

# Meaningful Use Workgroup Hearing

October 5-6, 2011

## Prepared Remarks for

### Panel 1. Meaningful Use: Supporting the Goals of Health Reform

#### [Opening greeting]

The reporting of Clinical Quality Measures (CQMs) as a Meaningful Use core measure via attestation began in CY/FY 2011 for Eligible Physicians (EPs) and Eligible Hospitals and Critical Access Hospitals (EHs/CAHs), respectively. EPs and EHs/CAHs can report on any continuous 90-day period within this first year of Stage 1.

#### CQMs Reported

Currently, EPs must report a total of 6 CQMs (3 core or up to 3 alternate core measures and 3 menu measures) and EHs/CAHs must report 15 CQMs. The submission period for attesting is not yet complete for either EPs or EHs/CAHs, but so far almost 7750 EPs and 300 EHs/CAHs have successfully reported CQMs.

[refer to tables in prepared summary for any additional #s to point out]

#### Challenges Identified

Some of the challenges we've identified so far include the relative immaturity of EHRs as well as electronically specified CQMs, identifying CQMs that can be applied across a broad spectrum of specialties and practices, keeping the measures e-specifications updated, and allocating enough time for vendors to code systems and for providers to implement those systems.

*[With respect to] "Immature" EHRs and CQMs:*

We understand that EHRs are completely new to some providers. Even those providers which previously implemented EHRs in their practices may not have included structured data and reporting capabilities such as those required to successfully submit CQMs. Likewise, the measure development community is adjusting to electronically specifying measures to include structured data elements that previously weren't necessary with manual chart abstraction data collection methods. In essence, we're all learning together how to best incorporate EHR technologies in the most efficient and effective manner possible in order to collect useful data that will ultimately help improve care for individuals and the population at-large and reduce healthcare costs.

*[With respect to] Applicability of CQMs Across Specialties and Practices:*

We acknowledge that some specialties had no or few applicable CQMs in our current measure sets (e.g., chiropractic, podiatry, dermatology). We also acknowledge that some practices or providers, by their own nature, do not have patient populations that apply to all measure denominators (e.g., CAHs are not

certified to perform certain procedures required by the measure specifications). To this end, we are working on e-specifying existing measures and developing new ones that apply to the specialties and practices that are underrepresented in our current measure sets. We will consider the potential for increased burden and implementation challenges of providers and their EHR vendors when we select new measures and develop reporting requirements.

*[With respect to] e-Specifications Requiring Updating and Lead Time Needed to Implement Updates:*

Since the Stage 1 Final Rule, some code sets included in the original measure sets need updating. Once those updates are made, the updated code sets need to be programmed into EHRs and subsequently implemented by providers. We appreciate the amount of time, effort, and coordination this requires for vendors to code updated specifications and for providers to implement the updated systems. We're working on improving how we incorporate these needs into Stage 2. We are also exploring, with ONC and others, options for more flexibility and adaptability so code sets, and even measures, can potentially be updated outside of a regulatory rule-making cycle.

### The National Quality Strategy and Measures for Stages 2 and 3

For Stage 2, CMS is considering measures based on several factors, such as and including the CQM's readiness for implementation and alignment with the National Quality Strategy; however, final decisions will be made via the rulemaking process. We value the HITPC and MU workgroup input into this process, especially when this input is provided with specificity.

### Measure Concepts Produced by the Quality Measure Workgroup

We concur with the measure concepts that were produced by the Quality Measure Workgroup. In fact, we have entered into an Inter-Agency Agreement with the Office of the National Coordinator whereby they are developing the measure concepts into e-specified CQMs, some of which will hopefully be ready for implementation in Stage 2.

### Aligning With or Extending Measures Available Through Other CMS Programs

Subject to rulemaking, we are aligning the quality measure reporting among our various reporting and incentive programs (e.g., IQR, PQRS). We are working towards allowing CQM data submitted via certified EHRs by EPs and EHS/CAHs to apply to all quality reporting programs. A longer term vision could be hospitals and clinicians reporting through a single, aligned mechanism and "receiving credit" for multiple CMS programs. This would lessen provider burden while also supporting our goal of the programs transforming our system to provide higher quality care, better health outcomes, and lower cost through improvement.