December 29, 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) appreciates the opportunity to comment on the Center for Medicare & Medicaid Services' (CMS), "Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year," published in the Federal Register on November 16, 2017.

CHIME is an executive organization serving more than 2,500 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.

Outlined briefly below are our top recommendations.

1. **Further simplify the program.**
2. **Exempt patient-facing, hospital-based clinicians from having to submit quality data.**
3. **Reconsider the 90-day reporting period for quality measurement and align it with the Meaningful Use policy for 2018.**
4. **Exempt rural clinicians who deliver most of their care in a rural health clinic but who are also part of an Accountable Care Organization (ACO) from the requirement to submit Advancing Care Information (ACI) data.**

Further Reducing Complexity

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CHIME strongly support efforts to reduce the regulatory burden on clinicians. We worry, however, that the Quality Payment Program (QPP) is still too complicated and burdensome.

An area that has elicited resounding concern among our members involves the requirement for clinicians who largely treat patients in the hospital and are patient-facing to report on quality measures. Prior to MIPS, under the Meaningful Use program, hospital-based physicians were not required to report quality measures. While CMS has said that non-patient facing clinicians do not have to report on quality metrics, citing radiologists and pathologists as examples, the patient-facing clinicians who largely work in a hospital setting still must submit quality data. This is creating a situation where patient-facing clinicians such as emergency department doctors, hospitalists and intensivists who have no ambulatory electronic health record (EHR) of their own must cobble together measures to meet the quality reporting requirements. That requirement will change in 2019, when a new facility-based policy starts that would allow a patient-facing clinician in the hospital to "ride" the facility's quality data. We recommend that CMS immediately address this concern and waive the quality requirements for patient-facing clinicians who deliver most of their care in the hospital setting. Unless remedied, this will present an enormous burden on these clinicians.

Another issue that has bubbled to the surface involves clinicians who are part of an Accountable Care Organization (ACO). If one clinician is part of an ACO, then every one of them must submit Advancing Care Information (ACI) data (assuming they are using certified EHRs). Thus, every clinician in the hospital who is part of the ACO's taxpayer ID (TIN) must submit ACI data. In rural areas many clinicians who treat most but not all of their patients in a Rural Health Clinic (i.e., surgeons) are generally be exempt from the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA); but as members of an ACO, they still must submit ACI data. A few of these clinicians (such as surgeons) go to the hospital and provide services outside of the RHC and qualify for MACRA. One CHIME member in a rural area described the situation she is facing: Of the 125 clinicians for whom her system must submit data, only four of the clinicians qualified for MACRA in the absence of being in an ACO. Said another way, she must report on 125 clinicians but 121 of them otherwise would not be required to submit data except for the fact they are part of an ACO. In this particular member's case, they dropped out of the ACO for this very reason. Other members report avoiding ACOs for this reason.

Several members have also reported they are avoiding the Improvement Activities performance category, choosing instead to rely on other performance areas to obtain their points. They believe documenting the data – given the current unknowns around CMS' plans to audit, coupled with challenges our members report some vendors are having capturing the activities in a manner they feel would sufficient – are hampering success in this area.

Several of our members are shying away from Advanced Alternative Payment Models (APMs), citing the complexity and rules are far too overwhelming and confusing. As one member reflected, "the risk is not worth it." Other members have tried going down this path only to later decide to drop out because it was too complicated.

Finally, while we also appreciate that CMS has created a series of bonuses and that this is intended to accommodate clinicians with varying needs, we also believe it introduces a level of complexity that makes it very hard to track and manage. We continue to believe a more streamlined approach would be make it more facile to manage.

Areas of Support

Outlined below are policies finalized within the final rule with comment that CHIME supports.

Overarching Policies:

- **Performance threshold to avoid a penalty:** We support CMS' decision to finalize 15 points as the score that must be met in 2018 to avoid a negative adjustment.
- **Extreme and uncontrollable circumstances:** CMS established an automatic extreme and uncontrollable circumstance exceptions policy for the quality, IA, and ACI performance categories for the 2017. CMS will re-weight all four categories at 0 percent for those clinicians who are granted exceptions. Further, no applications will be required for exceptions for those clinicians who have experienced triggering events. CHIME supports this policy.

Quality Performance Category:

- **Facility-based measurement:** CHIME supports clinicians being able to use their facility-based measurements to meet the quality reporting. However, we are disappointed this policy does not become effective until 2019. Our members are experiencing challenges reporting measures today for their facility-based clinicians because not all hospital EHRs compute ambulatory metrics.

Advancing Care Information Category:

- **Use of Certified Electronic Health Records (CEHRT):** CHIME strongly endorses the change CMS made to permit clinicians to continue using the 2014 Edition CEHRT in 2018. This not only aligns with what is now required of hospitals under the Meaningful Use program, but it also allows the clinician community additional time to acquire and begin using this new software, some of which has not been delivered to our members.
- **Transition measures:** In conjunction with the ability to use 2014 CEHRT another year, we are also very supportive of CMS' decision to continue allowing clinicians to meet MIPS using the transition measures made available for 2017.
- **Performance period:** CHIME strongly supports CMS' 90-day policy.
- **Timely access:** CHIME supports CMS' definition of "timely access" to medical records to mean four business days, a term that was previously undefined and which now aligns with Meaningful Use.

Improvement Activities

- **Performance period:** CHIME strongly supports CMS' 90-day policy.
- **Bonus:** We support offering the bonus to clinicians who meet certain Improvement Activities using their CEHRT.

Areas of Concern

Overarching Policies:

- **Patient selection:** Recent reports point to clinicians avoiding sicker patients under the MIPS program. Our members are concerned about biased selection resulting from the design of the MIPS program. A recent article in the *Journal of the American Medical Association (JAMA),* "Association of Practice-Level Social and Medical Risk with Performance in the Medicare Physician Value-Based Payment Modifier Program," found clinicians who treat more at-risk patients see fewer bonuses and more penalties (JAMA. 2017;318(5):453–461. doi:10.1001/jama.2017.9643). One significant challenge we see is clinicians having one foot in the "old" model of fee-for-service and the other foot in a model that is transitioning to value.
- **Data reporting:** CHIME supported CMS' proposal to allow clinicians to use multiple different methods to aggregate data within performance categories. Thus, we are disappointed that CMS has walked back this policy for 2018 and that it won't be available until 2019. Our members are also experiencing issues with discrepancies with the way data is scored when it originates from a registry versus an EHR.
- **Data blocking:** Our members continue to have concerns with the way CMS has defined data blocking in the three attestation statements and worry providers could be held liable for issues outside their control. For instance, some members have experienced challenges with some clinicians not obtaining Direct Addresses because they do not want to receive CCDAs electronically. If a provider has no other means of obtaining/sending those CCDAs (such as a health information exchange), we worry this situation could be perceived as data blocking, especially by the provider seeking places to send the CCDAs. Below are three specific examples from one of our members (vendor and provider names redacted):
    - **Example 1:** [Provider A] has [Product 1]. [Provider B] has [Product 2]. The format of CCDA that comes out of [Product 2] cannot be read by [Product 1]. The format is XDM. To this date, we cannot send CCDAs to [Product 1].
    - **Example 2:** [Provider C] using [Product 3] was trying to receive CCDA from [Product 4] (and other EHR vendors). [Product 4] kept getting messages that they were unsecure (not trusted). The Product 3 Direct Trust addresses were not receiving ANYTHING. We got ahold of [Product 3] and

we were told two different things (one was the we did not have “true Direct Trust email address” and we were told there was a bug with the new [Product 3] software. Upon notifying [Product 3] of this issue, [Product 3] fixed their software (after 2 weeks of no messages going through). This was not across all of our [Product 3] clients, just about 25%.

- **Example 3:** Another member shared with us this: “I have begged to get Direct Addresses for a whole lot of people and did the whole SoC and gave Direct Addresses. So frustrating. Half the vendors don’t accept attachments so you need to double your workload and have to do faxing so double the workload.”

Cost:

- **Threshold:** We continue to remain concerned about the increase in weight from 0 percent in 2017 to 10 percent in 2018. Remaining at 0 percent would be a more cautious and prudent approach. Has CMS considered offering feedback reports that compare what a 0 percent weight looks like compared to a 10 percent weight, yet not holding clinicians to the 10 percent? This may achieve the same intended effect, which is avoiding a precipitous increase between 2018 and 2019 since by law CMS must set the weight at 30 percent in the third year (2019).

Quality

- **Performance period:** For year 2 CMS has adopted a performance period of a full year. We are very disappointed that CMS did not adopt a minimum of a 90-day reporting period for the quality performance category. First, this does not align with what is required of hospitals; and second, we believe that if clinicians who feel that a full year is needed to help them meet a quality measure that this would be allowed though not mandatory. CHIME continues to strongly recommend mandatory reporting that spans no more than 90 days for both MIPS, Meaningful Use, and the hospital Inpatient Quality Reporting (IQR) program.
- **Patient-facing hospital-based clinicians:** As detailed above, we are very concerned about the burden placed on these clinicians surrounding the requirement that they report on quality data. This was not required under Meaningful Use and will create a large regulatory burden on these clinicians until 2019, when CMS plans to implement a facility-based policy that will allow these clinicians to meet the quality reporting using the hospital’s data.
- **Topped-out measures:** CMS finalized a policy whereby measures that have been topped out for at least two consecutive years will begin to be phased out and will be given a seven-point cap. We have concerns with this approach, the biggest issue being added complexity. Providers, as we have noted in previous comment letters, need more time to adapt to change. This policy will likely introduce more burdens in quality measurement. Many measures are used by providers (even though they may have variations of the same measure) to meet a variety of payer requirements and removing topped out measures could make it more burdensome to meet other payers’ requirements. Also, the quality measure specifications change annually and vendors must rebuild their systems. This in turn necessitates workflow redesigns by the provider and creates a trickle-down effect. We recommend at the very least that CMS consult with providers and other payers before measures are deemed topped out.

ACI

Rural clinicians in an ACO: As described earlier, we have concerns with CMS’ requirement that mandates that all clinicians must report data if they are part of an ACO even if they otherwise would not qualify for MACRA since they deliver most of their care in a Rural Health Clinic. This presents a burden on these clinicians and is driving some away from participating in ACOs.

Conclusion

CHIME appreciates the opportunity to lend our voice to the policy dialogue around the QPP. Our members stand ready to offer their experience with the program from the front lines and answer any questions CMS may have about how the program is working in practice. Should you have any questions about our letter, please contact Mari Savickis, Vice President, Federal Affairs at msavickis@chimecentral.org.

Sincerely,

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CHIME

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