions about their product's listing should contact the ONC-Authorized Testing and Certification Body (ONC-ATCB) that certified their product.

USING THE CHPL WEBSITE

To browse the CHPL and review the comprehensive listing of certified products, follow the steps outlined below:

1. Select your practice type by selecting the Ambulatory or Inpatient buttons below
2. Select the "Browse" button to view the list of CHPL products

To obtain a CMS EHR Certification ID, follow the steps outlined below:

1. Select your practice type by selecting the Ambulatory or Inpatient buttons below
2. Search for EHR Products by browsing all products, searching by product name or searching by criteria met
3. Add product(s) to your cart to determine if your product(s) meet 100% of the required criteria
4. Request a CMS EHR Certification ID for CMS registration or attestation from your cart page

STEP 1: SELECT YOUR PRACTICE TYPE

[Ambulatory Practice Type](#) [Inpatient Practice Type](#)

[ONC HIT Website](#) | [Privacy Policy](#)
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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 during the calendar year. 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



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



Exceptions/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.



Clinical Quality Measures (CQMs)

- Description of a CQM
 - What is a measure?
 - Anatomy of a CQM
 - What is unique about the CQMs in the EHR Incentive Program?
- CQMs and the Attestation Process
 - What CQMs you must meet
 - Eligible professionals
 - Eligible hospitals
 - How to report CQMs during attestation



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



Components of an eMeasure

1. Measure Overview and Other Information About the eMeasure that is located in a header
2. Population Criteria
 - Provides programming language to code the eMeasure in the EHR
3. Data Criteria
 - Identifies the codes that reflect the specific data elements (e.g., ICD-9/10)



eMeasure Example

Hypertension: Blood Pressure Measurement (NQF 0013)

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			

Title

Steward

Description



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
 5. Exceptions



Initial Patient Population

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

Patients \geq 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) \geq 18 years";
- o AND: "Diagnosis active: hypertension";
- o AND: \geq 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 \geq 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 \geq 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>



Exceptions

▶ Denominator Exceptions:

- Are an allowable reason for nonperformance of a quality measure for patients that meet the Denominator criteria and do not meet the Numerator criteria. Denominator Exceptions are the valid reasons for patients who are included in the denominator population but for whom a process or outcome of care does not occur.



Exceptions

- Exceptions allow for clinical judgment and fall into three general categories:
 1. Medical reasons
 2. Patients' reasons
 3. Systems reasons
- Not all CQMs have exclusions or exceptions

<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:

100 (N)

200 (D)



Which CQMs Apply to the EHR Incentive Programs?

- EPs and eligible hospitals have different criteria for the CQMs
- Note: In 2011, 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
 - 3 core or alternate core CQMs
 - 3 from a list of 38 additional CQMs
- Where to find the measures selected:
 - Final Rule
 - CMS electronic CQM Website:
http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp#TopOfPage
- Several measures overlap with the PQRS program



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



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

Clinical Quality Measures - EHR Incentive Program System - Windows Internet Explorer

https://ehrincentives1.cms.cmsval.bhtech/coreClinicalMeasures.action

File Edit View Favorites Tools Help

Clinical Quality Measures - EHR Incentive Program Sys...

Home | Help | Log Out

Home Registration **Attestation** Status Account Management

Core Clinical Quality Measures

Questionnaire: (1 of 3)

(*) Red asterisk indicates a required field.

Instructions: All three Core Clinical Quality Measures must be submitted. For each Core Clinical Quality Measure that has a denominator of zero, an Alternate Core Clinical Quality Measure must also be submitted.

NQF 0013

Title: Hypertension: Blood Pressure Measurement

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.

Complete the following information:

*Denominator: *Numerator:

Please select the **PREVIOUS** button to go back to the Topics Page, or the **SAVE & CONTINUE** button to proceed.

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Internet 100%



EHR Reporting for Attestation

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

The screenshot shows a web browser window titled "Core Clinical Quality Measures - EHR Incentive Program System". The address bar shows the URL "https://ehrincentives1.cms.cmsval.tech/coreClinicalMeasures.action". The browser interface includes a menu bar (File, Edit, View, Favorites, Tools, Help) and a toolbar with navigation icons. The main content area has a navigation menu with tabs for "Home", "Registration", "Attestation", "Status", and "Account Management". The "Attestation" tab is selected, and the page title is "Core Clinical Quality Measures".

Questionnaire: (1 of 15)

(*) Red asterisk indicates a required field.

NQF 0495 ,Emergency Department (ED)-1

Title: Emergency Department Throughput ??? admitted patients Median time from ED arrival to ED departure for admitted patients.

Description: Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department.

ED-1.1: All ED patients admitted to the facility from the ED.

Denominator All ED patients admitted to the facility from the ED. A positive whole number.

Numerator Median time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the ED. A positive whole number where N≤D or N≥D.
Exclusion = Observation & Mental Health Patients. A positive whole number.

*Denominator: *Numerator: *Exclusion:

ED-1.2: Observation ED patient stratification

Denominator ED Observation patients admitted to the facility from the ED. A positive whole number.

Numerator Median time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the ED. A positive whole number where N≤D or N≥D.

*Denominator: *Numerator:



Common CQM Questions

- No patients in the measure population
 - It is acceptable to report zero in the denominator, even for 1 or more measures, as long as that is the value displayed & calculated by the certified EHR?
- 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



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>



Q&A Overview

1. Select the “Q&A” tab at the top of the menu
2. Type your question
3. Click “Ask”
4. A CMS expert will take your question. A “pop up” box will appear, notifying you that your question has been answered

You will be able to see all the Q&As that have been asked by attendees and answered by the CMS experts

NOTE: The CMS expert who answered your first question may not be the same as the one who answers your follow up question(s). Be sure to explain your question in detail, if necessary