2014 Clinical Quality Measures Tipsheet

Last Updated: August, 2012

Criteria for Reporting Clinical Quality Measures

1. Medicare EHR Incentive Program

Beginning in 2014, the reporting of clinical quality measures (CQMs) will change for all providers. EHR technology that has been certified to the 2014 standards and capabilities will contain new CQM criteria, and eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) will report using the new 2014 criteria regardless of whether they are participating in Stage 1 or Stage 2 of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. Although clinical quality measure (CQM) reporting has been removed as a core objective for both EPs and eligible hospitals and CAHs, all providers are required to report on CQMs in order to demonstrate meaningful use.

2013

- Eligible Professionals (EPs), will continue to report from the 44 measures finalized for Stage 1 in the same schema laid out for Stage 1
  - 3 core/alternate core
  - 3 additional measures for EPs
- Eligible hospitals and CAHs will continue to report the 15 measures finalized for Stage 1
- Beginning in 2012 and continuing in 2013, there are two reporting methods available for reporting the Stage 1 measures:
  - Attestation (https://ehrincentives.cms.gov/)
  - eReporting Pilots:
    - Physician Quality Reporting System EHR Incentive Program Pilot for EPs
    - eReporting Pilot for eligible hospitals and CAHs

2014 and Beyond

- EPs must report on 9 of the 64 approved CQMs
  - Recommended core CQMs – encouraged but not required
    - 9 CQMs for the adult population
    - 9 CQMs for the pediatric population
    - NQF 0018 strongly encouraged since controlling blood pressure is high priority goal in many national health initiatives, including the Million Hearts campaign
  - Selected CQMs must cover at least 3 of the National Quality Strategy domains (See "Measure Selection Process" below.)
- Eligible Hospitals and CAHs must report on 16 of the 29 approved CQMs
  - Selected CQMs must cover at least 3 of the National Quality Strategy domains (See "Measure Selection Process" below.)
- Beginning in 2014, all Medicare-eligible providers beyond their first year of demonstrating meaningful use must electronically report their CQM data to CMS. (Medicaid EPs and hospitals that are eligible only for the Medicaid EHR Incentive Program will electronically report their CQM data to their state.) See "Reporting Options for EPs" and "Reporting Options for Eligible Hospitals and CAHs" below for more information.

Measure Selection Process

CMS selected the recommended core set of CQMs for EPs based on analysis of several factors:

- Conditions that contribute to the morbidity and mortality of the most Medicare and Medicaid beneficiaries
- Conditions that represent national public health priorities
- Conditions that are common to health disparities
- Conditions that disproportionately drive healthcare costs and could improve with better quality measurement
- Measures that would enable CMS, States, and the provider community to measure quality of care in new dimensions, with a stronger focus on parsimonious measurement
- Measures that include patient and/or caregiver engagement

In addition, CMS selected all CQMs to align with the Department of Health and Human Services' National Quality Strategy priorities for health care quality improvement. These domains include:

- Patient and Family Engagement
- Patient Safety
- Care Coordination
- Population and Public Health
- Efficient Use of Healthcare Resources
- Clinical Processes/Effectiveness

When selecting their CQMs to report, EPs, eligible hospitals, and CAHs must select CQMs that cover at least three of these six domains. A complete list of 2014 CQMs and their associated National Quality Strategy domains will be posted on the CMS EHR Incentive Programs website (www.cms.gov/EHRIncentivePrograms) in the future. CMS will also post the recommended core set of CQMs for EPs.

Reporting and submission periods for EPs, Eligible Hospitals, and CAHs in their first year of Meaningful Use submitting CQMs via attestation beginning with CY/FY 2014

Provider Type	Reporting Period for First Year of Meaningful Use (Stage 1)	Submission Period for First Year of Meaningful Use (Stage 1)*
EP	90 consecutive days	Anytime immediately following the end of the 90-day reporting period, but no later than February 28 of the following calendar year.
Eligible Hospital/CAH	90 consecutive days	Anytime immediately following the end of the 90-day reporting period, but no later than November 30 of the following fiscal year.

**For purposes of avoiding a payment adjustment, Medicare EPs and eligible hospitals that are in their first year of demonstrating meaningful use in the year immediately preceding a payment adjustment year must submit their CQM data no later than October 1 (EPs) or July 1 (eligible hospitals) of such preceding year.*

Reporting and submission periods for EPs, Eligible Hospitals, and CAHs beyond their first year of Meaningful Use submitting CQMs electronically beginning with CY/FY 2014

For 2014 only, all providers regardless of their stage of meaningful use are only required to demonstrate meaningful use for a three-month EHR reporting period. Medicare providers can either report their CQMs for the entire year or select an optional three-month reporting period for CQMs that is identical to their three-month reporting period for meaningful use.

For Medicare providers, this 3-month reporting period is fixed to the quarter of either the fiscal (for eligible hospitals and CAHs) or calendar (for EPs) year in order to align with existing CMS quality measurement programs, such as the Physician Quality Reporting System (PQRS) and Hospital Inpatient Quality Reporting (IQR). CMS is permitting this one-time three-month reporting period in 2014 only so that all providers who must upgrade to 2014 Certified EHR Technology will have adequate time to implement their new Certified EHR systems.

In subsequent years, the reporting period for clinical quality measures would be the entire calendar year (for EPs) or fiscal year (for eligible hospitals and CAHs).

Provider Type	Optional Reporting Period in 2014*	Reporting Period for Subsequent Years of Meaningful Use (Stage 1 and Subsequent Stages)	Submission Period for Subsequent Years of Meaningful Use (Stage 1 and Subsequent Stages)
EP	**Calendar year quarter:** January 1 – March 31 April 1 – June 30 July 1 – September 30 October 1 – December 31	**1 calendar year** (January 1 - December 31)	**2 months following the end of the reporting period** (January 1 - February 28)
Eligible Hospital/CAH	**Fiscal year quarter:** October 1 – December 31 January 1 – March 31 April 1 – June 30 July 1 – September 30	**1 fiscal year** (October 1 - September 30)	**2 months following the end of the reporting period** (October 1 - November 30)

**NOTE: The optional quarter reporting periods have the same submission period as a full year reporting period for electronic submission.*

Reporting Options for EPs

Category	Data Level	Payer Level	Submission Type	Reporting Schema
EPs in First Year of Demonstrating Meaningful Use*	Aggregate	All payer	Attestation	Submit 9 CQMs (includes adult and pediatric recommended core CQMs), covering at least 3 NQS domains
EPs Beyond the First Year of Demonstrating Meaningful Use				
Option 1	Aggregate	All payer	Electronic	Submit 9 CQMs (includes adult and pediatric recommended core CQMs), covering at least 3 NQS domains
Option 2	Patient	Medicare Only	Electronic	Satisfy requirements of PQRS group reporting options using CEHRT
Group Reporting (only EPs Beyond the First Year of Demonstrating Meaningful Use)**				
EPs in an ACO (Medicare Shared Savings Program or Pioneer ACOs)	Patient	Medicare Only	Electronic	Satisfy requirements of Medicare Shared Savings Program of Pioneer ACOs using CEHRT
EPs satisfactorily reporting via PQRS group reporting options	Patient	Medicare Only	Electronic	Satisfy requirements of PQRS group reporting options using CEHRT

**Attestation is required for EPs in their first year of demonstrating meaningful use because it is the only reporting method that would allow them to meet the submission deadline of October 1 to avoid a payment adjustment.*

***Groups with EPs in their first year of demonstrating meaningful use can report as a group, however individual EPs who are in their first year must attest to their CQM results by October 1 to avoid a payment adjustment.*

Category	Data Level	Payer Level	Submission Type	Reporting Schema
Eligible Hospitals in First Year of Demonstrating Meaningful Use*	Aggregate	All payer	Attestation	Submit 16 CQMs, covering at least 3 NQS domains
Eligible Hospitals/CAHs Beyond the First Year of Demonstrating Meaningful Use				
Option 1	Aggregate	All payer	Electronic	Submit 16 CQMs, covering at least 3 NQS domains
Option 2	Patient	Sample - all payer	Electronic	Submit 16 CQMs, covering at least 3 NQS domains ➢ Manner similar to the 2012 Medicare EHR Incentive Program Electronic Reporting Pilot

**Attestation is required for eligible hospitals in their first year of demonstrating meaningful use because it is the only reporting method that would allow them to meet the submission deadline of July 1 to avoid a payment adjustment.*

2. Medicaid EHR Incentive Program

2013 and Beyond

- EPs, eligible hospitals, and CAHs participating only in a Medicaid EHR Incentive Program will submit their CQM data directly to their State.
- Each State is responsible for sharing the details on the process for electronic reporting with its provider community.
- Subject to CMS's prior approval, the process and the timeline are within the States' purview.