Summary of Meaningful Use Measure Pros and Cons

Based primarily but not exclusively on the deliberations of the Quality Council (5-6-2015)

Measure: % PCPs that meet Meaningful Use

This meaningful use measure assess the percent of a Medicare ACO's primary care providers are participating in the Medicare or Medicaid MU incentive program and receiving incentive payments. An ACO will have a lower score if the ACO a) has providers that participate in the program but do not qualify for incentive payment, or b) has providers that do not participate in the program. Providers may not participate in the program because they are not eligible, e.g., due to insufficient percentage of Medicare or Medicaid patients in their panel. Providers may also elect not to participate because they do not want to adopt an EHR, or because they do not want the administrative burden of demonstrating compliance.

ACO-11
Data Steward = CMS

Pros	Cons
The measure only reflects meaningful use as it pertains to Medicare and Medicaid beneficiaries; commercial beneficiaries benefit because a provider is likely to adopt the same practices for all patients in their panel. Thus, although the measure is based on Medicare and Medicaid performance, it is reasonable to assume that improvement on this measure reflects an improvement in clinical practice for the entire panel, including commercial patients.	Measure only reflects meaningful use as it pertains to *Medicare* beneficiaries. Consequently, commercial shared savings dollars are being used to improve clinical practice for Medicare beneficiaries. May not be applicable for Commercial payers, because they do not administer an EHR Incentive Program. Administering such a program would be very costly. Unclear what the source of data would be for Commercial payers.
An ACO may try to increase PCP participation in Medicare and/or Medicaid so that they can qualify to participate in the MU program. This could improve access for Medicare and Medicaid beneficiaries.	Although one could argue this measure reflects meaningful use as it pertains to *Medicaid* beneficiaries, in fact, the measure only includes PCPs who are participating in the Medicare SSP and such PCPs are likely to be participating in the Medicare EHR incentive program, rather than the Medicaid EHR incentive program.
Aligning with Medicare's measures is a guiding principle. "Aligning with Medicare throws the power of Medicare behind what we are requiring. Would be more likelihood part of package deal"	Performance on this measure depends more on the capabilities of the ACO/Advanced Network system and less on practice-level capabilities or physician behavior. (The intent and/or validity of this comment is not clear.)
Medicare's rationale for using this measure also fits in with our transformation goals. Performance on this measure reflects the development and use of HIT infrastructure that ACO's need to effectively coordinate care. If ACOs and their PCPs have and use certified technologies, they are more likely to adhere to guidelines and support surveillance and monitoring. Moreover, it reduces medication errors and improves quality reporting, the identification of gaps in care, implementation of care guidelines, and surveillance.	Not all physicians who use EHRs and who use them well are participating in the EHR Incentive Program. There may be people who are better users of EHR but aren't receiving incentive payments. There is no added clinical value to having them formally participate in the program.
This measure promotes the adoption and effective use of EHRs. It may also enable the use of clinical data rather than	Commercial payers may feel that the ACO is being paid twice for adoption and MU (once through shared savings

claims data, which complements investments in the All Payer Claims Data base.	payments, once for Medicare or Medicaid EHR Incentive Program). Providers note that the cost of adoption and meaningful use is not covered by the MU incentive payments.
We should be aiming to retain measures for a minimum of three years to support providers in their effort to improve in a particular area over time. The meaningful use incentive payments on which this measure is based will be in place for more than three years, which is sufficient for inclusion in our measure set. "The horizon is far enough out to be doable."	As of yet, there is no evidence that performance on this measure is related to overall quality of care or quality improvement.
	Providers are already incentivized to do this through Medicare SSP, EHR incentive program and the new Medicare penalties for failure to adopt and meaningfully use. Thus, the additional burden of implementing this measure across payers will not materially influence provider behavior.
	Determining improvement on the measure depends on where providers begin, and the only way to determine this is the payment they are receiving.

Additional comments of Minakshi Tikoo, PhD, State of Connecticut, HIT Coordinator:

- In my opinion this measure does not have value.
- The challenge with this measure is one of meaningful attribution and weight as it relates to quality of care.
- The quality of the data is weak, for example a physician gets credit for "0" in the numerator and/or denominator when reporting eCQMs, which is an example of how the measure may not provide meaningful data.
- Recommend burden of measurement is worthwhile when a proposed measure adds clear and distinct value to answering the question at hand, in our case assigning shared savings.