

I. Introduction

Over recent years, the Centers for Medicare & Medicaid Services (CMS) has worked to outline a strategy to leverage emerging Health Information Technology (HIT) in the Medicare and Medicaid programs with the primary goal of improving care. Through the implementation of Stage 1 of Meaningful Use of the EHR Incentive Program, CMS worked to increase the adoption and implementation of EHR systems among providers across the country. In Stage 2 of the Meaningful Use Program, we outlined steps to help providers begin transitioning from the acquisition of EHR technology to the use of EHR technology in a meaningful way.

CMS' ultimate goal is to fully integrate the clinical quality measure (CQM) reporting requirements for eligible hospitals (including Critical Access Hospitals – CAHs), physicians, physician groups and other eligible professionals; and, to enable participating professionals to satisfactorily “report once” the quality reporting requirements for many, if not all, relevant CMS programs. Through alignment, CMS hopes to reduce the administrative burdens associated with the quality initiatives, increase focus in high-priority areas of care, and, in support of the National Quality Strategy, improve the quality of the care provided.

II. Three (3) Part Goal of Stage 2

1. **Move from Adoption to Meaningful Use:** Stage 1 to Stage 2 signals the intent to move from *promoting the adoption* of EHR technology to *promoting the meaningful use* of EHR technology.
2. **Improve the Quality of Patient Care:** Stage 2 includes new objectives to improve patient care through better clinical decision support, care coordination and patient

engagement. For example, the objective to use secure electronic messaging to communicate with patients on relevant health information was added to the core set of objectives for eligible professionals (EPs). We also required that providers report on measures that include 3 of the 6 domains of the National Quality Strategy, thus driving improvement across the entire spectrum of quality, not just clinical processes of care.

3. **Save Money, Time and Lives:** With this next stage, EHRs will further save our health care system money, save time for doctors and hospitals, and save lives.

III. Alignment – Parsimonious Measures and Measure Sets

In order to minimize duplication of effort and the need for multiple submissions of quality data, CMS is establishing policies that will facilitate alignment of measures and policies across programs. To that end, beginning in 2014, all providers, regardless of their stage of meaningful use will report on CQMs in the same way. Once implemented, the policies will enable EPs to “report once” and receive credit for multiple programs (PQRS, MU and VBM). For EHs and CAHs, the eReporting pilot will likely be the basis for electronic reporting. Its success will enable alignment across MU and the IQR programs.

- **Eligible Professionals:** Beginning in 2014, providers must report nine (9) CQMs covering at least three (3) domains. This policy is applicable to both the PQRS and the Electronic Health Record (EHR) Incentive Program.

- Beginning in 2014, the EHR Incentive and PQRS Programs are aligned on the same set of 64 electronic CQMs. The CQMs sit within the six (6) domains of quality of care (listed below) established in the National Quality Strategy.
 - Patient and Family Engagement
 - Patient Safety
 - Care Coordination
 - Population and Community Health
 - Efficient Use of Healthcare Resources
 - Clinical Processes/Effectiveness
- **Eligible Hospitals (EHs) & Critical Access Hospitals (CAHs):** Beginning in FY 2014, participating EHs & CAHs must report a minimum of sixteen (16) CQMs, from a total of 29, covering at least three (3) domains.
- CMS is actively working to align the EHR incentive program for hospitals with the existing IQR and HVBP programs. In addition to full alignment of measures across all programs, we anticipate that the measure submission process will also be in full alignment.

IV. Quality Measure Feedback Loop

- ***Reports Issued to the Provider community***

CMS currently issues feedback reports to providers through the PQRS program and is planning to issue additional reports for the value modifier program in the future.

- Current - (PQRS) Feedback Reports for EPs that includes performance information.
- 2012 – (PQRS) Dashboard Feedback Reports for claims-based reporters that will enable participating providers to drill down on one or more of the measures he/she reported to understand accuracy.
- Future - (VBM) Physician Quality Resource Use Reports:

In 2013 and 2014 CMS will provide resource use reports for groups with ≥ 25 providers.

These reports will provide a first look at the methodologies used to develop the value-based payment modifier and will include data on the cost measures.

CMS is exploring whether we can provide the reports for groups with fewer than 25 EPs and individual EPs in the future.

- ***Education Outreach to the vendor community:***

CMS began hosting and facilitating a series of educational sessions for EHR vendors and system developers after the Stage 2 CQM e-Specifications were posted. Because the sessions are technical in nature, the sessions are being targeted to system design and

vendors/implementation personnel. During the sessions, CMS and our partner agencies address questions regarding e-specs, measure logic, implementation, certification and identify resources for the end users. The goal of the sessions is to create a continual interactive feedback loop between CMS and its stakeholder community.

V. Future Directions for Reporting CQMs

Registry and EHR reporting are the fastest growing data submission methods for CMS programs. Our goal is to further increase provider participation and we think that we can achieve this by making it easier for providers to submit measures for multiple purposes including for Maintenance of Certification. Boards, specialty societies, and regional quality organizations often have a significant number of physicians and other EP's engaged in quality measurement and reporting activity. CMS could leverage this activity in a manner that is mutually beneficial to CMS, the professional and regional organizations, and to clinicians. To that end we are exploring the idea of developing criteria that such entities (such as registries and data submission vendors) would have to meet in order to be deemed a "PQRS qualified" entity. This idea is in its early phases but is something we hope to engage external stakeholders on in the near future.