CPCA
California Primary Care Association

Health Care Access for All

May 5, 2012

Cindy Mann
Director of Center for Medicaid and State Operations
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-0044-P
P.O. Box 8013
Baltimore, MD 21244-8013

RE: COMMENTS- 42 CFR Parts 412, et al. Medicare and Medicaid Programs; Electronic Health Record Incentive Program- Stage 2: Proposed Rule

Dear Ms. Mann:

On behalf of the California Primary Care Association (CPCA), the 18 regional health center associations and health center controlled networks, the nearly 900 nonprofit community clinics and health centers (CCHCs), and the 4.7 million patients they serve in California, I thank you for the opportunity to comment on the CMS Proposed Rule for Stage 2 of the EHR Incentive Program. As you are likely aware, CCHCs from their inception in the 1960s, have worked to engage patients in a culturally and linguistically competent manner, reduce racial disparities, improve patient safety, coordinate care, improve overall efficiency, and ultimately through this work have improved population health. CCHCs have been the medical home for low-income, uninsured, and medically under-served Americans long before the term medical home became popular. The principles used to craft the definition of meaningful use are the same principles that guide healthcare delivery in CCHCs.

Background

The community clinics and health centers CPCA represents are nonprofit, tax-exempt clinics that are licensed as community or free clinics, as defined under Section 1204 of the California Health and Safety Code, and provide services to patients on a sliding fee scale basis or, in the case of free clinics, at no charge to the patients. Over 450 of the 893 CCHCs in California are designated as Federally Qualified Health Centers (FQHCs). FQHCs receive federal grants under Section 330 of the Public Health Service Act (42 U.S.C. 254b) from the Bureau of Primary Health Care (BPHC), within the Health Resources and Services Administration (HRSA) of the Department of Health and Human Services (HHS). Additionally, 30 CCHCs in California are FQHC- Look Alikes. FQHC-LA's operate and provide services similar to FQHCs, however they do not receive a Section 330 grant. FQHC Look-Alike entities are expected to demonstrate the same commitment as grantees to serve all populations residing in their respective medically

underserved communities, and to satisfy the administrative, management, governance and service-related requirements unique to section 330 funded health centers.

Section 1402 in HR 1 specifically refers to FQHCs, which according to Medicaid law includes FQHCs, FQHC-look alikes, and specific IHS providers. For our comments, the term FQHCs refers to FQHCs, FQHC-LAs, and those specific IHS providers. Because the delivery model, mission, and payment mechanisms for community clinics and free clinics are nearly identical to FQHCs and FQHC-LA's, our comments will use CCHC to refer to all three types of entities.

We respectfully submit the following comments:

II. Provisions of the Proposed Regulations,

1. Uniform Definitions

CPCA agrees with CMS' proposal to revise the EHR reporting period to clarify that for providers who are demonstrating meaningful use (MU) for the first time their reporting period is 90 days, regardless of payment year.

While not explicitly requested, CPCA would like to endorse the recommendation first forwarded by CHIME that CMS should "follow the precedent set in Stage 1" and allow the Stage 2 reporting period to be "any continuous 90-day period within the first payment year of Stage 2 and a 365-day reporting period for all subsequent payment years within Stage 2." We have forwarded a similar proposal to the Health Resources and Services Administration (HRSA) who requires all 330 grantees to report Uniform Data System (UDS) measures. We have proposed that when new measures are released, health centers be given one year to "practice" reporting and then on the second year the data be considered formally submitted. New measures require new internal protocols and training. It often takes up to a year to ensure staff are all trained appropriately in how to collect and extract the data necessary to report on the measure. In like fashion, we support CHIME's recommendation that the first year of reporting in any new reporting stage be 90 days as opposed to 365 days.

3. Definition of Meaningful Use

CPCA is fully supportive of CMS' proposal for a 1-year extension of Stage 1 of meaningful use for providers who successfully demonstrated meaningful use for 2011. Nearly all of the providers at CCHCs will be participating in the Medicaid program, and thus their first year was AIU, we still are supportive of CMS' proposal to extend Stage 1. For many, Stage 1 is almost the hardest year because the climb was so steep and the longer in this Stage the better for overall provider engagement in the program.

b. Changes to Stage 1 Criteria for Meaningful Use

As long as the certified EHRs can capture the medications created, CPCA is supportive of CMS' proposal to change the denominator for CPOE to the number of orders for medication created by the provider during the reporting period.

CPCA is also supportive of CMS' proposal to change the age limitations on vital signs for Stage 1. To note, federally qualified health centers must report annually to the UDS and vital signs are

one of the many measures required. CPCA is supportive and recommends that CMS work with HRSA to align all like measures between meaningful use and UDS so that FQHCs need only follow one standard for capturing and reporting measures.

The measure regarding the capability to exchange key clinical information is, as CMS asserts, confusing for providers and thus difficult to report. However, CPCA agrees that this is an important measure, and recommends keeping the measure as is in Stage 1, and providing additional clarification and guidance to providers who struggle to understand how to meet this objective. There is a range of health information exchange capability among FQHCs in California and this measure accounts for this spectrum because it allows providers to still successfully achieve meaningful use Stage 1 even if this test fails. For those that can successfully exchange health information electronically it moves the continuum of health information exchange further along, which is one of the ultimate aims of the meaningful use program. As such we recommend leaving the measure and just providing additional support and clarification. Removing this measure would send the wrong signal to providers and the vendor community, while adding additional success requirements would force many providers out of participating. Safety net providers in California have absolutely been motivated by the meaningful use program and laying down any barriers to continuing this difficult pursuit of adoption and meaningful use would disrupt significant gains.

CPCA is supportive of CMS' proposal for making patient information available electronically. In 2014, for Stage 1, CMS proposes to replace objectives of providing patients with electronic copies of their health information and providing patients with timely electronic access to their health information with "view online, download and transmit" objectives.

CPCA is also supportive of the proposal to add "except where prohibited" to the regulation text for the public health measures. We would note, however, that California is far behind as a state in making this an option for providers. Currently in California public health reporting is managed at the county level, and there is no statewide capability yet. Hopefully, federal measures such as this one can accelerate California's timeline to standardized statewide public health reporting.

c. State flexibility for Stage 2 of Meaningful Use

CPCA is supportive of CMS' proposal to offer states flexibility with the public health measures and measures about generating lists of specific conditions to use for quality improvement, reduction of disparities, and research or outreach in Stage 2 as long as CMS requires states to assist providers in achieving the Stage 1 public health measures first. In California, as noted above, the state is far behind in having a standardized statewide format for public health reporting. There is a statewide immunization network, but currently only one of the ten regions has the capability to receive HL7 messaging. CMS should require proof of public health reporting capability for Stage 1 before allowing states any amount of flexibility for Stage 2. All providers in a state should be assisted in their achievement of Stage 1 before states are allowed to work on Stage 2 flexibilities.

CPCA is supportive of the proposal to move all the menu objectives of Stage 1 into Core for Stage 2 with the exception of the objective of "capability to submit electronic syndromic surveillance data to public health agencies."

(1) Discussion of whether certain providers can meet all Stage 2 Meaningful Use Objectives Given their Scope of Practice

CPCA is supportive of all of CMS' proposals to reduce confusion in Stage 2. CPCA is supportive of the proposal that would remove the distinction of which patients to include in the numerator and denominator and make it so that all patients are included in the denominator, not just those kept in the certified EHR, as well as the proposal to consolidate the denominators into one of four possibilities. While a tremendously important and well-received program, the meaningful use program is a complicated because of the nuances with eligibility and the array of reporting requirements. Any effort to reduce the variance in reporting or in capturing of measures is a welcome improvement to the program.

(6) Objectives and their Associated Measures

(a)Objectives and measures carried over from Stage 1 core set to Stage 2 core set (See Table 4)

CPOE: To CMS' request for comment on whether CPOE should be limited to licensed health care professionals, or if it can be expanded to include non-licensed healthcare professionals such as scribes, CPCA recommends not expanding this capability to other health care professionals. There is one FQHC in California that is using scribes, but they do not allow unlicensed staff to order medications due to risk management issues. They are soon to be engaged in a pilot project that would test scribes and other unlicensed staff to conduct CPOE, however CPCA recommends waiting until this pilot and others across the country are conducted before allowing this expansion of duties.

Generate and transmit permissible prescriptions electronically: To CMS' requests for comment on whether controlled substances should be included as well, CPCA recommends to keep controlled substances excluded because there remains much to be learned regarding two-factor authentication. Further, CPCA recommends continuing to exclude over-the-counter medications. CPCA is supportive of the measure generally, with one caveat related to providers in areas where ePrescribing is not feasible. Many pharmacies in underserved areas are not equipped to accept electronic transmission of prescriptions. Allowing transmission via fax for those pharmacies that cannot accept electronic transmissions would allow eligible professionals (EPs) serving these populations to meet the meaningful use criteria. We recommend these pharmacies be identified and targeted for specific incentive programs to install technology that will allow them to receive prescriptions electronically. As long as these pharmacies cannot accept prescriptions electronically, we will continue to experience a digital divide in these communities and they will continue to provide less than optimum healthcare for underserved populations.

Providing a Summary of Care Record: CPCA is supportive of CMS' proposal to combine objectives "maintaining an up-to-date problem list, active medication list, and active medication allergy list" into "providing a summary of care record for each transition of care or referral and including each of these as fields in the summary."

Demographics: CPCA is supportive of the measure to record patient demographics and encourages CMS and all other federal agencies requiring similar information to align the reporting requirements. Specifically, CPCA suggests CMS and the HRSA align meaningful use and UDS measures. Currently, UDS requires demographic data collection as well. As such, no additional requirements should be added to meaningful use that are not already required in UDS.

Record and Chart changes in the following vital signs: CPCA agrees with CMS' proposal for this measure.

Record smoking status for patients 13 years of age and older: To CMS' request for information on whether meaningful use should include information about other tobacco products or second hand smoke exposure, CPCA recommends requiring information about other tobacco products used, but not including second hand smoke. The UDS measures capture the other tobacco products used, and adding this to the meaningful use measure would work to align the meaningful use and the UDS measures as we have suggested previously.

Use clinical decision support to improve performance on high-priority health conditions: CPCA agrees with CMS' proposal.

Provide clinical summaries for patients for each office visit: CPCA agrees with CMS' proposal as long as the additional fields to be required would be built-in functionalities to the certified EHRs. The additional fields provide for a more comprehensive health summary that is important for patients, but the fields must be easily added to the summary, which should be a requirement of the vendors.

Protect electronic health information: CPCA is supportive of CMS' proposal to protect electronic health information, however it should be noted that EHR vendors are not currently encrypting "at rest" data. Including this measure will force vendors to begin this added layer of security.

(b) Objectives and measures carried over from Stage 1 menu set to Stage 2 core set

Incorporate clinical lab-test results into the certified EHR technology as structure data: CPCA agrees with the intent and direction of this measure and threshold, but advises CMS to consider the challenges providers in rural areas face in purchasing interfaces. Smaller rural labs may not be able to afford building a lab interface to a CCHC. This measure could inadvertently provide an unfair competitive advantage to large labs that can afford to provide the interface to their contracted providers versus smaller labs that cannot.

Generate lists of patients by specific conditions: CPCA agrees with CMS' proposal.

Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care: CPCA agrees with CMS' proposal.

Provide patients with the ability to view online, download, and transmit their health information within 4 business days: CPCA recommends that CMS remove the second measure for the following reasons: Many of our patients live below the federal poverty line and therefore do not

have the means to procure computers or Internet access. As such, they would not have the capability to view, download, or transmit their health information to a third party. Moreover, English is the only language currently supported by most EHR vendors today, however 43 percent of our patients in California are best served in a language other than English. We urge CMS and ONC to push the vendors to support multiple language formats so patients can interpret these notes and in turn they can take better control of their health. Our FQHCs have no control over patient access to computers or their inclination to view, download, or transmit to a third party.

In regards to the first part of the objective and measure that more than 50 percent of all unique patients are provided online access to their health information, CPCA recommends that CMS allow such information to be provided via email and not require the use of a patient portal. For the same reasons stated above, CCHC patients are predominantly under 100% FPL, do not have at home Internet access, and patient portals and EHRs are not in the main languages of our patients. Information provided for the sake of providing information is not meaningful to patients. CPCA recommends that CMS and the ONC work with the vendor community to make health information available in multiple languages, at the appropriate literacy level of low-income individuals, and available through other means than a personal computer, such as a smart phone.

Use clinically relevant information from certified EHR Technology to identify patient-specific education resources: CPCA agrees with this measure, however recommends that CMS develop a clear definition for what constitutes patient-specific education resources. CPCA further recommends that CMS modify the measure to be about condition-specific resources, rather than patient-specific. Lastly, CPCA recommends that CMS create a mechanism for providers to include the resources they provide outside of the EHR in their achievement of meeting this measure.

The provider who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation: CPCA agrees with CMS' proposal however suggests that further clarification on the measure is required. For example, does this measure mean that an EP must reconcile the receiving organization's list with what the patient reports they are taking? Or does this measure mean that the receiving organization reconciles their list with the sending organization's list, which would require electronic exchange of a medication list from the sending organization to the receiving organization, or access to a medication list in an HIE portal? CPCA would support the former interpretation. Also, if the transition of care is within the same organization, such as the dental clinic to the medical clinic in an FQHC, CPCA recommends that there be a transition of care summary required as well.

Summary care record for each transition of care or referral: CPCA agrees with this measure as it will put pressure on vendors to make this requirement easily achievable. We recommend that CMS consider combining this measure with the prior medication reconciliation measure as all that would be necessary would be adding medications to the transition of care document. Having medication in the transition summary would require medication reconciliation. Also, as we cannot control what certified systems other providers are using it should not be a requirement that an EP share information with EPs that have differing systems from their own.

Capability to submit electronic data to immunization registries: CPCA agrees with this measure, however would note that in California the immunization network, CAIR, is not functioning for all providers. Further, in California there are counties that are carved out of the statewide immunization network, which further exacerbates the difficulties of providers successfully meeting this measure. CPCA recommends that CMS put pressure on states to standardize and streamline this process.

Capability to submit electronic syndromic surveillance data: CPCA agrees with this measure, however recommends that CMS put pressure on states to standardize and streamline this process. In California all the counties handle syndromic surveillance data differently and most CCHCs do not currently have the capability to submit electronic syndromic surveillance data.

(d) New core and menu set objectives and measure for Stage 2

Imaging results and information are accessible through certified EHR technology:
CPCA supports the objective, but like the CMS Health Committee would recommend a lower threshold at 10% with an exclusion if the provider has no access to electronic images (e.g., local imaging centers do not offer electronic access). The lower threshold is necessary because providers cannot control if the radiology lab they partner with can interface with their EHR. Some of our CCHCs have built lab interfaces that cost upwards of $20,000, and such a cost is just not feasible for all sites and providers. HIE organizations are the preferred route for such exchanges of data as its far more economical.

Record patient family health history as structured data:
CPCA supports the spirit of this objective, however we are not aware of adopted standards in this area. Before this measures becomes core or menu, we recommend clearly identifying the standards that would be used to capture the data for this measure. Until we see the standards for this measure, CPCA cannot support its inclusion as core or menu for Stage 2.

Capability to identify and report cancer cases to a State cancer registry:
CPCA supports the spirit of this objective, however we recommend more specificity be added to this measure. Further, as registries pose challenges for most states, we recommend prioritizing immunization registries before expanding reporting to cancer registries.

Capability to identify and report specific cases to a specialized registry (other than a cancer registry):
CPCA supports the spirit of this objective, however we recommend more specificity be added to this measure. Further, as registries pose challenges for most states, we recommend prioritizing immunization registries before expanding reporting to specialized registries.

Use secure electronic messaging to communicate with patients on relevant health information:
CPCA supports the intent of this measure and the direction towards increased electronic patient engagement in Stage 2, however we have concerns about this measure. Secure electronic messaging is not a standard function of an EHR, but an add-on that must be purchased. For many providers struggling to just implement their EHRs, this measure adds a cost that could penalize safety net providers who have limited resources to invest in their systems beyond what is already

required in meaningful use. Further, our patient population is predominantly low-income, below 200% FPL which means they do not have home computers. Additionally, EHRs are not equipped to send messages to patients in their preferred language, and in California nearly 50% of all patients speak a language other than English at home. For all of these reasons we are not supportive of this measure as core, and recommend that this measure be left as menu, or that an additional exclusion be added for providers who serve a disproportionate (40% or greater) share of low income and non-English speaking patients, or that the menu be reversed so that the requirement is that providers send the message rather than the patients be the sender.

B. Reporting on clinical quality measures using certified EHR technology by eligible professionals, eligible hospitals, and critical access hospitals

1. Time periods for reporting clinical quality measures

CPCA is supportive of CMS' proposal that the submission period for clinical quality measure data to CMS be no longer than 2 months immediately following the end of the reporting period (ie. January 1-February 28). However, we recommend that there be flexibility allotted to providers in states where there are delays in providers being able to report data. In California, for example, the state continues to work on the portal where providers will report meaningful use Stage 1 data, and this portal will not be available until this summer. CMS should allow providers to report data from anytime during the payment year during the 90 day reporting period in Stage 1 to account for the delays that may not be within the provider's control.

5. Proposed Clinical Quality Measures for Providers

CPCA was very excited to see CMS' long term vision for providers to be able to report through a single, aligned mechanism for multiple CMS programs, and the discussion regarding aligning the array of quality programs such as PQRS, Medicare Shared Savings Program, NCQA, HRSA UDS, CHIPRA, and final section 2701 adult measures under the ACA. Our providers need to be focused on patient care, not reporting, and anything that CMS and the other federal agencies can do to align measures and create one single reporting engine would be welcome relief to safety net providers at CCHCs. CPCA would like to specifically request that CMS work with HRSA to align the meaningful use and UDS measures. For example, UDS 2012 includes measures 0074 CAD-LDL, but this is not one of the proposed Meaningful Use Core measures. There are also several meaningful use core measures being proposed by CMS that are not in UDS. CPCA would be supportive of the two agencies working closely to align the measures so these discrepancies stop occurring.

c) Proposed clinical quality measures for providers beginning in CY 2014

We have attached table 8 (Attachment A) with CPCA's recommendations on certain clinical measures. The measures we are recommending for inclusion are generally applicable to many population groups across varying socioeconomic backgrounds, and would be helpful not only for clinicians but dentists as well.

We applaud the inclusion of 2 oral health measures in the proposed CQMs and urge CMS to continue working with their national partners and professional organizations to make Meaningful Use more applicable for both dental and behavioral healthcare providers which are core to the health center program.

(d) Group Reporting for Medicare and Medicaid Providers Beginning with CY 2014
CPCA is supportive of making group reporting an option for providers in the Medicare and Medicaid program. For the Medicaid program, reporting on the clinical measures as well as the functional measures should be an option for states. While not specifically requested or opened for comment, we recommend that the option be available to providers reporting in Stage 1 as well. There is still time for many Medicaid programs as they are still building the reporting portals to allow for group reporting and if it will be allowed in Stage 2 it ought to be allowed in Stage 1. It would an inefficient use of resources for CCHCs to expend the energy on creating reporting systems for individual providers to later have to switch to group reporting, when most CCHCs in California will choose to report as a group.

To CMS's questions about a definition for group, CPCA recommends that "group" not have a definition that includes a set number of providers. Rather the definition should be a common tax identification number (TIN). In California, we have group eligibility and the ability to use the group eligibility methodology is allowed for providers that operate and bill under a common TIN. Groups should also be allowed to exclude providers from their group and should not be required to include encounters their providers provide outside of their group. Many providers in CCHCs practice at more than just the CCHC and its impractical to aggregate what the provider is doing at other practices and then report on it as part of the CCHC group.

To the question about groups and using the same certified EHRs, we recommend that providers in the same group be allowed to use different certified EHRs. In the case of CCHCs, often the dental clinic and the primary care clinic will have different certified EHRs, and yet these providers are part of the same group and seeing the same patient population. For providers who fail to individually meet the meaningful use measures on their own, we believe this should be the group's responsibility to manage and not CMS'. Groups have an incentive to ensure all their providers are successful and they will self-monitor, thereby alleviating this responsibility from CMS.

To the questions regarding reassignment, CPCA recommends that providers that reassign to the group should be required to participate in the group reporting. Providers that leave before the reporting period would have to forfeit their incentive payment. Also, the incentive program should be reconstructed so that payment is directed at the groups and not the providers. We commented in Stage 1 that we were not in favor of the incentive payments being directed at providers, and while we have worked with the reassignment system and have managed to still garner signification buy-in and participation from groups in California it still would be easier, more efficient, and more representative of the health care delivery system infrastructure to assign payments to groups rather than to the providers who then have to reassign to the groups. While it has generally gone smoothly for the providers to reassign, there are definitely providers refusing to participate unless they receive the full incentive and even provider movements organizing entire systems of providers that no provider reassign unless the administration agree to the providers' terms. The incentive payments were never intended to be bonuses for providers, but rather to pay for the systems and encourage additional capture and achievement of quality measures. The meaningful use incentives, for all the good intention that created it, did unfortunately reinforce in many practices the uncomfortable dynamic between administrators and providers. This could all be avoided by assigning the payment from the beginning to the

groups. Groups could receive incentive payments based on the FTE's in their practice or the number of licenses they purchase for their EHRs, or reconstruct the incentive payments to mimic what is in place for hospitals, which for all intensive purposes are treated as groups.

F. Proposed Revisions and Clarifications to the Medicaid EHR Incentive Program

3. Medicaid Professionals Program Eligibility

CMS proposes that at least one of the clinical locations used for calculation of a provider's patient volume needs to have certified EHR technology during the payment year for which the provider is attesting to adopt, implement or upgrade in their first participation year, or to meaningful use in subsequent years. CPCA agrees with CMS on this proposal.

CMS goes on to propose to allow states the option for their providers to calculate total Medicaid or total needy individual patient encounters in any representative, continuous 90-day period in the 12 months preceding the provider's attestation. CPCA does not recommend that CMS adopt this flexibility. While we appreciate how flexible CMS has been with meaningful use and eligibility, this flexibility has also caused a great deal of confusion among the provider community about who is eligible and who is not. We would actually encourage hardening the boundaries on the eligibility rules so that it's easier to understand, thus our recommendation not to include.

While few CCHC's in California are using panel data for eligibility we do agree with CMS' proposal that for patients to be considered active, the period be 24 months instead of 12 months.

CMS proposes to revise the definition of "practices predominantly" so that providers could use either (1) the most recent calendar year; or (2) the most recent 12 months prior to attestation. CPCA does not recommend that CMS adopt this flexibility. While we appreciate how flexible CMS has been with meaningful use and eligibility, this flexibility has also caused a great deal of confusion among the provider community about who is eligible and who is not eligible. We would actually encourage hardening the boundaries on the eligibility rules so that it's easier to understand, thus our recommendation not to include.

3. Hospital-Based Eligible Professionals

CMS requests feedback on the prohibitions to hospital-based providers. The definition in Stage 1, while well intentioned has created barriers for some CCHCs. We have some CCHCs that have a heavy focus on maternal and child care, and thus follow their patients into the hospital, deliver their babies, who then in turn are cared for at the CCHC. The construct of the CCHC – provider delivering the babies is as follows: the CCHC employs the provider, the provider has admitting privileges at the hospital, the provider bills the delivery Medi-Cal FFS and the payment while under the provider's name goes directly back to the CCHC. The payment mechanism was constructed as such because FFS delivery is most cost effective than building delivery into the FQHCs prospective payment system rate. The provider delivering the baby at the hospital also uses the CCHC's certified EHR. The provider is for all intensive purposes the CCHC's provider, he/she is only just operating outside of the four walls of the CCHC. The hospital is not capturing any of what the provider is doing for the CCHC in this relationship. Because the CCHC provider is billing the POS codes included in the definition of hospital-based, these providers have not been able to participate in California's Medi-Cal Meaningful Use Program to date, however, we

believe CMS does not intend to exclude providers who are functioning in this manner. We request that CMS make allowances for this type of provider relationship.

Thank you for allowing CPCA to share our recommendations. Should you have any questions about these comments, please do not hesitate to contact our Deputy Director of Regulatory Affairs, Andie Patterson, at (916) 440-8170 or apatterson@cpca.org. Thank you for your attention and consideration.

Sincerely,

Carmela Castellano-Garcia, Esq.
President and CEO
California Primary Care Association

Attachment A

TABLE 8: CLINICAL QUALITY MEASURES PROPOSED FOR MEDICARE AND MEDICAID ELIGIBLE PROFESSIONALS BEGINNING WITH CY 2014

Measure Number	Clinical Quality Measure Title & Description	CPCA Comment
NQF 0001	Title: Asthma: Assessment of Asthma Control Description: Percentage of patients aged 5 through 50 years with a diagnosis of asthma who were evaluated at least once for asthma control (comprising asthma impairment and asthma risk).	Both clinicians and dentists are supportive, but we recommend aligning with the UDS measure that captures asthma control.
NQF 0002	Title: Appropriate Testing for Children with Pharyngitis Description: Percentage of children 2-18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.	CPCA is supportive of this measure for insured patients, however it adds another cost to non-insured patients, and thus we recommend removing this measure.
NQF 0004	Title: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement Description: The percentage of adolescent and adult patients with a new episode of alcohol and other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis and who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.	CPCA is supportive of this measure for insured patients, however it adds another cost to non-insured patients, and thus we recommend removing this measure.
NQF 0018	Title: Controlling High Blood Pressure Description: Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year.	CPCA's clinicians and dentists are supportive of this measure.
NQF 0022	Title: Use of High-Risk Medications in the Elderly Description: Percentage of patients ages 65 years and older who received at least one high-risk medication. Percentage of patients 65 years of age and older who received at least two different high-risk medications.	CPCA recommends that a better definition of "high risk" medication be constructed before including this measure.

NQF 0024	Title: Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents Description: Percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or OB/GYN and who had evidence of body mass index (BMI) percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.	CPCA's clinicians and dentists are supportive of the intent of this measure; however we recommend more work be done to better define the elements or break the measure into various measures to effectively capture the intent. In its current state it reads that every patient needs nutritional counseling, regardless of their BMI and the U.S. Preventive Services Task Force does not recommend this due to a lack of evidence that nutritional counseling for all patients is helpful. Further, this measure is attempting to measure three metrics, capturing BMI percentile and nutritional and physical activity counseling, in one measure, and from our experience the most useful and effective measures are very limited in scope.
NQF 0028	Title: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention Description: Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	CPCA's clinicians and dentists are supportive of the intent of this measure; however we recommend that this measure be altered before it is included in the meaningful use Stage 2 program. There is not sufficient evidence to prove that counseling non-smoking adults on the risks of smoking is helpful. Counseling should be reserved for patients who do smoke. Further, this measure is attempting to measure two metrics, screening for tobacco use and counseling, and from our experience the most useful and effective measures are very limited in scope.
NQF 0052	Title: Use of Imaging Studies for Low Back Pain Description: Percentage of patients with a	CPCA is supportive of this measure being included as long as there is a distinction between

	primary diagnosis of low back pain who did not have an imaging study (plain x-ray, MRI, CT scan) within 28 days of diagnosis.	acute back pain verses chronic back pain in a new patient. CCHCs have experience with patients requesting narcotics and providing a history of multiple years with this condition. It can take months to receive the medical records from the patient's previous providers, if the records arrive at all. Our preference is to distinguish patients with chronic back pain from those who have acute back pain.
NQF 0055	Title: Diabetes: Eye Exam Description: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had a retinal or dilated eye exam or a negative retinal exam (no evidence of retinopathy) by an eye care professional.	CPCA's clinicians and dentists are supportive of this measure.
NQF 0056	Title: Diabetes: Foot Exam Description: The percentage of patients aged 18 - 75 years with diabetes (type 1 or type 2) who had a foot exam (visual inspection, sensory exam with monofilament, or pulse exam).	CPCA's clinicians and dentists are supportive of this measure.
NQF 0058	Title: Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis Description: Percentage of adults ages 18 through 64 years with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription on or within 3 days of the initial date of service.	CPCA's clinicians and dentists are supportive of this measure, with the recommendation that providers be allowed to remove from the denominator patients with COPD as it is considered a standard of care to treat patients with COPD with acute bronchitis with antibiotics.
NQF 0059	Title: Diabetes: Hemoglobin A1c Poor Control Description: Percentage of patients 18 - 75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c > 9.0%.	CPCA's clinicians and dentists are supportive of this measure.
NQF 0061	Title: Diabetes: Blood Pressure Management Description: Percentage of patients 18 - 75 years of age with diabetes (type 1 or type 2) who had blood pressure <140/90 mmHg.	CPCA's clinicians and dentists are supportive of this measure.
NQF 0069	Title: Appropriate Treatment for Children with Upper Respiratory Infection (URI)	CPCA's clinicians and dentists are supportive of this measure,

	Description: Percentage of children who were given a diagnosis of URI and were not dispensed an antibiotic prescription on or three days after the episode date.	as long as URI is the only diagnosis. Should a patient be diagnosed with multiple conditions during this visit and some of the conditions necessitating the prescription of antibiotics, we would recommend these patients be excluded from the measure.
NQF 0097	Title: Medication Reconciliation Description: Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.	CPCA's clinicians and dentists are supportive of this measure.
NQF 0105	Title: Anti-depressant Medication Management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment Description: The percentage of patients 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment.	CPCA's clinicians and dentists are supportive of this measure.
NQF 0312	Title: Lower Back Pain: Repeat Imaging Studies Description: Percentage of patients with back pain who received inappropriate imaging studies in the absence of red flags or progressive symptoms (overuse measure, lower performance is better).	CPCA cannot be supportive of this measure until we fully understand what is meant by "inappropriate imaging studies." We recommend a more robust definition be crafted before adding to stage 2.
NQF 0406	Title: Patients with HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy Description: Percentage of patients who were prescribed potent antiretroviral therapy.	CPCA's clinicians and dentists are supportive of this measure.
NQF 0419	Title: Documentation of Current Medications in the Medical Record Description: Percentage of specified visits as defined by the denominator criteria for which the eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list must	CPCA's clinicians and dentists are supportive of this measure.

	include ALL prescriptions, over-the-counters, herbals, vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route.	
NQF 0421	Title: Adult Weight Screening and Follow-Up Description: Percentage of patients aged 18 years and older with a calculated body mass index (BMI) in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside of normal parameters, a follow-up plan is documented. Normal Parameters: Age 65 years and older BMI . 23 and < 30 Age 18-64 years BMI . 18/5 and < 25	CPCA's clinicians and dentists are supportive of this measure.
NQF 0575	Title: Diabetes: Hemoglobin A1c Control (<8.0%) Description: The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c <8.0%.	CPCA's clinicians and dentists are supportive of this measure.
NQF 1335	Title: Children who have dental decay or cavities Description: Assesses if children aged 1-17 years have had tooth decay or cavities in the past 6 months.	CPCA's clinicians and dentists are supportive of this measure.
NQF 1401	Title: Maternal depression screening Description: The percentage of children who turned 6 months of age during the measurement year who had documentation of a maternal depression screening for the mother.	CPCA recommends rewriting this measure to "the percentage of patients who are mothers of children who turned 6 months of age during the measurement year who had documentation of a maternal depressions screening." While CCHCs are working to achieve medical home recognition, if a CCHC sees only the child and the mother goes elsewhere for her care, the CCHC should not be responsible for the health care for the mother.
NQF 1419	Title: Primary Caries Prevention Intervention as Part of Well/Ill Child Care as Offered by	CPCA's clinicians and dentists are supportive of this measure.

	Primary Care Medical Providers Description: The measure will a) track the extent to which the PCMP or clinic (determined by the provider number used for billing) applies FV as part of the EPSDT examination and b) track the degree to which each billing entity's use of the EPSDT with FV codes increases from year to year (more children varnished and more children receiving FV four times a year according to ADA recommendations for high-risk children).	
NQF 1335	Title: Children who have dental decay or cavities Description: Assesses if children aged 1-17 years have had tooth decay or cavities in the past 6 months.	CPCA's clinicians and dentists are supportive of this measure.
TBD	Title: Hypertension: Blood Pressure Management Description: Percentage of patients aged 18 years and older with a diagnosis of hypertension seen within a 12 month period with a blood pressure <140/90mmHg OR patients with a blood pressure .140/90mmHg and prescribed 2 or more anti-hypertensive medications during the most recent office visit.	CPCA recommends removing this measure for the following reasons. First, if a patient has a blood pressure of 141/91, this measure would not apply as written; it only applies to patients with hypertension with either blood pressure under 140/90 or those with blood pressures exactly at 140/90. Further, there could be an explanation why the patient would have a blood pressure of greater than 140/90, for example the patient forgot to take their medication that day or they cannot afford to purchase the medication, and thus adding a second medication would be inappropriate.