August 21, 2017

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Administrator Verma:

The College of Healthcare Information Management Executives (CHIME) welcomes the opportunity to submit comments regarding the Centers for Medicare & Medicaid Services' (CMS) proposed rule, *Medicare Program; CY 2018 Updates to the Quality Payment Program*, published on June 30, 2017.

CHIME is an executive organization serving more than 2,400 chief information officers (CIOs) and other senior health information technology leaders at hospitals and clinics across the nation. CHIME members are responsible for the selection and implementation of clinical and business technology systems that are facilitating healthcare transformation.

CHIME appreciates the opportunity to comment on the proposed QPP rule for Year 2. Our comments will focus largely on the MIPS program. Below is an overview of our chief recommendations followed by a more detailed discussion.

I. Key Recommendations

1. **Reduce Complexity:** CHIME's single largest concern with the MIPS program is that it is too complex and difficult to navigate and more efforts to streamline it are needed.
2. **Advancing Care Information:** Finalize the proposal for allowing the use of 2014 Edition certified electronic health record (CEHRT) and meeting the "Transition" (aka Modified Stage 2-like) measures in 2018.
3. **Cost:** Finalize a weight of 0 percent weight for 2018.
4. **Quality:** Retain a minimum of 90-days reporting for the quality, Advancing Care Information (ACI), and Improvement Activities (IA) categories in perpetuity.
5. **Improvement Activities**: Add measures that reward clinicians for using innovative technologies not addressed by CEHRT, and give credit to clinicians for taking steps to improve their cybersecurity posture.

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II. MIPS Provisions

A. CEHRT & Flexibilities for Year 2

We strongly support CMS' proposal to continue many of the policies under 2017's "pick-your-pace" into Year 2 beginning in 2018. Specifically, we are very pleased CMS took our and other stakeholders' feedback into account in calling for clinicians to continue using Transition measures, as well as 2014 Edition CEHRT in 2018. Many clinicians still do not have access to the 2015 Edition CEHRT, jeopardizing their chances of being successful in the ACI category. As recently as the start of August we have members reporting that they are not sure when they expect to receive their 2015 Edition CEHRT. Therefore, permitting clinicians to continue using the 2014 Edition and Stage 2 measures provides much needed relief and removes the likelihood of forgoing credit in this performance category for a situation that is well outside their control.

Additionally, we strongly endorse CMS' proposal to allow another year to transition to 2015 Edition CEHRT and Stage 3 as this will align well with the recently finalized policies in the Inpatient Prospective Payment System (IPPS) rule for hospitals. It is critical, from our members' perspective, that CMS programs be as closely aligned as possible to remove uncertainly, confusion and unnecessary regulatory burdens for providers. As one of our members reflected, "I have some vendors who will not be certified by January 1. Some of my vendors may never be certified (to 2015 Edition)."

B. Further Need for Streamlining and Removing Complexity

CHIME appreciates that CMS is making some strides to reduce regulatory complexity and we strongly support CMS' efforts to meet this goal. As CMS continues to consider ways to reduce the regulatory burden for providers, we respectfully request you take the following input into consideration.

The overall picture being painted by our members implementing MIPS is that it is extremely complicated and there is a resounding need to further simplify the program. We understand that the MACRA statute is fairly prescriptive in many areas and that CMS' ability to revise some policies is limited. There are ways within the existing law, however, for CMS to streamline the current policies and make them less burdensome for clinicians. For instance, we would prefer that rather than layering on multiple new and complicated bonus structures such as the one for improving quality, that CMS instead look to ways to take a more minimalistic approach that removes rather than adds more layers.

The current program requirements are complicated for even larger groups to navigate and we worry the complexity will be too much for smaller groups and individual clinicians to manage. **From our perspective, the focus should be on minimizing the complexity within each performance category, providing a straightforward set of measures that must be met by clinicians in each, and working to ensure that MIPS and other reporting programs are harmonized as much as possible. Many of our members operate in both the hospital and physician practice space and they report that with each passing year, their ability to navigate CMS reporting programs' policies becomes more complicated. Specifically, they cite the divergence among MIPS, Meaningful Use Medicare hospital policies, Meaningful Use Medicaid provider policies, and specific quality reporting programs as being extremely challenging to manage collectively. More than anything else, they seek simplification and consistency from year to year.**

C. Performance Periods

CMS established a performance period of a minimum of 90 days for the first year of MIPS for the ACI, IA and quality categories (with limited exceptions for quality, including web-based interface submissions) performance periods. For Year 2, CMS has called for a minimum of 90 days for the ACI and IA performance categories, and a full year for the cost and quality performance categories. Adopting a full-year performance period under MIPS for quality reporting will not align it with what CMS has proposed for hospitals. Recently, CMS finalized in the IPPS final rule a reporting period for 2018 consisting of any continuous 90 days for Meaningful Use and any single quarter for the Inpatient Quality Reporting Program for both 2018 and 2019. **CHIME appreciates that CMS has proposed retaining a 90-day minimum reporting period for ACI and IA categories; however, we believe this same reporting period should also be extended to the quality category. CHIME members have consistently**

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sought a less than full-year reporting period for all CMS reporting programs. Last, we recommend CMS establish 90 days across all reporting programs to improve consistency (including removing quarterly reporting for hospitals).

D. Performance Threshold

For 2017, in order for clinicians to avert a financial penalty of negative four percent (-4%) in 2019 under MIPS, they must meet a performance threshold of at least three points. For 2018 (2020 payment) CMS has proposed increasing the payment threshold to 15 points. **CHIME supports CMS' proposal.**

E. Data Submission Flexibilities

CMS permits data to be submitted through a variety of mechanisms (i.e., QCDR, Qualified Registry, EHR, claims) which vary by performance category. For 2017, CMS finalized allowing clinicians to use only one submission mechanism per performance category. However, beginning in 2018 and beyond CMS has called for allowing clinicians to use multiple submission mechanisms for a single category to increase reporting flexibility.

Generally speaking, CHIME appreciates that CMS has proposed to allow a more flexible approach to reporting data. We think the proposal that calls for CMS to select the higher performing score on a measure/activity submitted multiple ways is helpful. We do think there could be some burdens with requiring clinicians to use multiple reporting mechanisms if they have fewer than the required number of measures and activities applicable and available under one submission mechanism but understand, as CMS notes, that the requirements for the performance categories remain the same regardless of the number of submission mechanisms used.

F. New Bonus Points for Small Practices

New for 2018 is CMS' proposal to offer a small practice a bonus that would be calculated by adjusting the final score of any eligible clinician or group in a small practice (defined in the regulations as 15 or fewer professionals) by adding five points to the final score. This would be allowed as long as the eligible clinician or group submits data on at least one performance category in an applicable performance period. CHIME appreciates the efforts to support small practices. Our members are concerned that there are several practices that consider themselves small – many of them in rural areas – but which fail to meet the definition of "small." Specifically, we refer to practices that rely heavily on part-time clinicians and locum tenems to meet staffing needs. As one member reflected, she has to "get five people to cover a single clinician" and the policy is tied to the clinician's taxpayer identification number (TIN). With more than 15 TINs, the practice cannot take advantage of the small practice bonus even though not all of the TINs are full-time.

We understand that CMS is bound by the statutory definition of a small practice, but nonetheless want to share with CMS our concerns around how this requirement is having unintended consequences for small practices, including those in rural locations. This policy is hurting the very ones it is intended to help. Although we worry about creating too many additional layers of complexity with multiple bonus structures, given these limitations we support the new bonus points policy proposed by CMS for small practices.

G. Feedback Reports

Under MACRA, CMS is required to make feedback reports available to providers starting July 1, 2017 on the quality and cost performance categories with the option to also furnish reports on IA and ACI. It is our understanding that clinicians have not yet received their first reports and CMS has proposed providing cost performance feedback in the fall of 2017. Concerning the format of feedback on cost measures, we are considering utilizing the parts of the Quality and Resource Use Reports (QRURs) that user testing has revealed beneficial while making the overall look and feel usable to clinicians. CMS has also proposed that starting July 1, 2018 they will supply clinicians with feedback reports on cost and quality and if possible IA and ACI data. CMS proposes to make this data available annually and more frequently if possible. Specifically, for the cost category, CMS plans to offer feedback in the fall of 2017 and summer of 2018 on a new set of episode-based cost measures.

CMS is seeking comments on Quality and Resource Use Reports (QRURs). It is the agency's expectation that they will offer clinicians access to these newly formatted reports by July 1, 2018 via the CMS website. **As CMS rolls out**

the QRURs under MIPS, we agree with CMS that outreach to clinicians will be needed on these reports and recommend that they offer education to ensure the reports are well-understood.

Given CMS' requirements in several reporting programs that providers use certified EHRs to help them successfully meet a multitude of requirements, we believe that the certification requirements for these systems include the ability to send and receive data directly to and from CMS. We urge CMS to work with ONC to fold this into future certification requirements. Additionally, providing a direct feed between CMS and certified EHRs could help reduce costly middleware products used by our members and would serve to ease the burden on providers having to hunt down their reports.

H. Improving Performance

We recognize that the statute requires CMS, when scoring clinicians, to account for historical performance standards, improvement and the opportunity for continued improvement. In the rule, CMS has proposed to reward improvements in quality and cost. As noted earlier in our letter, our members are very concerned that this program is overly complex. **We believe that CMS' proposal for rewarding performance will add another layer of complexity and we recommend CMS not adopt this proposal. Rather, we recommend instead that the score a clinician accrues under these categories each year should adequately depict a clinician's performance and improvement over time. We also wonder whether this new policy could result in a scenario where some clinicians "low ball" their performance this year so they can benefit more next year.**

I. Facility-based Measurement

The statute permits CMS to use measurement data attained through another CMS reporting program (i.e. inpatient hospital) for the purposes of meeting the cost and quality performance categories of MIPS. CMS did not make this option available in 2017 and in our comment letter last year we supported adding it for quality measurement for future years. CMS has proposed offering this as an option for both the cost and performance categories for clinicians who have at least 75 percent of their covered professional services supplied in the inpatient hospital setting or emergency department. **CHIME supports allowing clinicians to use facility-based data to meet MIPS as this has the potential for reducing the reporting burden on clinicians. However, the formula CMS has outlined for achieving this is very complicated and we urge the agency to look for ways to simplify this.**

J. Low-volume Thresholds

For 2017, CMS established a low-volume threshold allowing clinicians who have $30,000 or less in Part B charges or 100 or fewer Medicare beneficiaries to be exempt from MIPS. CMS has proposed to expand the low-volume thresholds to be $90,000 or less in Part B charges or 200 or fewer Medicare beneficiaries. While we understand the rationale for increasing the thresholds, providers have been working with these clinicians and know who is in and who is out of MIPS. **Changing the thresholds takes clinicians out of the pool who may already be participating, who want to continue participating, and could create more work than less for those who have already begun working with these clinicians. We recommend retaining the existing thresholds and making the higher threshold optional.**

CMS is also proposing a new policy that would allow clinicians to opt into MIPS if they meet one or two of the low-volume thresholds described above. **CHIME supports CMS' proposal to allow clinicians to opt into MIPS. Further, we recommend CMS adopt a similar policy for 2017.**

K. Information Blocking

CHIME continues to have concerns with CMS' approach around the information blocking attestation statements. We have outlined our concerns in detail in our December 16, 2016 letter in response to the MIPS final rule with comment for 2017, as well as, our comment letter dated June 27, 2016 in response to the proposed rule. In short, we feel the 2nd and 3rd attestation statements CMS has finalized exceed what is required in statute. **We recommend CMS: 1) Limit the data blocking attestation to statement one at this time; 2) Do not require providers to attest to the exchange of structured data; and 3) Adopt an appeals process.**

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III. MIPS Performance Categories

A. COST

Last year CMS finalized a policy for 2018 which would weight the cost category at 10 percent. However, in the proposed rule CMS has called for maintaining the same weight established for 2017, which is 0 percent. We understand CMS is bound by the statute to weight this category at 30 percent beginning in 2019; however, we feel that an increase from 0 percent to 30 percent from 2018 to 2019 is too precipitous of an increase and our members are very concerned about that the cost category will be weighed this high so soon. **Ideally, we would like to see the cost category remain weighed at zero for now and increased to 10 percent in 2019. We recommend CMS finalize their proposal for maintaining a weight of 0 percent for Year 2 in 2018.**

B. IMPROVEMENT ACTIVITIES (IA)

The statue assigns a weight of 15 percent to the Improvement Activity category. The statute defines a clinical practice improvement activity as "an activity that relevant eligible professional organizations and other relevant stakeholders identify as improving clinical practice or care delivery and that the Secretary determines, when effectively executed, is likely to result in improved outcomes." CHIME believes there is a lot of room for opportunity with this category but we also find that our members are reporting several concerns and apprehension with reporting and we believe this category may be getting underutilized.

i. Leveraging Technology to meet IA

CMS finalized a policy last year that called for giving physicians/clinicians bonus credit for using CEHRT to meet ACI and IA's. CMS has not proposed to change this policy, but they said they "will continue to consider including emerging certified health IT capabilities as part of activities within the Improvement Activities Inventory in future years."

Many commented to CMS that they wanted to see more activities that offer credit for using CEHRT to help meet the IA, as well as integrating ACI and IA more closely. CMS said, "In response to the comments, we will continue to focus on incentivizing the use of health IT, telehealth, and connection of patients to community-based services." They also said, "We received several comments in support of the concept to include emerging certified health IT capabilities as part of the activities in the Improvement Activities Inventory and several commenters supported our assessment that using CEHRT can aid in improving clinical practices and help healthcare organizations achieve success on numerous improvement activities, as well as the continued integration of improvement activities and advancing clinical information."

CHIME continues to support ways that CMS can further align the four performance categories. Though, as noted earlier, we worry that the various bonus-point options, while well intended, create additional layers of complexity that could make it even harder for clinicians to navigate. We nonetheless support CMS' efforts to offer bonus ACI credit to clinicians performing certain IAs using CEHRT.

In addition to focusing on IAs for which clinicians can get credit under ACI, CHIME also recommends CMS establish more IAs that leverage technology that is not part of a certified EHR. We recognize that these would not qualify for credit under ACI since the statute requires use of CEHRT to receive credit under this performance category; but we nonetheless feel that incenting clinicians for using cutting-edge technology that can facilitate better care should be rewarded under the IA category. For instance, we think there would be value in rewarding clinicians for using technology that incorporates artificial intelligence, 3D imagery and virtual machines/robotics. As far as we can tell, there is nothing in the statute that precludes CMS from reimbursing under the IA category for technology-facilitated solutions that are not part of a certified EHR.

ii. Subcategories

In the final rule published last year, CMS finalized nine subcategories for which IAs must be assigned and that applicants should submit ideas that fit into one of these nine areas when CMS does its "Annual Call for Activities." The nine areas include: 1) Expanded Practice Access; 2) Population Management; 3) Care Coordination; 4) Beneficiary Engagement; 5) Patient Safety and Practice Assessment; 6) Participation in an APM; 7) Achieving Health Equity; 8) Integrating Behavioral and Mental Health; and 9) Emergency Preparedness and Response. While

CMS has not proposed to add any new categories, they have said they are considering new ones for the future. Among the ideas they are considering is a new subcategory for health IT. CHIME appreciates that CMS is focused on ways to incent the use of technology further. As noted above, we believe that CMS should add more IAs facilitated by technology that is outside of CEHRT. **To the degree a new technology-oriented subcategory could be used to offer credit to clinicians who employ innovative technology solutions (as described above) for patient care which are not part of CEHRT, CHIME sees utility in this.**

iii. Measuring IA and Measurement Thresholds

CMS sought feedback on whether they should establish a measurement threshold for improvement activities (i.e., 50 percent). **CHIME recommends against establishing measurement thresholds under IAs.** Based on our experience with the Meaningful Use program, this would introduce an unnecessary level of complexity and burden.

CMS has also asked for feedback on how it can measure performance under IA rather than relying on attestation. On the one hand CMS says they plan to use a yes/no attestation process for communicating that an IA was met for both 2017 and 2018; however, the agency also notes that this could change in future years. **CHIME recommends CMS continue its attestation policy for the foreseeable future.** We believe this would help improve participation in the IA category. Second, because many clinicians are worried about how CMS will audit on this piece of MIPS, CMS should not move ahead with performance measurement at this time until major obstacles are addressed. Namely, many EHR vendors are still struggling to account for these activities in their systems, making it more likely that clinicians may stay away from this category. As one member shared with us, they have six EHR vendors and only one of them has outlined how they plan on handling IAs.

Finally, CMS has yet to articulate its audit strategy for this category. Clinicians need some assurance that if audited, their documentation of meeting such IAs could demonstrate to CMS' satisfaction that they have indeed adequately met an IA. **We recommend that CMS publish the criteria against which clinicians will be audited and that they work with ONC to inventory vendors to better understand the current capabilities of certified EHRs to document IAs. Finally, we urge CMS to consider the regulatory impact on both clinicians and vendors in documenting and demonstrating successful performance of IAs.**

iv. Annual Call for Activities

We want to continue to express our concerns that CMS elected not to include for 2018 an IA related to good cyber hygiene. Two massive worldwide cyberattacks were launched during the first half of 2017, crippling much of Britain's healthcare system. **We continue to urge CMS to take this matter into consideration and reconsider adding a measure that supports clinicians' efforts to improve their cyber posture in future years.**

v. Extreme and Uncontrollable Circumstances

Clinicians affected by extreme and uncontrollable circumstances are currently allowed to submit an application to be considered for reweighting of the ACI category. CMS proposes to extend this policy, beginning with the 2020 MIPS payment year to the remaining categories. CMS has clarified that scenarios involving issues with leases and problems with third-party intermediaries (i.e. EHRs, Qualified Registries, or QCDRs) that submit on behalf of a clinician would not qualify for an exception. CMS has also proposed that they would assign a final score equal to the performance threshold if fewer than two performance categories are scored for a clinician. CHIME supports CMS' proposal to expand the extreme and uncontrollable circumstances application process to the other three performance categories. We recommend, however, that CMS establish the most flexible process possible for determining what constitutes an extreme and uncontrollable circumstance. For instance, a situation that may be extreme for one practice may not be the same for another. Also, we recommend CMS consider the impact a cyberattack and a brown/blackout could have on a clinician/practice. While most hospitals have the ability to continue several operations during a brownout, many ambulatory practices are not similarly situated.

C. QUALITY

i. Need for Measure Reporting Harmonization

Our members' single largest concern with the quality performance category is the need for CMS to continue to work to align measure reporting requirements across other CMS programs, and to work more closely with private payers

to do the same. From our perspective, aligning measure reporting among payers and programs will reduce significantly the regulatory burden faced by clinicians and other healthcare providers.

ii. Weight

As discussed earlier in our letter, we are very concerned with the rapid increase in required weighting of the cost category in 2019 which is required by law to be 30 percent. Ideally, we would like to see the cost category remain weighted at 0 percent in 2018 and gradually increase to 10 percent in 2019. **However, given the limits imposed by statute, our recommendation is to maintain the existing weight of 0 percent for the cost performance category in 2018. Further, we agree CMS adopt a weight of 60 percent for the quality performance category as previously finalized in last year's rule, for Year 2.**

iii. Performance Period

As noted above, **we recommend that CMS not adopt a full-year performance period for quality reporting and that they adopt a minimum 90-day period for the foreseeable future.**

iv. Data Completeness Standards

For 2017, clinicians are required to report at least 50 percent of their patients who meet the criteria in a measure's denominator when reporting data using a QCDRs, qualified registries, EHRs or Part B claims data (web-based interface excluded). For 2018, CMS has proposed to increase the data completeness standard to 60 percent. We do worry how smaller practitioners will be able to meet this standard. We share CMS' concerns that increasing the data completeness standards too much too quickly could negatively impact those who are the least experienced with quality data submission. However, we would also argue that even larger providers continue to experience several challenges when it comes to quality data submission and these are not limited to smaller or less experienced clinicians.

CHIME recommends that CMS maintain the existing data completeness standard of 50 percent since providers are still wrestling with several issues and glitches that make quality reporting through these vehicles a challenge. The build for submitting PQRS data directly from EHRs was extremely complicated and many vendors were not ready. While things are working more smoothly than they did with PQRS reporting, submission of data still requires some members to place numerous calls to the CMS hotline. And, members still report issues submitting data via a QCDR and EHRs and several are still not ready for this.

v. Web-based Interface

Our members also continue to confront several issues with the web-based interface. We still get complaints about the registration process to use the web-based interface with members reporting that it takes too much time and effort to get validation to submit measurement data.

vi. Topped-out Measures

CMS did not establish a policy for handling topped-out measures in 2017. However, for 2018 and beyond CMS has laid out a plan that calls for capping the number of points a clinician would receive when reporting a topped-out measure. Specifically, CMS calls for only allotting a maximum of six points per topped out measure. And, they plan on removing measures that are topped out the fourth year after being identified as such.

As we noted above, our primary concern with quality reporting is the multitude of overlapping and varying quality measurement reporting requirements they must meet has created an extraordinary level of complexity and burden. **We thus recommend that CMS not proceed with their proposal to remove topped-out measures as these measures could be ones that they are using to meet other program and payer needs.**

D. ADVANCING CARE INFORMATION (ACI)

CMS has retained the previously adopted two-part structure consisting of base measures and performance measures, though they have proposed changes to the scoring methodology. And, as noted at the start of our letter, CMS will permit the use of 2014 CEHRT and meeting Transition measures in 2018, a change CHIME strongly endorses.

vi. Scoring

The ACI performance category weight remains 25 percent for 2018, though a variety of scenarios can result in CMS reweighting it and shifting these points to other performance categories, namely quality.

CMS has, however, proposed to increase the number of bonus points available from 15 in 2017 to 25 in 2018 for those ready to meet Stage 3 by offering an extra 10 percentage points for those using 2015 Edition CEHRT in 2018.

CMS has also rejiggered the scoring for the Public Health and Clinical Data Registry Reporting objective in 2017; clinicians could get up to 10 percentage points under the performance scoring of ACI for meeting the immunization measure. And, if they were unable to meet the immunization measure, they had the option of trying to report to a public health agency or registry for an additional 5 percentage bonus points. CMS has recognized that not everyone has access to an immunization registry and thus may be unable to meet this measure; consequently, for 2018 they have said that if you can't meet this measure you are eligible to get 5 percentage points for each additional registry/public health agency you report to for a maximum of 10 percentage points.

CHIME appreciates that CMS has acknowledged that not all clinicians may have access to an immunization registry and has created a fairer point structure. However, we believe the overall structure of the ACI category is too confusing. We also feel the weighting of each measure is overly complicated and could be substantially streamlined. **Ideally, we would like to see a simple set of measures for which clinicians can pick and choose with equally weighted values and that the bonus points should be folded into this single list.**

vii. Changes to Measures

CMS left largely untouched the measures previously adopted in 2017, with some notable exceptions. CMS has proposed to define "timely" access to patient records to mean four business days. **CHIME supports CMS' proposal.**

CMS also proposes starting in 2017 to add an exclusion to the health information exchange Transition measure, "Send Summary of Care" such that clinicians who transfer or refer patients fewer than 100 times during a performance period would qualify. And, for the "Request/Accept Summary of Care" measure, clinicians who receive transitions of care/referrals fewer than 100 times during a performance period, would also qualify for an exclusion. CMS has said stakeholders have reported clinicians are unable to meet these measures to qualify for the ACI base score and that to not disadvantage them they are creating these exclusions. **CHIME supports this proposal.**

CMS has also proposed an exclusion starting for 2017 for the e-prescribing measure that clinicians who write fewer than 100 permissible prescriptions during the performance period can claim an exclusion. **CHIME supports this proposal as well.**

viii. Decertification

CMS has proposed that a clinician may demonstrate through an application process that reporting on the measures specified for the ACI performance category is not possible because their CEHRT was decertified under ONC's Health IT Certification Program. CMS is also proposing that if the clinician's demonstration is successful and an exception is granted, that they would assign a 0 percent weighting to the advancing care information performance category in the MIPS final score for the MIPS payment year. This proposal is rooted in changes made under the 21st Century Cures Act. **We support CMS' proposal to offer a process for clinicians to apply for an exception to meeting ACI if their product becomes decertified. We recommend that CMS also consider adding products that have been suspended given the possibility that there could be safety concerns.**

ix. Hardships

CMS has proposed to add a new significant hardship exception for clinicians in small practices (15 or fewer) under the ACI category. As noted under our comments on bonus points for small practices, for the same reasons outlined above, we recognize the benefit of establishing a hardship that would allow small practitioners with 15 or fewer clinicians to claim a hardship from having to meet the ACI category; however, due to the statutory definition of small practice, we believe some practices that consider themselves small and that could benefit from this policy will be

unable to do so because they are technically more than 15 full-time equivalent employees. Expanding the statutory definition of small would better advantage practices in rural America.

x. Hospital-based Clinicians

CHIME supports CMS' policy to assign a weight of 0 to the ACI category for hospital-based clinicians.

IV. Conclusion

CHIME appreciates the opportunity to comment and looks forward to continuing to share our members' experience with the new program to better inform the policymaking process. Should you have any questions concerning our letter, please contact Mari Savickis, Vice President, Federal Affairs at msavickis@chimecentral.org.

Sincerely,

Russell P. Branzell, CHCIO, LCHIME
President and CEO
CHIME

Liz Johnson, MS, FAAN, FCHIME, FHIMSS,
CHCIO, RN-BC CHIME Board
Chair; CIO, Acute Care Hospitals & Applied Clinical Informatics, Tenet Healthcare

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