

# Clinical Quality Measures for Providers

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*Papers 5a and 5b in this series reviewed the health IT functionality measures for providers and hospitals as described in the meaningful use final rule. This paper offers an overview of the requirements for reporting clinical quality measures for eligible providers. A companion paper (6b) provides an overview of the requirements for hospitals.*

One of Congress's goals in developing the meaningful use program was to improve the quality and efficiency of care for the Medicare and Medicaid populations. Accordingly, hospitals and providers that choose to participate in the voluntary program will be required to capture and report clinical quality measures in addition to the functionality measures they must report to prove they are using EHR technology in a meaningful way.

For purposes of the incentive program, CMS defines clinical quality measures as the “processes, experience, and/or outcomes of patient care, observations or treatment that relate to one or more quality aims for health care such as effective, safe, efficient, patient-centered, equitable, and timely care.”

Many of the clinical quality measures required for eligible providers (EPs) have been selected from CMS's Physician Quality Reporting Initiative (PQRI), a quality reporting initiative currently in use. CMS intends to create an added incentive for EPs to adopt EHRs by leveraging the PQRI measures and eventually integrate both programs. CMS envisions a single reporting infrastructure for electronic submission in the future, eliminating redundant or duplicative reporting.

## **Stage 1 Clinical Quality Measures for EPs**

The HITECH Act required that in selecting clinical quality measures CMS give preference to those endorsed by the National Quality Forum. NQF is a nonprofit organization that ensures clinical quality measures are developed and maintained through a consistent and collaborative process. All clinical quality measures selected in the final rule are endorsed by NQF.

In addition, all of the measures have current electronic specifications. In writing the final rule, CMS eliminated the measures put forth in its proposed rule that currently lack electronic specifications. These measures will be considered in future rulemaking.

CMS also eliminated the proposed measures that were only concepts at the time of publication, because it lacked adequate time to consider them for the final rule. Finally, one measure was removed because it has since been retired—NQF 0026, the measure pair for tobacco use

prevention for infants, children, and adolescents/tobacco use cessation for infants, children, and adolescents.

In all 44 clinical quality measures were adopted for EPs. They appear in table 6 of the final rule (beginning p. 44398). The table includes the applicable NQF measure number and the PQRI implementation number, title, description, owner/steward. Where applicable, link are provided to existing electronic specifications. All of the measures have broad applicability to the range of Medicare-designated specialties and the services provided by EPs.

The electronic specifications for the measures, which can be found at [http://www.cms.gov/QualityMeasures/03\\_ElectronicSpecifications.asp](http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp), are derived from the certification specifications for EHRs.

EPs must report clinical quality measures results (numerators, denominators, and exclusions) to CMS. Details regarding the reporting of the specifications for eligible professionals and eligible hospitals/CAHs are outlined at <https://www.cms.gov/EHRIncentivePrograms>.

**Clinical Quality Measure Priorities**

PQRI measures 1, 2, 3, 5, and 7 represent CMS and Health and Human Services healthcare quality priorities. They address chronic conditions of diabetes, coronary artery disease, and heart disease.

PQRI measures 66, 110–115, and 128 support screening and prevention, also a high priority for CMS and HHS.

**Measures for 2011 and 2012 Reporting Years**

The 44 clinical quality measures are comprised of three types: three core measures, three alternate core measures, and 38 additional measures.

For the 2011 and 2012 reporting periods, EPs must submit calculated results for a total of six measures: three core measures and three of the 38 additional quality measures.

In instances where the denominator for one or more of the core measures is zero, the provider must report results for up to three of the alternate core measures. The core measures and alternate core measures, listed in table 7 of the final rule (p. 44410), are shown below:

**TABLE 7: Measure Group: Core for All EPs, Medicare and Medicaid**

<b>NQF Measure Number &amp; PQRI Implementation Number</b>	<b>Clinical Quality Measure Title</b>
NQF 0013	<b>Title:</b> Hypertension: Blood Pressure Measurement
NQF 0028	<b>Title:</b> Preventive Care and Screening Measure Pair: a. Tobacco Use Assessment b. Tobacco Cessation Intervention

NQF 0421 PQRI 128	<b>Title:</b> Adult Weight Screening and Follow-up
<i>Alternative Core Measures</i>	
NQF 0024	<b>Title:</b> Weight Assessment and Counseling for Children and Adolescents
NQF 0041 PQRI 100	<b>Title:</b> Preventive Care and Screening: Influenza Immunization for Patient $\geq$ 50 Years Old
NAF 0038	<b>Title:</b> Childhood Immunization Status

In the final rule, CMS does not delineate which measures may or may not apply for particular specialties. EPs need only report the required clinical quality measures. Additionally, the value may be zero for the numerator, denominator, or exclusions for any or all of those fields, if these are the results as displayed by the certified EHR technology. For reporting in 2011 and 2012, CMS does not require the measures to meet any particular thresholds or, in all cases, to have patients that fall within the denominator of the measure.

The final rule does not include exemptions. An EP will not be excluded from reporting any core, alternate, or additional clinical quality measures because the measure does not apply to the EP's scope of practice or patient population. EPs are not excluded if zeros are reported in the denominator values. EPs are not penalized in the stage 1 reporting years as long as they have adopted a certified EHR, it calculates the measures, and the EP submits the required information as defined in the final rule.

### **Reporting via Attestations for 2011**

For the payment year 2011, EPs may report through attestation by using a secure mechanism specified by CMS, or the states for Medicaid. They must specify the certified EHR technology in use, attest that the objectives and measures are satisfied, and specify their reporting period.

The final rule lists the following elements for attestation in 2011 (p. 44431):

#### **Elements for EPs submitting clinical quality measures:**

- The information submitted with respect to clinical quality measures was generated as output of an identified certified electronic health record.
- The information submitted is accurate to the best of the knowledge and belief of the EP.
- The information submitted includes information on all patients to whom the clinical quality measure applies for all patients included in the certified EHR technology.
- The national provider identifier (NPI) and tax identification number (TIN) of the EP submitting the information at §495.10. The numerators, denominators, and exclusions for each clinical quality measure result reported, providing separate information for each clinical quality measure including the numerators, denominators, and exclusions for all

applicable patients contained in the certified EHR technology irrespective of third party payer or lack thereof.

- The beginning and end dates for which the numerators, denominators, and exclusions apply.

Medicaid EPs will attest using a state mechanism and will be required to report on any CMS approved state meaningful use requirement. They are exempt from reporting meaningful use in the first payment year. Medicaid EPs have the option to adopt, implement, or upgrade certified EHR technology in the first payment year.

### **Duplicate Reporting**

To avoid duplication, the Medicare and Medicaid programs will coordinate payment through a data matching process utilizing NPIs to the extent practicable. CMS will create a registry of participating EPs and the program they have selected, and it will ensure that each state has access to the information.

EPs will be required to provide CMS with administrative information for the registry. This information also will be used to fulfill CMS requirements for online posting and ensure accurate and timely incentive payments. The administrative data includes the following:

- Name, NPI, business address, and business phone of each EP.
- TIN to which the EP wants the incentive payment made. For Medicaid EPs this must be consistent with assignment rules at §495.10.
- The program in which the EP will participate (Medicare or Medicaid).
- Whether the EP is a meaningful user.
- The remittance dated and amount of any incentive payments made to an EP.
- Other information as specified by CMS.

CMS, its contractors, and the states will have access to these data through the National Level Repository (NLR) maintained by CMS. The states will have to provide CMS with information on whether EPs participating in the Medicaid program are meaningful EHR users, when Medicaid incentive payments are made, and the amount of the payment.

### **Other Reporting Methods**

For participants in the Medicare program, CMS requires that the data source be from certified EHR technology. EPs may use intermediaries (data warehouses) to submit the EHR-generated clinical quality measure data if available, assuming all requirements are met.

States may seek CMS prior approval via their state Medicaid HIT plans for how they expect Medicaid providers to report the required meaningful use data, including clinical quality measures. For example, states may propose that the certified EHR-generated data be reported through a health information exchange or registry as an intermediary.

## **Reporting Period**

EPs must report the results of the clinical quality measures once a year. The reporting year period for clinical quality measures is aligned with the period for the functionality measures—any continuous 90-day period within the first payment year. Subsequent years, however, will require reporting for the entire year.

For Medicaid providers, there is no EHR reporting period for adopting, implementing, or upgrading for their first payment year. However, in their second payment year or first year of demonstrating meaningful use they have a 90-day EHR reporting period. It is in the third payment year/second year of demonstrating meaningful use that EPs must report for a 12-month EHR period.

*Paper 6b addresses the clinical quality measures required for eligible hospitals.*

## **Reference**

Centers for Medicare and Medicaid Services. “Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Final Rule.” *Federal Register* 75, no. 144 (July 28, 2010): 44314–588. Available online at <http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf>.