

<p>CQM - Reporting 2014</p>	<p>(b) Reporting Methods Beginning with FY 2014 Under section 1886(n)(3)(A)(iii) of the Act, eligible hospitals and CAHs must submit information on the clinical quality measures selected by the Secretary "in a form and manner specified by the Secretary" as part of demonstrating meaningful use of Certified EHR Technology. Medicare eligible hospitals and CAHs that are in their first year of Stage 1 of meaningful use may report the 24 clinical quality measures from Table 9 through attestation for a continuous 90-day EHR reporting period as described in section II.B.1. of this proposed rule. Readers should refer to the discussion in the Stage 1 final rule for more information about reporting clinical quality measures through attestation (75 FR 44430 through 44431). Medicare eligible hospitals and CAHs would select one of the following two options for submitting clinical quality measures electronically.</p> <ul style="list-style-type: none"> <li>● Option 1: Submit the selected 24 clinical quality measures through a CMS-designated portal. For this option, the clinical quality measures data would be submitted in an XML-based format on an aggregate basis reflective of all patients without regard to payer. This method would require the eligible hospitals and CAHs to log into a CMS-designated portal. Once the eligible hospitals and CAHs have logged into the portal, they would be required to submit through an upload process, data that is based on specified structures produced as output from their Certified EHR Technology.</li> <li>● Option 2: Submit the selected 24 clinical quality measures in a manner similar to the 2012 Medicare EHR Incentive Program Electronic Reporting Pilot for Eligible Hospitals and CAHs using Certified EHR Technology.</li> </ul>	<p>pp. 233-234</p>	<p><i>Quality Measures WG Information Exchange Workgroup</i></p>	<p><i>QMWG supports the hospital reporting structure- reporting 24/49 measures. The group did not discuss option 1 vs option 2.</i></p>
<p>CQM - Patient population</p>	<p>We are considering the following 4 options of patient population – payer data submission characteristics:</p> <ul style="list-style-type: none"> <li>● All patients – Medicare only.</li> <li>● All patients – all payer.</li> <li>● Sampling – Medicare only, or</li> <li>● Sampling – all payer.</li> </ul> <p>Currently, the Hospital IQR program uses the "sampling – all payer" data submission characteristic. We request public comment on each of these 4 sets of characteristics and the impact they may have to vendors and hospitals, including but not limited to potential issues with the respective size of data files for each characteristic. We intend to select 1 of the 4 sets as the data submission characteristic for the electronic reporting method for eligible hospitals and CAHs beginning in FY 2014.</p>	<p>p. 234</p>	<p><i>Quality Measures WG</i></p>	<p><i>QMWG discussed but did not ellicit a consensus opinion about which payers to include in the incentive program reporting</i></p>

CQMs - Time period	<p>We are not proposing any changes to the time periods for reporting clinical quality measures. The EHR reporting period for clinical quality measures under the EHR Incentive Program is the period during which data collection or measurement for clinical quality measures occurs. The reporting period is consistent with our Stage 1 final rule (75 FR 44314) and will continue to track with the EHR reporting periods for the meaningful use criteria:</p> <ul style="list-style-type: none"> <li>• Eligible Professionals (EPs): January 1 through December 31 (calendar year).</li> <li>• Eligible Hospitals and Critical Access Hospitals (CAHs): October 1 through September 30 (Federal fiscal year).</li> <li>• EPs, eligible hospitals, and CAHs in their first year of meaningful use for Stage 1, the EHR reporting period would be any continuous 90-day period within the calendar year (CY) or Federal fiscal year (FY), respectively.</li> </ul>	pp.164 -165	<i>Quality Measures WG</i>	<i>The committee seeks input from the policy committee</i>
Vitals - age limitations	Encourage public comment on the age limitations of vital signs.	p. 65		
Vitals - exclusions	We believe there are situations where height/length and weight may be relevant, but blood pressure is not. We are less certain that there would be cases where blood pressure is relevant, but height/length and weight are not. We propose for Stage 2 to split the exclusion so that an EP can choose to record height/length and weight only and exclude blood pressure or record blood pressure only and exclude height/length and weight. We encourage comments on this split and whether it should or should not go both ways.	p. 67		
Smoking status - age limit	We have not observed any significant consensus around when it is appropriate to collect smoking status, regardless of the presence or absence of other risk factors. If commenters disagree with our age limitation, we encourage them to include their reasons for disagreement and any evidence that may be available as to improved consensus among healthcare providers on what age limit is appropriate.	p. 68		
Smoking status - expand to tobacco use	In Stage 1 of meaningful use, we considered whether to expand the collection of information from smoking status to other forms of tobacco use. We continue to believe that there are insufficient electronic standards for collecting information on other types of tobacco use and that situations where a patient might use multiple types of tobacco would damage the standardized collection of smoking data, but we request comment on whether this is the case.	p. 69		

<p>Stage 2 Core and Menu Objectives</p>	<p>In the Stage 1 final rule we outlined Stage 1 criteria, we finalized a separate set of core objectives and menu objectives for both EPs and eligible hospitals and CAHs. EPs and hospitals must meet or qualify for an exclusion to all of the core objectives and 5 out of the 10 menu measures in order to qualify for an EHR incentive payment. In this proposed rule, we propose to maintain the same core-menu structure for the program for Stage 2. We propose that EPs must meet or qualify for an exclusion to 17 core objectives and 3 of 5 menu objectives. We propose that eligible hospitals and CAHs must meet or qualify for an exclusion to 16 core objectives and 2 of 4 menu objectives. Nearly all of the Stage 1 core and menu objectives would be retained for Stage 2. The "exchange of key clinical information" core objective from Stage 1 would be re-evaluated in favor of a more robust "transitions of care" core objective in Stage 2, and the "Provide patients with an electronic copy of their health information" objective would be removed because it would be replaced by an "electronic/online access" core objective. There are also multiple Stage 1 objectives that would be combined into more unified Stage 2 objectives, with a subsequent rise in the measure threshold that providers must achieve for each objective that has been retained from Stage 1.</p>	<p>pp. 16-17</p>	