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*Intermountain Healthcare*

Charles Christian, LCHIME, FCHIME, CHCIO, FHIMSS  
(Foundation Chair) *Indiana Health Information Exchange*

Re: 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 Proposed Rule

Charles Anastos (Foundation Rep.)  
*Pricewaterhouse Coopers*

Cara Babachicos, CHCIO  
*Partners Healthcare*

Zane Burke (Foundation Rep.)  
*Cerner*

Dear Mr. Slavitt:

Myra Davis  
*Texas Children's Hospital*

The College of Healthcare Information Management Executives (CHIME) welcomes the opportunity to submit comments regarding the 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 proposed rule. This proposed rule was published by the Centers for Medicare & Medicaid Services (CMS) in the April 27, 2016, issue of the *Federal Register*.

Cletis Earle  
*St. Luke's Cornwall Hospital*

David Finn (Foundation Rep.)  
*Symantec Corporation*

CHIME has more than 1,900 members, composed of chief information officers (CIOs) and other senior information technology executives at hospitals and clinics across the nation. CHIME members are responsible for the selection and implementation of clinical and business information technology (IT) systems that will facilitate healthcare transformation.

Indranil Ganguly FCHIME, CHCIO, FHIMSS  
*JFK Health System*

Liz Johnson  
*Tenet Healthcare Corporation*

The majority of our comments pertain to the use of health IT as it relates to improving value and outcomes through CMS' proposals for standing up MIPS and APMs. Our members appreciate that CMS made a number of attempts to increase flexibility for clinicians. They are concerned, however, that the proposed rule creates a number of complexities that are challenging to navigate for clinical settings that lack both human and financial resources. To achieve success in multiple care settings, it is critical that CMS simplify the program, while maintaining the flexibility needed for clinicians to use technology in the manner best suited to drive care

Theresa Meadows  
*Cook Children's Healthcare System*

Frank Nydam (Foundation Rep.)  
*VMWare*

Albert Oriol  
*Rady Children's Hospital-San Diego*

Donna Roach  
*Via Christi Ascension Information Systems*

Jan-Eric Slot (International Rep.)  
*Bernhoven Hospital*

Russell P. Branzell, FCHIME, CHCIO  
(President & CEO) - CHIME

Dennis J. Gallitano, Esq. (General Counsel)  
*Gallitano & O'Connor LLP*

**College of Healthcare Information Management Executives (CHIME)**

710 Avis Drive, Suite 200 | Ann Arbor, MI 48108 | 734.665.0000 | [www.chimecentral.org](http://www.chimecentral.org)



improvements. Our comments are focused on the intersection of health IT and clinicians' ability to drive value and better patient outcomes.

Additionally, CHIME members stress that the requirements hospitals must meet under Meaningful Use program and the requirements that clinicians will be expected to meet under MIPS, must be as closely aligned as possible. Creating too many differences between these sets of requirements will add unnecessary complexity to the healthcare system and be unduly burdensome for providers to manage. Moreover, we continue to emphasize the need for greater flexibility for hospitals under Meaningful Use.

**Below is a summary of our top recommendations.**

- 1. Support for Health Information Exchange and the Prevention of Information Blocking**
  - a. **Modify the data blocking attestation statements.**
  - b. **Access to hospital's CEHRT for surveillance purposes must be reasonable and implemented with security as a high priority.**
- 2. Hospital alignment:**
  - a. **Create a more flexible approach for hospitals to meet Meaningful Use.**
  - b. **Do not to require Stage 3 attestation any earlier than the 2019 reporting year, yet those ready to move ahead should be able to do so.**
- 3. ACI Category:**
  - a. **Institute a 90-day reporting period for ACI.**
  - b. **Do not require reporting of Stage 3-like measures until 2019, yet those ready to move ahead should be permitted to do so.**
  - c. **Clinicians who are using modified Stage 2-like measures should be offered the same number of points to achieve 100 percent success in the ACI performance category as those using Stage 3-like measures by getting credit for meeting other Stage-2 like measures (i.e. CPOE and CDS).**
  - d. **Offer more than one bonus point for use of extra registries.**
  - e. **Institute a call for measures for future redesign of ACI category requirements.**
- 4. CPIA Category:**
  - a. **Give all activities the same weight (20 points each).**
  - b. **Add participation in OpenNotes to the CPIA category inventory.**
  - c. **Create a CPIA that gives credit to clinicians for engaging in security-related activities.**
  - d. **Offer credit in the form of a CPIA for using a Health Information Exchange (HIE).**
- 5. Quality Category:**
  - a. **Use a more flexible definition of end-to-end testing in order to incentive greater adoption of Certified Electronic Health Record Technology (CEHRT).**
  - b. **Increase the bonus potential to 10 percent for clinicians who use their CEHRT systems to capture and report quality information using end-to-end electronic reporting.**
- 6. APMs: Track 1 ACOs should be recognized as an Advanced APM.**



## I. Changes to Attestation

### A. Data Blocking

CHIME recognizes that effective April 1, 2016, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires both clinicians and hospitals to attest they are not “data blockers.” Accordingly, in this rule CMS calls on providers to demonstrate that they have not knowingly and willfully taken action (such as disabling functionality) to limit or restrict the compatibility or interoperability of CEHRT. We commend HHS for its interest in combatting information blocking practices within the healthcare industry. CHIME has long contended that there is no place for data blocking in healthcare and patients have a right to timely and secure access to their health information. However, we are concerned that CMS’ proposal, as outlined in the regulation, does not recognize the limitations of current technology, regulatory barriers, and challenges some resource-strapped providers face.

In terms of limiting or restricting the compatibility or interoperability of CEHRT, we offer a note of caution relative to the legal complexity that can ensue depending on how “information blocking” is defined. Technology, social, economic and community factors must all be accounted for and meticulously evaluated when determining what constitutes “information blocking.” CHIME believes that robust information exchange and nationwide interoperability can flourish only once we can confidently identify a patient across providers, locations and vendors, however, that is not happening today. We cannot stress enough, the importance of a coordinated national approach to linking patients to their healthcare data. Ensuring that patients are positively identified and matched to their records is a linchpin to increasing interoperability and improving the quality and safety of patient care, especially in a highly digitized environment. CHIME believes that when clear, enforceable standards are in play and patients can be safely and securely matched to their data in order to facilitate exchange, acts of blatant information blocking will become apparent.

A priority for CHIME is the importance of being able to confidently and consistently identify patients across the care continuum. Clinicians may experience challenges matching patients to their records when records are exchanged; however, this should not be considered data blocking. Given the current congressional prohibition on the Department of Health & Human Services’ (HHS) spending on developing a universal health identifier, CHIME, through its Healthcare Innovation Trust, has launched a [\\$1 million crowd-sourcing challenge](#) to find a safe, private and secure approach to ensure accurate patient identification. The first phase of the competition saw 113 innovators from around the world submit ideas; more than 350 individuals and teams from 40 countries have registered for the National Patient ID Challenge. We expect to announce a final patient identification solution in February 2017.

Facilitating information exchange still requires enormous effort and resources from providers. Having to attest to the data blocking statement as proposed puts many providers at risk of noncompliance through no fault of their own. Further, there are still a number of challenges with exchanging information that are not indicative, from our perspective, of data blocking by providers. In fact, many of our members are seeing more challenges exchanging data with other providers than they are with providing timely access for patients to their information.

In terms of the second proposed attestation statement which references standards, if providers are being asked to attest that they have been compliant with the standards applicable to exchange information, it’s imperative that such standards are clearly defined and appropriately matured to facilitate meaningful data exchange. While a focus on standards may seem overly simplistic, a more defined technical infrastructure is needed to catalyze innovations



in digital health. **Because the work underway at the Office of the National Coordinator for Health IT (ONC) to tackle these challenges is not yet complete, CMS is inadvertently asking providers to attest to more than they reasonably can at this time. The attestations in the final rule should be modified to recognize this.**

In acknowledging the limitations around interoperability, under no circumstances can we support a requirement that is interpreted as meaning providers must provide direct electronic feeds to other providers since the capability to support is prohibitively expensive to establish between all likely providers.

**Recommendations:**

**CHIME offers the following, suggested revisions to the data blocking, attestation statements:**

- 1. For the first attestation statement, “Did not knowingly and willfully take action (such as to disable functionality) to limit or restrict the compatibility or interoperability of certified EHR technology,” we recommend CMS clarify how providers can meet this requirement while factoring in the real life challenges we describe above.**
- 2. Modify attestation statement # No. 2, to read: “Implemented policies that the certified EHR technology was at all relevant times: connected in accordance with applicable law; implemented in a manner that allowed for timely access by patients to their electronic health information.”**
- 3. Modify attestation statement # No. 3 to read: “Responded in good faith and in a timely manner to requests to retrieve or exchange electronic health information.”**

**B. Surveillance of CEHRT**

CMS proposes that as part of demonstrating meaningful use of CEHRT, an eligible professional, eligible hospital, or Critical Access Hospital (CAH) must attest that they have cooperated in good faith with ONC surveillance and direct review of CEHRT. A similar attestation is proposed for eligible clinicians under the Advancing Care Information (ACI) category of MIPS. Such cooperation would include accommodating ONC or ONC-Authorized Certification Bodies (ONC-ACBs) requests for access to a provider’s CEHRT for the purpose of executing surveillance activities. We appreciate that CMS has conditioned this requirement by stating that such access would be allowed, “to the extent that doing so would not compromise patient care or be unduly burdensome for the eligible clinician, EP, eligible hospital, or CAH.”

While we appreciate ONC’s efforts to oversee CEHRT to ensure products are performing as intended, we have three major concerns with the provision as proposed. First, we are concerned that this requirement could pose a security threat unless implemented with adequate precautions. Our members do not agree that the federal government, or their designees, should be provided unlimited access to the CEHRT itself. Second, it could be very hard to monitor such access. Maintaining access or creating generic accounts to facilitate such access is labor-intensive and extremely costly. Third, while we recognize the proposed rule indicates that ONC-ACBs would be considered "health oversight agencies" per the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, our concerns go beyond HIPAA violations. Providers work daily to protect their systems from attacks and granting unrestricted access to a provider’s EHR could introduce more security threats depending upon how this is operationalized.



**Recommendation:**

**CMS should make clear that requests for access to an eligible clinician's, eligible hospital's or CAH's CEHRT for surveillance purposes must be reasonable and implemented with security as a high priority.**

**II. Need for Flexibility and Alignment with Hospitals**

CHIME continues to have many concerns with the fact that hospitals and clinicians are on separate trajectories for pathways to achieve Meaningful Use. We appreciate, as discussed in more detail later in our letter, that CMS has made efforts to improve flexibility for clinicians in proposing requirements for the ACI category. However, we are very concerned that hospitals are still governed by onerous Meaningful Use criteria. The "pass / fail" construct and full year reporting period -- which is far too long given all of the challenges hospitals and CAHs are experiencing -- does not advance interoperability enough to achieve the goals of a value-based delivery system.

**Recommendations:**

**Consistent with the ongoing feedback we have offered the agency in the past, we continue to request relief for hospitals under Meaningful Use. Specifically, we request CMS:**

- 1. Create a more flexible approach for hospitals to meet Meaningful Use. Most importantly, CMS should eliminate the "pass / fail" approach to determining whether a hospital or CAH has met Meaningful Use requirements. Hospitals should not be penalized if they meet most but not all requirements.**
- 2. Do not require that hospitals meet Stage 3 any earlier than the 2019 reporting year, which will provide a much-needed level of stability and more time for vendors to meet CHEHRT mandates. Those ready to do so, should be permitted to move ahead though.**

**III. MIPS**

Under MIPS, eligible clinicians will have an opportunity to accrue points under four different categories of performance: 1) Advanced Care Improvements; 2) Quality; 3) Clinical Practice Improvement Activities (CPIA); and 4) Resource Use. CMS will use a 100-point system to arrive at a composite performance score (CPS) which will determine their reimbursement beginning with the 2019 payment year.

**A. Advanced Care Improvements (ACI)**

The ACI category is derived from the measures under the Meaningful Use program for eligible professionals. MACRA requires the ACI category represent 25 percent of the overall CPS score for 2019 payment. CMS proposes a two-part grading system. The maximum score a clinician could achieve under this portion of the CPS is 100



points; however, to assist clinicians in achieving as many points as possible, the proposal would make a total of 131 points available. While CHIME appreciates that CMS made an effort to increase the flexibility with the ACI portion of MIPS, we believe further changes are warranted.

*i. Reporting Period*

**CHIME strongly opposes the proposed full year reporting period of January 1, 2017 through December 31, 2017 for the ACI category.** We are very concerned that CMS has underestimated the ability of vendors to deliver, and clinicians to adopt, the necessary updated software in time for January 1, 2017. The rule must be finalized by November 1, 2016, thus leaving only 60 days for all of this to happen which we believe is entirely unrealistic. This schedule would rush new software to the marketplace and leave little if any time to test and safely deploy it. Further, the MIPS requirements are complex, and there are many moving pieces which may be difficult for providers to navigate. Adopting a 90-day reporting period for this component will help clinicians focus on other aspects and become acclimated to the program. They will be adjusting to a new way of business not only for the ACI category, but in managing change associated with the other components of this rule.

**Recommendations:**

- 1. Institute a 90-day reporting period for ACI.**

*ii. Primary Base Score*

Under the ACI base score (worth 50 out of the 131 total available points), clinicians would be evaluated on measure reporting. CMS has proposed a “primary” base score and an “alternate” base score option for clinicians. Under both approaches clinicians would report the measure numerators and denominator of at least one patient; for “yes / no” measures at least one “yes” response would be required. Additionally, clinicians would also need to report that they successfully met the risk assessment requirement. The primary base score includes 11 measures that clinicians would be required to report, including e-prescribing but excluding computerized clinician order entry (CPOE) and clinical decision support (CDS) measures which are included in the alternate base score. All these measures would be included under the alternate base score option, for a total of 16 measures.

We appreciate the effort CMS has made to create certain flexibilities in proposing the ACI category requirements that do not exist within the Meaningful Use program. Notably, CMS has made efforts to remove the “pass / fail” approach that has plagued providers under Meaningful Use. **CHIME has concluded that the ability to meet the base score seems fairly straightforward, and should be attainable for many clinicians. However, we believe Stage 3-like measures should not be required before the 2019 reporting year. Also, some small providers may find it unnecessarily punitive to fail a clinician for the entire ACI score for failure to report a single measure’s denominator (or “yes” response).**

**Recommendation:**

- 1. CHIME supports CMS adopting the primary base score consisting of 11 measures, however, Stage 3-like measures should not be required prior to the 2019 reporting year.**





***iii. Using Version 2014 CERHT in 2017 (CMS refers to as “Base Score Modified Primary and Alternate Proposals for Modified Stage 2 (in 2017))***

The proposed base score is premised on the assumption that clinicians would report Stage 3-like measures. However, CMS acknowledges that some clinicians may not have Version 2015 CEHRT, which is needed in order to meet some of the more advanced measures. Therefore, for 2017 only, CMS proposes a pathway for those who either don't have the requisite software or who are not yet ready to report Stage 3-like measures. For clinicians who choose this pathway, CMS proposes they would have to meet 16 measures, however, these would differ slightly from those under the primary and alternate base proposals. Specifically, clinicians would not be required to report the more advanced exchange measures (patient care record exchange and request/accept patient care record), the patient-generated data measure, and the more expansive medical record reconciliation measure. However, they would have to report on two additional public health reporting measures (on top of immunization) including syndromic surveillance and specialized registry reporting requirements.

**As noted above, CHIME has serious concerns with CMS' assumption that Version 2015 of CEHRT will be widely available for use by clinicians by January 1, 2017.** Vendors have made it clear they will not be ready to deploy Version 2015 CERHT on a wide-scale basis beginning in 2017, which jeopardizes provider readiness. CHIME continues to believe, as we have expressed in the past, that most providers will not be properly situated to meet Stage 3 prior to 2019, leaving insufficient time to adjust to Modified Stage 2 measures and requiring a leap to Stage 3 prematurely. Based upon historical performance, many providers have needed three years at a single stage before advancing to the next stage.

**CHIME continues to believe that Stage 3 or the use of Stage 3-like measures, should not be required any sooner than the 2019 reporting year. Moreover, CMS has previously made use of Version 2015 CEHRT optional for Meaningful Users in 2017. Most hospitals are not planning on moving to Version 2015 CEHRT prior to January 1, 2017, which affects those clinicians who obtain their EHRs from hospitals. For the purpose of MIPS, given most measures under the base and alternate proposal are reliant upon a Stage 3-like construct requiring Version 2015 CEHRT, we are very concerned that most clinicians will not be able to meet all the base or alternate base requirements and will be forced to pursue the “base score modified alternative” pathway. Without their ability to meet Stage-3 like measures this could markedly impact their ability to maximize their ACI score. Nonetheless, to the degree there are some clinicians ready to advance to Stage-3 like measures in 2017, CHIME believes they should be permitted to do so.**

**Recommendation:**

- 1. CHIME recommends CMS make meeting Stage 3-like measures optional and not require their use until the 2019 reporting year.**
- 2. CMS should permit clinicians to report using modified Stage 2-like measures through 2018.**

***iv. Performance Score***

Under the ACI category performance score, clinicians would be assessed on up to eight measures which are carried over from Meaningful Use Stage 3. The eight measures are: 1) patient electronic access to their



information; 2) patient education; 3) view, download and transmit; 4) secure messaging; 5) patient-generated data; 6) patient care record exchange; 7) request / accept patient care record; and 8) clinical information reconciliation. Proposing a maximum possible performance score of 80 points offers various ways for clinicians to achieve the 50 points needed for a maximum score on the ACI performance category. **CHIME appreciates CMS' efforts in this area to give clinicians credit without risking complete failure for meeting some measures (and a portion of each) vs. all measures as is the case today under Meaningful Use.** However, because we believe that most clinicians will be not be able to report on Stage 3 measures until the 2019 reporting year, we are concerned that it may be difficult to achieve performance points based on Stage 3 measures.

CMS has also proposed a single extra bonus point for use of additional registries above and beyond the required immunization use. It's important to recognize the limited capabilities of many public health and clinical data registries. There is great variability in data definitions to facilitate data exchange and standardization is necessary across organizations and states. CHIME members continue to cite the complexity around capturing and reporting other registry data. While most providers currently capture a significant amount of data in a discrete manner, registry reporting still relies heavily on manually abstracted data. **CHIME appreciates the flexibility in achieving points but we believe the proposal for one extra point for the use of registries falls short of the credit a clinician should receive for investing and using a registry given the tremendous amount of effort associated with their use.**

#### **Recommendations:**

- 1. Clinicians who are using modified Stage 2-like measures should be offered the same number of points to achieve 100 percent success in the ACI performance category as those using Stage 3-like measures by getting credit for meeting other Stage-2 like measures (i.e. CPOE and CDS).**
- 2. CMS should offer more than one bonus point for use of extra registries.**

#### ***v. Driving Patient Care and Outcomes Requires Integrated Approach***

There appears to be a disconnect between many of the various sections comprising the CPS score. CMS states at the outset of the rule that they are "focused on three core strategies to drive continued progress and improvement." These include: 1) Focusing on improving the way clinicians are paid to incentivize quality and value of care over simply quantity of services; 2) improving the way care is delivered by providing clinical practice support, data and feedback reports to guide improvement and better decision-making; and 3) making data more available and enabling the use of CEHRT to support care delivery. The ability to accomplish much of this is rooted in clinicians having the appropriate technology and functionality.

As noted above, CHIME acknowledges CMS' attempts to offer more flexibility in the ACI section; however, we question whether this category will support delivery system reform and drive better care. Given how unlikely it would be to substantially change the measures in ACI before 2017, we believe that changes to the measures within ACI should be explored for future years in order to best support quality improvement, outcomes, care coordination, and value. We offer the example of behavioral health. The CPIA section contains behavioral health activities, yet today's EHRs are not designed to handle this type of sensitive information. Encouraging clinicians to engage in these activities needs to be supported by technology that facilitates this.





Further, there are several activities under the CPIA which are health-IT specific and other measures that are not health-IT specific, but could benefit from the use of different technologies, which may or may not be part of an EHR. Ensuring clinicians are supported in their pursuit of better outcomes and value will require they be permitted to be nimble in how they use health IT.

**Recommendation:**

- 1. Similar to the quality and CPIA sections, which include a call for measures, we recommend CMS do the same for ACI by seeking stakeholder feedback on what technology-related requirements will best support clinicians in their pursuit for better outcomes and value.**

**B. Clinical Practice Improvement Activities (CPIA)**

For 2019 payment, CPIA will represent 15 percent of the total CPS score. Since CPIA is a brand new category, CMS will not have any baseline data upon which it can assess past performance. There will be 60 possible points available to clinicians under this category. Clinicians would be rewarded for activities such as those focused on care coordination, beneficiary engagement, and patient safety. For the 2017 performance period, clinicians would report on activities they select from a list with more than 90 choices.

**i. Reporting Period**

CMS proposes CPIAs must be reported for at least 90 days during the performance period (calendar year 2017 for 2019 payment). Activities may be ongoing as long as they are reported for a 90-day period; CMS plans on expanding the reporting period for CPIAs in the future. **CHIME strongly supports the proposed 90 day-reporting period for this category.**

CMS will allow submission of data using a qualified registry, EHR, qualified clinical data registries (QCDRs), CMS Web Interface and attestation data submission mechanisms and will use claims data when possible. CHIME looks forward to seeing more details from CMS on how reporting would occur, as this is not outlined in detail in the proposed rule. For the purpose of audits, we seek additional detail from CMS as to how a provider will be expected to substantiate their activities. Precious vendor development time should not be used unnecessarily simply to facilitate audits in this space.

**ii. Scoring**

CMS proposes to weight some activities as “medium” and others as “high.” Medium activities would count for 10 points while high activities would count for 20 points. Clinicians can choose a mix of activities to reach the total 60 points. CHIME is very pleased with the flexibility and number of activities that have been proposed by CMS which would count as CPIAs. Many in fact are health-IT specific. However, we disagree with CMS’ proposal to weight some activities as medium and others as high. We believe this is too subjective and, depending upon the individual clinician, one activity that may be considered “harder” to achieve may indeed be easier for another clinician.

**Recommendation:**

- 1. We recommend CMS weight all CPIA activities the same (20 points each).**



### iii. New Activities

CHIME recommends that three additional activities be added to the list of CPIA choices for 2017. First, is participation in the OpenNotes program, an initiative aimed at empowering patients to become more involved in their care by providing easy and secure access to the medical notes in their EHR. This program has been widely supported by the administration and is an excellent example of how clinicians can better engage their patients. Through CHIME's [partnership with the OpenNotes](#), which was announced during the White House precision medicine event on February 26<sup>th</sup>, our goal is to help expand this access from the 5 million patients who have this today, to 50 million in the next three years. However, it is worth pointing out that the "view, download, and transmit" measure under ACI does not give credit for participating in Open Notes, thus we believe it is another reason that inclusion in the list of CPIA activities makes sense.

Additionally, notably absent from the proposed inventory shown in Table H, were any activities related to protecting and securing patient information. Given the proliferation of patient information that is expected to flow as clinicians begin offering access to patients' medical information facilitated by application programming interfaces (APIs) and other applications, we believe clinicians should be incented for activities aimed at ensuring this information is protected.

Finally, given the priority around speeding interoperability and data exchange, we believe it makes sense to offer credit for participation in a health information exchange (HIE).

#### Recommendations:

1. **Include participating in OpenNotes among the activities for which clinicians could get credit under CPIA for 2017.**
2. **Create a CPIA that gives credit to clinicians for engaging in activities that strengthen their systems to better protect patient information such as improving anti-phishing or ransomware deterrent software.**
3. **Offer credit in the form of a CPIA for using an HIE.**

### C. Quality

The quality performance category will account for 50 percent of the CPS for the 2019 payment year, as required under MACRA. CMS has proposed a 12-month performance period for this and all categories, and clinicians would need to report at least six measures including one cross-cutting measure and at least one outcome measure. Each measure would be scored using performance benchmarks and a 10-point system to universally compare different types of measures across different types of MIPS eligible clinicians. **CHIME supports CMS' proposal that allows clinicians to get credit for performance on any measures reported even if they do not meet all the reporting requirements.**

#### i. Incentives to use CEHRT

Pursuant to MACRA, CMS is required to encourage clinicians to use CERHT or QCDRs to report quality measures. To meet this mandate CMS has proposed a scoring incentive for clinicians who use their CEHRT systems to



capture and report quality information. Under the proposal clinicians would receive one bonus point under the quality performance category score, up to a maximum of 5 percent of the denominator of the quality performance category score, if they engaged in what CMS has termed “end-to-end electronic reporting,” a cap we believe is too low. Specifically, clinicians could receive this bonus if:

1. They use CEHRT to record the measure’s demographic and clinical data elements in conformance to the standards relevant for the measure and submission pathway, including but not necessarily limited to the standards included in the CEHRT definition proposed in 414.1305;
2. Export and transmit measure data electronically to a third party using relevant standards or directly to CMS using a submission method as defined at §414.1325; and
3. The third party intermediary (for example, a QCDR) uses automated software to aggregate measure data, calculate measures, perform any filtering of measurement data, and submit the data electronically to CMS using a submission method as defined at §414.1325.

**CHIME appreciates that CMS is looking for ways to encourage use of CEHRT by adding bonus points for clinicians.** We also agree that the end goal should be end-to-end electronic reporting and recognize that CMS is interested in progressing to a reporting system under which manual entry of data is unnecessary. While end-to-end electronic reporting is a sound policy goal, the vast majority of providers are not able to accomplish this today. Most hospitals, for instance, use a third party to help facilitate data extraction and reporting. Clinicians continue to report data in unstructured text fields, and EHRs are not yet designed to capture the data needed to substantiate numerators and denominators due to the data residing in multiple areas of the EHR.

**Recommendation:**

1. **The incentive to encourage the use of CEHRT should use a more flexible definition of end-to-end testing that permits clinicians to scrub data for accuracy prior to submission.**
2. **Increase the bonus potential to 10 percent, up from the five percent of the denominator as proposed, for clinicians who use their CEHRT systems to capture and report quality information using end-to-end electronic reporting.**

**ii. Application of Additional System Measures**

MACRA allows CMS to use measures used for payment systems other than for physicians, such as measures used for inpatient hospitals, for purposes of the quality and resource use performance categories. CMS notes in the proposed rule that it is considering for future years an option for facility-based clinicians to elect to use their institution’s performance rates as a proxy for the MIPS’ clinician’s quality score. This could allow clinicians working in hospitals to base MIPS performance on hospital quality reporting measures. **CHIME strongly endorses this proposal.**

**IV. Alternative Payment Models**

MACRA also creates incentives for clinician participation in APMs. Starting in 2019, clinicians who meet the requirements to be a “qualified professional” (QP) for a year will be excluded from MIPS and may qualify for a lump



sum payment equal to 5 percent of their previous year's Medicare fee-for-service reimbursement. To be a QP in 2019 or 2020 a clinician must meet certain thresholds for participating in a designated Medicare "Advanced APM."

A critical component of how CMS defines an Advanced APM is the amount of financial risk the entity takes on. Many stakeholders believe that CMS has set the bar too high and that in particular is not accounting for the substantial up-front business investments that accountable care organizations (ACOs) have made to participate in Track 1 of the Medicare Shared Savings Program. CHIME agrees. We believe that the substantial investments (some more than a million dollars) up front should count towards CMS' financial risk criterion.

**Recommendation:**

- 1. We urge CMS to modify its definition of nominal risk so clinicians participating in other APM programs, like Track 1 ACOs, will be credited as participating in an Advanced APM.**

**V. Conclusion**

CHIME appreciates the opportunity to comment on CMS' proposed rule. We look forward to remaining engaged to ensure that clinicians are afforded every opportunity to leverage health IT under the physician fee schedule as modified by MACRA and that the use of technology can best support their drive towards better value and patient outcomes. Should you have any questions concerning our comments please contact Mari Savickis, vice president, Federal Affairs at [msavickis@chimecentral.org](mailto:msavickis@chimecentral.org).

Sincerely,

A handwritten signature in black ink, appearing to read "Russell F. Branzell".

Russell Branzell, FCHIME, CHCIO  
CEO & President, CHIME

A handwritten signature in black ink, appearing to read "Marc Probst".

Marc Probst, CHCIO  
Chairman, CHIME Board of Trustees & CIO, Intermountain Healthcare