June 27, 2016

Mr. Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

REFERENCE: File code CMS-5517-P; RIN 0938-AS69 Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models

Dear Mr. Slavitt:

On behalf of the members of the Health IT Policy and Standards Committees, created by the American Recovery and Reinvestment Act of 2009 (ARRA) under the auspices of the Federal Advisory Committee Act (FACA), we respectfully submit the attached comments on the Quality Payment Program (QPP), principally the Merit-based Incentives Payment System (MIPS), which are designed to implement statutes included in the Medicare Access and CHIP Reauthorization Act (MACRA), enacted in April 2015.

In general, we applaud CMS and its stated intent to be responsive to stakeholders and to continually engage with multiple audiences to ensure the Quality Payment Program supports providers as they aim to deliver high quality, person-centered care. We welcome the QPP's focus on measuring and improving outcomes, particularly information sharing, care coordination, and patient engagement, and encourage CMS to seek every opportunity to clearly, distinctly, and repeatedly demonstrate how each component of QPP aligns to drive delivery system reform and the Program's goals.

Nonetheless, with such a complex program, we believe that CMS also needs to take additional steps to simplify QPP even further and reduce the regulation's complexity, both to make the program's components easier to understand and implement, and to encourage as many eligible clinicians as possible to participate. We do not believe CMS will have achieved its goal of reduced burden and increased flexibility if providers cannot understand the program's requirements and timelines. This will be especially difficult for those providers who were not eligible to participate in the CMS Medicare EHR Incentives program, and those new to the challenges and opportunities offered through certified health IT use to improve their practices and populations' health.

We will continue to support CMS as it implements this important regulation, and hope we can continue to offer additional guidance that can facilitate CMS's program and policy development of specific components related to standards, implementation of certified health IT, and the exchange of health information.

Sincerely,

/s/
Paul Tang
Co-chair, Health IT Policy Committee

/s/
Kathleen Blake
Co-chair, Health IT Policy Committee

/s/
Arien Malec
Co-chair, Health IT Standards Committee

/s/
Lisa Gallagher
Co-chair, Health IT Standards Committee

Quality Payment Program Task Force
On Behalf of the Health IT Policy and Standards Committees
Comments on the CMS Proposed Rule 5517-P

Overall Comments

1. Overall, the proposed rule is responsive to stakeholder feedback by moving clinicians towards measuring and improving outcomes, while seeking to reduce burden and increase flexibility.
    a. However, in striving to meet these goals, the proposed rule has become too complex to understand and to implement, and will be challenging for many stakeholders to confidently engage in measure selection, electing between MIPS or APM participation, and selecting practice improvement activities.
2. The proposed rule introduces many new options and requires participants to make choices in an unreasonably short timeframe. Without timely transparency about how eligible clinicians will be benchmarked, they cannot make appropriate practice and technology choices in time to participate effectively by the proposed performance period of 2017, particularly if they do not have access to certified health IT that allows them to meet the MIPS performance categories.
    a. It will be especially difficult for smaller providers to understand the rule and ensure that their practices and use of health IT comply with the requirements. Complexity will also be a barrier to eligible clinicians deciding whether, and how, to migrate toward APM participation.
    b. Requiring participants to meet scoring and reporting for the Advancing Care Information category may set a high bar that discourages clinicians from participating in the program. Ironically, the diversity of choices in 2017 (between 2014 Edition and 2015 Edition CEHRT, and Modified EHR Stage 2 and Stage 3 objectives and measures) may negatively impact technology developers' ability to support program participants, especially for the new categories of eligible clinicians, rural practices, those in underserved areas, and those not within large organizations.
3. Groups deciding whether to report as a group or as individuals for MIPS are highly dependent on many factors (e.g., timing of decisions, basic processes including selection of reporting mechanisms, impact on clinical workflow, measure selection, which providers in multi-group practice fit in APMs or in MIPS) and will have significant impact on practices. Helping them gain a clear understanding of requirements, timelines and technology availability is critical.

Key Focus Areas

1. **Increase accessibility throughout the final rule and communicate a compelling story that is relevant to clinicians and consumers.** The final rule language should explicitly communicate how the QPP requirements build on and modify existing programs, and what participants will need to do to meet program requirements, improve performance, avoid penalties, and earn positive payment adjustments.

    - CMS should increase understanding of the rule by including graphics/illustrations where possible to clarify the elements of the program and their inter-relationships.
    - CMS should clearly describe, with tables and graphics, which components of existing programs will change within MIPS, which will remain, and how the changes result in improved value and reduced burden for participants while improving person-centered care.
    - CMS should clearly explain how participating Eligible Clinicians will be benchmarked and how the payment incentives and adjustments will be applied under the QPP, ensuring that policies are clear and the scoring methodology is easy to understand.
    - CMS technical assistance, education and outreach efforts should extend well beyond those required in the MACRA statute and current planned efforts to ensure that eligible clinicians understand the benefits of the program and understand how they can engage and fully participate in MIPS and proceed into APMs.

DETAILED COMMENTS

i. **Develop additional visual materials to help providers understand the rule.** Add the following illustrations to the rule: a figure that depicts the overarching goals of MACRA and how the program components achieve their objectives to transform care; a diagram mapping the current programs to MIPS and APM to highlight how the new programs provide additional flexibility, reduce burden for the eligible clinician, and improve person-centered care; and a graphical depiction of how a clinician transitions from the MIPS program to an APM, highlighting the benefits of moving to an APM. (*See Sample Tables provided below as supplemental materials to this document.)*

ii. **Further revise the ACI category for clarity.** CMS should revisit its explanation of the base and performance scores under the ACI category. Combining the tables and scoring for the different components will allow providers to see the relationship between scoring and incentives and communicate the concepts more clearly.

iii. **Provide additional clarity around the CPIA Inventory.** Given the short and somewhat ambiguous definitions in Table H, CMS should enhance the clarity of the CPIA definitions so that providers understand more fully what they must do to qualify, and what they may be expected to retain as documentation and provide to an auditor.

2. **Identify opportunities to further simplify the final rule and reduce burden for eligible clinicians.** The Quality Payment Program, as a whole and within each component, will be very difficult for many providers to put in place, and for health IT developers and others to support. Without significant preparation, education, and coordination, QPP may be too challenging for the health care market to achieve within the proposed timeframe. CMS should seek to make the program highly accessible so that all eligible clinicians gain substantial proficiency in the steps required to succeed in MIPS, APMs, and in future Other Payer APMs.

    - CMS should take every opportunity to simplify program requirements, even at risk of reduced flexibility, so that the overall burden of understanding and complying with the program is reduced. CMS should build upon the NPRM's stated strategic goal to "advance a program that is meaningful, understandable, and flexible for participating MIPS eligible clinicians." (FR 28173)

DETAILED COMMENTS

i. **Adopt CMS primary proposal to reduce the number of objectives to report for ACI.** CMS should finalize the "primary proposal" (as opposed to the "alternate proposal") for objectives in the ACI category, which would remove objectives around CDS and CPOE that were finalized for the EHR Incentive Program. (FR 28220)

ii. **Create an "on-ramp" for the ACI category for eligible clinicians that have not participated in the EHR Incentive Programs.** While the NPRM has important provisions recognizing the challenges MIPS eligible clinicians face that have not previously participated in the EHR Incentive Programs in 2018, CMS can go further to reduce burden for these providers. CMS should acknowledge that health information exchange will be more challenging for behavioral health providers, and recognize they may have different exchange restrictions that will likely impact their ability to participate fully in the MIPS program. Possible strategies could include the following:
    - ***Adopt a shorter (6-month) reporting period***. For some eligible clinicians, implementation of CEHRT will be challenging, and a shorter reporting period may provide more time for eligible clinicians to install CEHRT and gather enough data to be eligible potentially for performance scoring incentives.
    - ***Reweight ACI scoring to other MIPS categories for providers without experience in Meaningful Use*.** CMS should use its authority to reweight ACI scoring to other MIPS categories until 2019 for newly eligible clinicians such as behavioral health providers, allowing these clinicians additional time to gain experience with CEHRT and ACI objectives and measure reporting. (FR 28232)

iii. **Significantly reduce process-oriented measures in the CPIA category and build on activities clinicians are already completing.** The current list of items in the CPIA Inventory is too

process-oriented and eligible clinicians will view attesting to the activities as "busy work" not connected to the Quality Payment Program's stated goals. Where relevant CPIAs are not otherwise available, CMS should reduce burden for clinicians by allowing deeming of certified improvement activities (e.g., professional certification through Maintenance of Certification Part IV) as partial or complete satisfaction of CPIA requirements. Minimize new process requirements in CPIA and reserve eligible CPIA tasks to those which improve care coordination or patient engagement.

iv. **More clearly integrate the use of health IT into the CPIA category.** CMS should emphasize the use of CPIA as a "test bed" for innovation to help identify how activities will lead to improved outcomes and readiness for APM participation, including: providing illustrative examples of how to meet CPIA activities and where health IT may play a role; identifying how CPIA elements relate back to capabilities in the 2015 Edition; and encouraging participants to test health IT functionalities that could be considered in future APMs and certification requirements.

v. **Reduce reporting burden for providers in APMs and assist providers in decision-making around APM participation.** Develop operational solutions to prevent the burden of dual reporting by potential Advanced APM participants (FR 28234). Possible strategies could include the following:

- Allow an eligible clinician that achieves QP status to automatically satisfy MIPS reporting for the following year if they indicate they plan to continue participation in an advanced APM, so that the eligible clinician is exempted from MIPS reporting for that year.
- Convey whether new models will have Advanced APM status when they are first publicly released, so that eligible clinicians will have that information when determining participation in new models.

3. **Focus policies more distinctly and clearly on the program's desired outcomes, especially interoperability and patient engagement.** Clearly delineate how each component within the Program aligns to drive delivery system reform.

- Ensure that each requirement throughout each program area clearly drives behavior toward care coordination, patient engagement, and effective information sharing. Otherwise, consider eliminating the requirement to help simplify the rule.
- Motivate clinicians to move towards advanced payment models by more strongly and clearly rewarding innovation and learning, rather than prescribing specific processes and accounting ("check the box").
- Focus on the outcomes that matter to patients and consumers, and incentivize measures of outcomes that are most important to them.
- Leverage and develop as needed HIE-sensitive performance measures to reward care coordination, patient engagement, and effective information sharing.

DETAILED COMMENTS

i. **Establish additional bonuses for performance on information sharing measures.** For future rulemaking, consider a scoring system that specifically rewards demonstrated electronic information sharing and patient engagement. CMS could award bonus points to be added to the composite performance score, as well as within individual MIPS performance categories, for eligible clinicians with marked improvement or achievement in these high-priority areas. (FR 28259)
ii. **Tailor rewards to outcomes achievement.** Over time, the rewards should be tailored to outcomes achievement (e.g., HIE-sensitive outcomes), and not on process measures that track certain capabilities within interoperability and patient engagement. (FR 28217)
iii. **Develop effective methods to reward clinicians for improvement.** For example, to reward improvement without penalizing baseline good performance, one could calculate progress towards the target goal on a relative basis. One method of calculating relative improvement is to set the target objective for a measure and calculate the % progress for "closing the gap" between the prior year's performance and the target goal [example: if the target is 70% and the provider achieved 50% last year and 60% this year, the % closing the gap = 10 / 70-50 = 50% closing the gap]. (FR 28217)

4. Take further advantage of opportunities under MACRA to promote more seamless measurement and reporting infrastructure across stakeholders. Encourage private payers to construct value-based programs that align with the QPP and to build in incentives to submit electronic clinical data using standards for data capture and format.

- Utilize the QPP to facilitate greater partnership among providers and public and private payers to reward information sharing, by building a common infrastructure for data submission that can be used by any payer, and simplifying and standardizing quality measures.
- Create a pathway for providers to move toward wholly electronic information collection, one that allows for equivalent information to be widely distributed to all qualified entities that request it.
- Make sure the most important information for Quality Measurement and Improvement is submitted to QCDRs, even if this is not imported electronically. Focus on the information first, and perfect the process over time.
- Normalize methods across domains and be clear what certified capability needs to be present.

DETAILED COMMENTS

i. **Increase bonuses for electronic reporting.** Increase the bonus from 5% to 10% within the MIPS Quality performance category for electronic reporting of quality measurement data derived from use of CEHRT. This percentage could be modified to a requirement rather than

a bonus structure in future years if the percentage of meaningful users of CEHRT reaches 75% and the ACI category weighting is reduced. (FR 28255-56)

ii. **Clarify where certified technology is required for third-party data submission methods.** CMS should clarify what constitutes a submission method that is required to be certified, and what does not need to meet certification criteria. This policy should avoid imposing new barriers on submission methods that did not previously exist.

iii. **Increase bonus points for using eCQMs.** Increase bonus from 1 to 2 points for providers using an eCQM for the high-priority reporting of patient safety, efficiency, patient experience, and care coordination measures, as these are deemed most critical to patient care and electronically reporting (FR 28255).

iv. **Clarify links to CMS measure development initiatives.** Directly reference language from the CMS Quality Measure Development Plan within final rule preamble language to demonstrate the breadth of changes CMS is undertaking to establish collaborative alignment between public and private payers.

v. **Allow sufficient time for developers to implement any new electronic clinical quality measures.** Based on the anticipated regulatory timeline for the Final Rule each year (by Nov. 1), if new electronic clinical quality measures or other QPP requirements that require implementation in HIT are introduced, CMS must allow at least 18 months between the announcement of the required functionality and the expected implementation date.

Quality Payment Program Task Force
On Behalf of the Health IT Policy and Standards Committees
Supporting Materials for Comments on the CMS Proposed Rule 5517-P

Sample Table Showing Implications of both Base and Performance Scores across Objectives in ACI Category

Objective	2017 Base Score (50 Points)	2017 Performance Score (80 Points)	2017 Bonus Point (added to Base + Performance)	2018 Base Score	2018 Performance Score	2018 Bonus Point
Use CEHRT 2014 Edition or 2015 Edition*	Use either			2015 Edition		
Do a security risk analysis or review*	Required			Required		
Attest that they are not info blocking*	Required			Required		
Have the function for implementing CDS including drug-drug, drug-allergy+	Required			Required		
Write at least 1 prescription electronically*	Required			Required		
Have the function for CPOE for medication orders+	Required			Required		
Have the function for CPOE for lab orders+	Required			Required		
Have the function for CPOE for radiology or diagnostic imaging orders+	Required			Required		
Provide access for at least 1 patient to VDT and API	Required API (optional)	Provide access to VDT for greater than 1 patient (10 points)		Required	Provide access to VDT and API for greater than 1 patient (10 points)	

Objective	2017 Base Score (50 Points)	2017 Performance Score (80 Points)	2017 Bonus Point (added to Base + Performance)	2018 Base Score	2018 Performance Score	2018 Bonus Point
Provide patient specific education for at least 1 patient	Required	Provide patient specific education for more than 1 patient (10 Points)		Required	Provide patient specific education for more than 1 patient (10 Points)	
Ensure at least 1 patient takes action to VD or T or to use an API to access their health information	Required API optional	More than 1 patient takes action to download, or transmit their record (10 Points)		Required API Required	More than 1 patient takes action to view, download, or transmit their record or to use an API to access their health information (10 Points)	
Send or respond to a secure message for at least 1 patient	Required	Send or respond to more than 1 secure message (10 points)		**Required**	Send or respond to more than 1 secure message (10 points)	
Incorporate patient generated health data, or data from a "non-clinical" setting, for at least 1 patient	Optional	Incorporate patient generated data (or data from a non-clinical setting) for more than 1 patient (10 points)		Required	Incorporate patient generated data (or data from a non-clinical setting) for more than 1 patient (10 points)	
Send an electronic summary of care document for at least 1 transition of care*+	Required	Send an electronic summary of care document for more than 1 transition or referral (10 points)		**Required**	Send an electronic summary of care document for more than 1 transition or referral (10 points)	

Objective	2017 Base Score (50 Points)	2017 Performance Score (80 Points)	2017 Bonus Point (added to Base + Performance)	2018 Base Score	2018 Performance Score	2018 Bonus Point
Receive directly, request and receive, or query and obtain at least 1 electronic summary of care document for a transition of care received[+]	Optional	Receive, request, or query for a summary of care document for more than 1 transition or referral (10 points)		Required	Receive, request, or query for a summary of care document for more than 1 transition or referral (10 points)	
Conduct medication reconciliation or clinical information reconciliation for at least 1 transition or referral	Required	Conduct medication, medication allergy, and problem list reconciliation for more than 1 transition of care or referral or patient never before seen by the provider Optional - Medication allergy and problem list reconciliation (10 points)		Required	Conduct medication, medication allergy, and problem list reconciliation for more than 1 transition of care or referral or patient never before seen by the provider (10 points)	
Report on immunizations	Required		Active engagement to report data to any public health agency or specialized registry beyond immunization Reporting (1 point)	Required		Active engagement to report data to any public health agency or specialized registry beyond immunization Reporting (1 point)

*These items are required for a meaningful user of EHR technology within the HITECH Act.

[+] These items are required as part of a qualifying EHR which must be used for a provider to be a meaningful user.

Quality Payment Program: Comparison of Existing Program and Proposed Requirements

Physician Quality Reporting System Transition to MIPS Quality Performance Category

PQRS in 2016	Quality in 2017
9 CQMs	6 CQMs 1 of which must be a cross-cutting measure, and 1 of which must be an outcome measure, or Another high priority measure if outcome is unavailable
CQMs must cover at least 3 of the 6 National Quality Strategy Domains	No domain requirement
Electronic reporting is the preferred (but not required) submission option.	Electronic reporting is an option which is incentivized by offering 1 potential bonus point per eCQM, up to 5% of total score, when reporting via "end-to-end" electronically. May report via CEHRT, QCDR, registry, or third-party vendor
Certification is required for electronic reporting.	Electronic reporting may take many forms as long as the data is captured using certified EHR technology.

Quality Payment Program: Comparison of Existing Program and Proposed Requirements

Medicare EHR Incentive Program to MIPS Advancing Care Information Performance Category

For EHR Incentive Programs in 2016 a provider must	Comparison	For MIPS ACI in 2017 an eligible clinician must	Comparison	For MIPS ACI in 2018 an eligible clinician must
Use CEHRT 2014 Edition	=	Use CEHRT 2014 Edition or 2015 Edition	=	Use CEHRT 2015 Edition
Do a security risk analysis or review	=	Do a security risk analysis or review	=	Do a security risk analysis or review
Attest that they are not info blocking	=	Attest that they are not info blocking	=	Attest that they are not info blocking
Implement 5 CDS plus drug-drug, drug-allergy	↓	Have the function for implementing CDS including drug-drug, drug-allergy	=	Have the function for implementing CDS including drug-drug, drug-allergy
Write 50% of prescriptions electronically	↓	Write at least 1 prescription electronically	=	Write at least 1 prescription electronically
Use CPOE for 60% of medication orders	↓	Have the function for CPOE for medication orders	=	Have the function for CPOE for medication orders
Use CPOE for 30% of lab orders	↓	Have the function for CPOE for lab orders	=	Have the function for CPOE for lab orders
Use CPOE for 30% of radiology orders	↓	Have the function for CPOE for radiology **Optional** May include all diagnostic imaging orders	=	Have the function for CPOE for diagnostic imaging orders
Provide Access for 50% of patients to VDT their health information	↓	Provide access for at least 1 patient to VDT **Optional** Provide access through an API	= ↑	Provide access for at least 1 patient to VDT and API

For EHR Incentive Programs in 2016 a provider must	Comparison	For MIPS ACI in 2017 an eligible clinician must	Comparison	For MIPS ACI in 2018 an eligible clinician must
Provide patient specific education for 10% of patients	↓	Provide patient specific education for at least 1 patient	=	Provide patient specific education for at least 1 patient
Ensure at least 1 patient takes action to VD or T their health information	=	Ensure at least 1 patient takes action to VD or T their health information	= IT↑	Ensure at least 1 patient takes action to VD or T or to use an API to access their health information
Send or respond to a secure message for at least 1 patient	=	Send or respond to a secure message for at least 1 patient	=	Send or respond to a secure message for at least 1 patient
Send an electronic summary of care document for 10% of transitions of care	↓	Send an electronic summary of care document for at least 1 transition of care	=	Send an electronic summary of care document for at least 1 transition of care
Conduct medication reconciliation for at least 50% of transitions and referrals	↓	**Required** Conduct medication reconciliation for at least 1 transition or referral **Optional** May conduct medication, medication allergy and problem list reconciliation	↑	**Required** Conduct medication reconciliation for at least 1 transition or referral **Required** Conduct medication, medication allergy and problem list reconciliation
Report to at least 2 public health registries	↓	Report on immunizations	=	Report on immunizations

For EHR Incentive Programs in 2016 a provider must	Comparison	For MIPS ACI in 2017 an eligible clinician must	Comparison	For MIPS ACI in 2018 an eligible clinician must
Not applicable	N/A	**Optional** Incorporate patient generated health data, or data from a "non-clinical" setting, for at least 1 patient	↑	**Required** Incorporate patient generated health data, or data from a "non-clinical" setting, for at least 1 patient
Not applicable	N/A	**Optional** Receive directly, request and receive, or query and obtain at least 1 electronic summary of care document for a transition of care received	↑	**Required** Receive directly, request and receive, or query and obtain at least 1 electronic summary of care document for a transition of care received