

ID	Recommendation	Accompanying Comments	QMWG Additional Commentary/Edits
1.0	<p><b>CONTINUE TO DEVELOP OUTCOME MEASURES THAT REPRESENT QMWG SUPPORTED CONCEPTS</b></p>	<p>After comparing the 2011 QMWG recommendations to the 2012 NPRM EP and EH measure sets, the workgroup reports the following:</p> <ul style="list-style-type: none"> <li>-All 5 original domains have at least one concept that is fully represented (an NPRM measure closely extends the intention of the recommended concept) in a Stage 2 NPRM measure.</li> <li>-All domains also have both a fully represented and at least one partially represented concept in a Stage 2 NPRM measure.</li> <li>- The NPRM reflects efforts to drive innovation in e-measurement. For three domains, Population/Public Health, Care Coordination, Patient Safety, the Stage 2 NPRM includes measures that the WG suggested for Stage 3 MU (such as Longitudinal Improvement in Blood Pressure).</li> <li>- The Clinical Appropriateness and Population and Public Health domains have the complete coverage and also contain a plurality of the NPRM measures that represent 2011 WG concepts.</li> <li>-Care Coordination is the domain at greatest risk. Of the 5 Care Coordination measure concepts that the WG recommended, only one is fully represented and one is partially represented. The sub-domain Effective Care Planning has no measure representation in</li> </ul>	
1.1	<p>Falls risk screening. Encourage broad measurement of falls risk that captures risk across care settings.</p>	<ul style="list-style-type: none"> <li>- There is no proposed inpatient eCQM that addresses fall risk, but hospitalized patients and recently discharged patients are at especially high risk for falls.D4</li> <li>-Consider an inpatient measure for fall risk in future versions of the incentive program.</li> <li>-The WG appreciates such a measure may be out of scope for validation/feasibility testing in time for MU2 FR.</li> </ul>	

ID	Recommendation	Accompanying Comments	QMWG Additional Commentary/Edits
1.2	Medication Reconciliation. The QMWG recommends a wider age band for Medication Reconciliation.	<ul style="list-style-type: none"> <li>- The measure proposed in the NPRM tracks medication reconciliation for patients older than age 65. Medication reconciliation should be encouraged in all patients, regardless of age.</li> <li>- Medication reconsolidation is such an important issue, for quality of care and patient safety, that the practice should be measured across settings and age bands.</li> </ul>	
1.3	ADE Prevention & Monitoring. The QMWG recommends clarity for the type of medication and monitoring tracked by this measure.	<ul style="list-style-type: none"> <li>-The QMWG recommends warfarin as the measured drug and INR as the monitored test.</li> <li>-The QMWG recommends an outcome measure to monitor ADEs.</li> <li>- The measure description is currently vague in its description of what drug will be the measure target and which tests results should be monitored.</li> </ul>	
1.4	NQF 407. The QMWG recommends MU Stage 2 minimize the influence of "check-box" compliance.	<ul style="list-style-type: none"> <li>- This measure accepts the presence of HAART on a provider attestation that a patient on HAART or has a plan or care.</li> </ul>	

QMWG Response to NPRM MU2 Matrix 20120424 v 0 0 2

ID	Recommendation	Accompanying Comments	QMWG Additional Commentary/Edits
1.5	The QMWG recommends the MU quality measure set emphasize patient experience.	<p>- The QMWG reaffirms its recommendation that MU eCQMs quantify patient experience and recommend CMS consider CAHPS measures or a similar measure set that broadly captures and describes patient experience and satisfaction.</p> <p>-The QMWG supports CMS efforts to use The MU CQMs to drive development of valid, EHR-enabled patient reported measures.</p>	
2.0	<b>CONTINUE TO ALIGN CQMs ACROSS QUALITY IMPROVEMENT PROGRAMS</b>	To encourage provider adoption, reduce administrative burden and support focused improvement, CMS should continue to align measures across its suite of measurement and payment programs. MU 1 was challenging for small practices. CMS should appreciate the extent to which increasing requirements can be barriers for MU2.	
2.1	Allow MU qualification to satisfy PQRS requirements.	<p>P 13748 of the proposed rule suggests “Medicare EPs who submit and satisfactorily report Physician Quality Reporting System clinical quality measures under the Physician Quality Reporting System’s EHR reporting option using Certified EHR Technology would satisfy their clinical quality measures reporting requirement under the Medicare EHR Incentive Program.”</p> <p>-The QMWG encourages CMS to also permit the reverse this option, so that EPs who fully satisfy the meaningful use requirements may be deemed to have also satisfied the PQRS requirements.</p> <p>-The QMWG does not believe that satisfying the PQRS requirements provides an indication of “meaningful use” that would qualify for incentive payments.</p>	
2.2	Expand EP and EH eligibility to allow behavioral health and long term care facilities to be eligible providers and facilities.	<p>-The QMWG encourages CMS to extend eligibility as EPs and EHs to behavioral health providers and facilities involved in long-term care.</p> <p>-This would encourage EHR Incentive Program participation among behavioral health providers and long term facilities that report to other CMS quality improvement programs.</p>	JJ: The FR for MU1 reports that EP is defined in Sect 1903(t)(3)(B) of the HITECH Act. CMS may be statutarly constrained to the Act's definition: physician, NP, rural or FQHC PA, and nurse mid-wife.

ID	Recommendation	Accompanying Comments	QMWG Additional Commentary/Edits
3.0	<b>MINIMIZE PROVIDER BURDEN BY ADDING FLEXIBILITY TO REPORTING OPTIONS</b>	<p>Page 178 of the Proposed Rule states:                      " We are proposing two reporting options that would begin in CY 2014 for Medicare and Medicaid EPs, as described below:</p> <p>Options 1 and 2. For Options 1, we are proposing the following two alternatives, but intend to finalize only a single method:                      - Option 1a: EPs would report 12 clinical quality measures from those listed in Table 8, including at least 1 measure from each of the 6 domains.                      - Option 1b: EPs would report 11 "core" clinical quality measures listed in Table 6 plus 1 "menu" clinical quality measure from Table 8."</p>	
3.1	Reporting option: Select 1a as the process for individual EP reporting.	-The QMWG suggests that the 1a option be selected for EP reporting.	
3.2	Reporting option: Require individual EPs to report as few as 6 measures via option 1a.	<p>- The QMWG recognizes that many providers will confront a significant challenge when choosing a dozen measures that are relevant to their field of practice from the 6 domains.</p> <p>- The QMWG also appreciates that the number of measures in the final rule may be reduced from the 125 proposed.</p> <p>-We are confident that internists, family medicine physicians and geriatricians will find a variety of relevant measures to their practice but many other specialists/subspecialists will have a greater challenge</p>	

ID	Recommendation	Accompanying Comments	QMWG Additional Commentary/Edits
4.0	<b>CREATE A PATH TO SIGNAL MU STAGE 3 INTENTIONS</b>	<p>CMS should consider an interim publication, following the FR of Stage 2 MU and preceding the Stage 3 MU NPRM. CMS should also consider advancing the release date for Stage 3 MU NPRM to allow vendors more time to develop the appropriate functionality and allow providers time to adjust applicable clinical workflows.</p> <p>To the extent that such a timetable switch is infeasible, the WG encourages CMS to send clear, strong signals through the Stage 2 MU FR this fall. Although the committee recognizes that CMS cannot make Stage 3 final decisions without experience from implementation of Stage 2, a clear signal of intentions would be very helpful to make vendor and provider implementation more feasible. Furthermore, the availability of measures to satisfy reporting domains remains weak and will need substantial attention for Stage 3. Data elements and data types needed for Stage 3 should be captured by Stage 2 certification.</p>	
4.1	The QMWG recommends advancing its timetable for the release of future MU NPRMs.	-An earlier release of future NPRMs or future informational letters will allow additional software design and development time for vendors and workflow planning time for providers.	
5.0	<b>CONTINUE TO USE MU TO ADVANCE EHR-BASED QUALITY MEASUREMENT</b>	The QMWG encourages CMS to accelerate the design, develop and testing of eQMs that take advantage of functional capabilities of EHR captured data that were previously unavailable or unfeasible via abstracted and claims-based quality measurement.	
5.1	Use MU to test novel measures.	-The QMWG supports the release of "pilot" eQMs to allow testing of EHR-enabled measurement on a national scale in broad range of vendor platforms.	

ID	Recommendation	Accompanying Comments	QMWG Additional Commentary/Edits
5.2	Use MU as a forum to demonstrate local, operational, practice-level EHR-based eQMs.	<p>-The QMWG recognizes that IDNs, ACOs, and other provider networks have developed, tested and deployed unique eQMs that measure and enhance quality care for diverse patient populations across the nation.</p> <p>-The QMWG also recognized that these practice-level eQMs are often not vetted by national quality endorsers.</p> <p>-The QMWG encourages CMS to use the MU as a forum to focus national attention on practice-level innovation eCQM deployment and depolyment.</p>	
5.3	Allow EPs and EHs to choose their own eQMs and report them via MU EHR Incentive Program	<p>-The QMWG encourages CMS to create a reporting option via which providers can report on eQMs developed and deployed on their local systems.</p> <p>-The QMWG encourages CMS to allow EH and EP reporting on eQMs that cater to their individual institution needs. This will create a path by which a broad group of stakeholders are engaged in measure specification, QDM mapping, MAT insertion, NQF endorsement.</p>	