

September 13, 2021

Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Brooks-LaSure,

On behalf of the nearly 30 member companies of the Electronic Health Record (EHR) Association, we are pleased to offer our comments to the Centers for Medicare & Medicaid Services (CMS) on the Medicare Program: CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-Payment Medical Review Requirements Proposed Rule (CMS-1751-P). We appreciate this opportunity to provide input on CMS' efforts to create a health care system that results in better accessibility, quality, affordability, empowerment, and innovation.

The EHR Association's member companies serve the vast majority of hospitals, post-acute, specialty-specific, and ambulatory healthcare providers using EHRs across the United States. Our core objective is to collaborate to accelerate health information and technology adoption, advance information exchange between interoperable systems, and improve the quality and efficiency of care through the use of these important technologies.

We appreciate this opportunity to provide CMS with our input and look forward to continued collaboration toward improved patient care. At all levels, as new standards are considered and introduced, we feel it important to encourage CMS to continue to work closely with the ONC to maintain alignment between the certification program and CMS to avoid confusion and potential conflict.

We are concerned with the widespread impact and burden for EHR developers and healthcare providers alike of the overlapping timelines for MVP, MIPS, FHIR, and dQM, as even voluntary reporting years will require all EHRs to fully support the functionality.

AdvancedMD	CPSI	Experity Health	MEDHOST	Nextgen Healthcare
Allscripts	CureMD	Flatiron Health	MEDITECH, Inc.	Office Practicum
Athenahealth	eClinicalWorks	Foothold Technology	Medsphere	Sevocity - Division of Conceptual Mindworks, Inc.
BestNotes	eMDs	Greenway Health	Modernizing Medicine	STI Computer Services
Bizmatix	Endosoft	Harris Healthcare Group	Netsmart	Varian Medical Systems
Cerner Corporation	Epic	Lumeris	Nextech	

Our detailed comments follow.

Sincerely,



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Chair, EHR Association
Cerner Corporation



David J. Bucciferro
Vice Chair, EHR Association
Foothold Technology

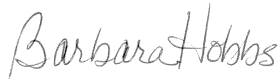
HIMSS EHR Association Executive Committee



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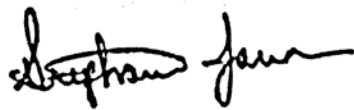
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Cherie Holmes-Henry
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Stephanie Jamison
Greenway Health



Alya Sulaiman, JD
Epic

About the HIMSS EHR Association

Established in 2004, the Electronic Health Record (EHR) Association is comprised of nearly 30 companies that supply the vast majority of EHRs to physicians' practices and hospitals across the United States. The EHR Association operates on the premise that the rapid, widespread adoption of EHRs will help improve the quality of patient care as well as the productivity and sustainability of the healthcare system as a key enabler of healthcare transformation. The EHR Association and its members are committed to supporting safe healthcare delivery, fostering continued innovation, and operating with high integrity in the market for our users and their patients and families. The EHR Association is a partner of HIMSS.

For more information, visit www.ehra.org.

Electronic Health Record Association

Comments on Calendar Year (CY) 2022 Medicare Physician Fee Schedule Proposed Rule
(CMS-1751-P)

III. Other Provisions of the Proposed Rule

F. Appropriate Use Criteria for Advanced Diagnostic Imaging

4. Proposals for Continuing Implementation

b. Claims Processing

v. Deny or Return Claims that Fail AUC Claims Processing Edits

Claims that do not properly include AUC consultation information will not be paid once we fully implement the AUC claims processing edits. We are considering whether claims that do not pass the AUC claims processing edits, and therefore will not be paid, should be initially returned to the health care provider so they can be corrected and resubmitted, or should be denied so they can be appealed.

We are requesting comments to help us better understand which path would be most appropriate once we fully implement the AUC program claims edits. Additionally, we are requesting comments on whether the payment penalty phase should begin first with returning claims and then transition to denying claims after a period of time, which may be helpful to furnishing professionals and facilities as they become more proficient in submitting claims under the AUC program.

Two providers share joint responsibility for AUC consultation information—the ordering provider and the performing provider—but given that claims are submitted by the performing provider, the EHR Association suggests that the claim should be initially returned to the performing provider to determine what is necessary to correct and resubmit the claim, or involve the ordering provider as needed. The interoperability standards necessary to help manage this communication across providers do not currently exist, adding to the burden on both providers in this already complex, multi-provider process.

vi. Medicare as a Secondary Payer

We propose to exclude claims that identify Medicare as the secondary payer from application of the AUC consultation and reporting requirements.

If implemented, this would change how primary and secondary payor information are currently captured and conveyed in HIT. HIT systems would need sufficient advance notice to update accordingly.

5. Summary

We are also proposing to begin the AUC claims processing systems edits and payment penalty phase of the program on the later of January 1, 2023, or the January 1 of the year after the year in which the PHE for COVID-19 ends.

The EHR Association supports this delay if sufficient clarity on expectations are established in the Final Rule.

We are especially concerned with clarification regarding the claim denial process—specifically related to the process for denials for both ordering and performing providers, and request clarification on the role of the ordering provider from a compliance standpoint.

J. Medicare Shared Savings Program

Update the APM Performance Pathway (APP) measure set to remove the Risk-Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions (MCC) for ACOs and replace it with the Risk Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions for MIPS.

The EHR Association supports consolidating measures where possible to reduce reporting complexity.

1. Quality and Other Reporting Requirements

c. Amending the Reporting Requirements under the APM Performance Pathway for Performance Years 2022 and 2023

However, in light of the concerns raised during the public comment period for the CY 2021 PFS proposed rule, in the CY 2021 PFS final rule, we decided to extend the use of the CMS Web Interface as a collection type under the APP for performance year 2021

While this extension appears to offer some benefit, the one APP measure is still required beginning in 2023 for those who chose to submit ten web interface measures. Therefore the burden remains the same for ACOs to gather this information of all patient/all payer data. The EHR Association requests the single reported eCQM remain optional in future years until there is a more established process for aggregating data.

We are seeking comment on whether we should extend the CMS Web Interface collection type for more than the 2 years proposed.

The EHR Association supports an extension of the CMS Web Interface.

(1) Solicitation of Comments on Addressing Health Disparities and Promoting Health Equity

We are seeking comments and recommendations on how ACOs can utilize their resources to ensure that patients, regardless of racial/ethnic group, geographic location and/or income status, have access to equal care and how ACOs can improve the quality of care provided to certain communities, while addressing the disparities that currently exist in healthcare.

Healthcare providers, ACOs, and agencies are all on a learning curve to understand how to collect, analyze, and apply SDOH data to improve access, care, and health of their community. Ongoing best practice sharing, including challenges, is critical to evolve a consistent approach across and within providers.

The EHR Association would encourage CMS to clearly define the specific data intended to measure disparities in order for stakeholders to comment on standards, readiness for adoption, etc. Different types of data have different levels of maturity and adoption; some vocabulary or classifications are widely used, some are just emerging, and some are being expanded. Certain social determinants of health are routinely being captured because they were included in Meaningful Use or other programs promoting interoperability, but there are newer emerging data classes and elements that do not yet have the same level of adoption. It will be necessary to evaluate and comment on those on an individual basis.

The EHR Association strongly encourages the requirement of standardized data that has been embraced by the industry as a whole; the exchange of information is more effective when everyone is speaking the same language. The consistent collection and use of standardized data classifications and vocabulary enables broader census reporting and facilitates in identifying and addressing the disparities that currently exist in healthcare.

Finally, the EHR Association is concerned that CMS not consider ACOs separately. We recommend that there should be consistency across programs within CMS, including programs and demonstration projects coming out of CMMI in the coming years.

(2) Solicitation of Comments on Feasibility of TIN Level Reporting and Sampling for eCQMs/MIPS CQMs

We are seeking comment on allowing ACO providers/suppliers to submit eCQMs/MIPS CQM measures to CMS at the ACO participant TIN level. CMS would then calculate/aggregate the TIN level quality data to create an ACO level score.

The EHR Association would encourage this. Given the complexity of the score, we suggest that ACOs should have the opportunity to review the results.

While we believe that the move to all-payer measures is the next step in quality reporting, we acknowledge that the denominator of patients for a given quality measure for an ACO may be significantly higher, depending on ACO size and composition, than for MIPS groups. Therefore, we seek comment on how stakeholders would envision CMS determining an appropriate beneficiary population. For example, should ACOs report on a small sample size similar to the sample size for the CMS Web Interface? Should CMS broaden the beneficiary sample to include all assigned beneficiaries that meet the denominator for a given measure? Should CMS provide ACOs with a bigger sample size, larger than the size that has historically been used for CMS Web Interface but smaller than all the assigned beneficiaries that meet the denominator for a given measure? We seek comment on

whether CMS should create a specific sampling methodology for ACOs, alternate sampling methodologies that could be used, as well as phase-in and tiered implementation strategies

The EHR Association believes that a staggered approach would introduce unnecessary complexity; a stepping stone adds more change more frequently and it makes it harder to prepare for the end state. We would prefer to use the all-payer option, as that is consistent with other programs, but recommend continued use of QRDA III as we have concerns with volume of data if QRDA I is used.

O. Modifications Related to Medicare Coverage for Opioid Use Disorder (OUD) Treatment Services Furnished by Opioid Treatment Programs (OTPs)

4. Counseling and therapy furnished via audio-only telephone

We are proposing to allow OTPs to continue to furnish the therapy and counseling portions of the weekly bundles, as well as any additional counseling or therapy that is billed using the add-on code, using audio-only telephone calls rather than via two-way interactive audio/video communication technology following the end of the PHE for COVID-19 in cases where audio/video communication technology is not available to the beneficiary, provided all other applicable requirements are met.

Accordingly, we are proposing to revise the regulations at § 410.67(b)(3) and (4) to allow OTPs to furnish therapy and counseling using audio-only telephone calls rather than via two-way interactive audio/video communication technology after the conclusion of the PHE for COVID-19 in cases where audio/video communication is not available to the beneficiary, provided all other applicable requirements are met.

Two-way audio/video communications are not available to a significant portion of the US. In order to support the equitable access of care, the EHR Association agrees that this would continue to be beneficial beyond the PHE.

Q. Requirement for Electronic Prescribing for Controlled Substances for a Covered Part D drug under a Prescription Drug Plan or an MA-PD plan

4. Proposed Timeframe for EPCS Adoption

We are proposing to revise § 423.160(a)(5) to change the EPCS compliance date from January 1, 2022 to January 1, 2023. We welcome comments on this proposal, including whether commenters believe that we should maintain the January 1, 2022 compliance date, given the benefits of EPCS, and the feasibility for prescribers to adopt EPCS for Part D prescriptions by January 1, 2023.

We propose to extend the compliance deadline for Part D controlled substance prescriptions written for beneficiaries in long-term care (LTC) facilities, excluding beneficiaries who are residents of nursing facilities and whose care is provided under Part A of the benefit, from January 1, 2022 to January 1, 2025.

The EHR Association believes in the public health benefits of implementing EPCS and we support its implementation as scheduled on January 1, 2022. As a health IT provider community, we are prepared to meet the requirements of compliance.

We understand from experience that when deadlines are repeatedly pushed, people are less likely to take them seriously. We are concerned that continued delay may cause implementation to be postponed until the last possible moment, impeding considerable benefit to providers and patients.

It will be crucial for provider organizations to comment on the need to maintain the compliance date, however, given that not all states currently have the necessary infrastructure in place as they continue to devote resources to pandemic response.

6. Proposed Classes of Exceptions

b. Cases where Prescribers Issue Only a Small Number of Part D Prescriptions

Based on our conversations with stakeholders, the cost of EPCS transactions is less than the cost of transmitting certain transactions manually, we believe that the initial investment to install EPCS equipment and software is likely justified once prescribers transmit more than 100 Part D controlled substance prescriptions per year.

The EHR Association is in agreement with this, and does not foresee extensive additional programming necessary to achieve this.

In order to implement this exception using the data that we have available, we are proposing that this exception be given to individual prescribers, regardless of the size of the group practice that they belong to.

Inconsistency with other MIPS measurements would be burdensome and require additional time for implementation. The EHRA feels this will diminish the value of the EPCS information being collected.

We believe an exception for prescribers working under a research protocol who do not otherwise meet these exceptions is unnecessary because we believe that EHR companies will set up the appropriate EHR equipment, provided around 100 Part D controlled substance prescriptions are transmitted per year.

The EHR Association requests clarification from CMS regarding the calculation of this <100 prescription exception. We assume if CMS makes the determination based on claims that it is different from the other e-prescribing exclusion that is calculated within the EHR.

Based on our conversations with Prescription Drug Plans (PDPs), MA-PD plans, and other organizations with which prescribers are affiliated, we are aware that some are willing to donate the technology and services necessary for prescribers to adopt EPCS. Based on those conversations, we believe that they are more willing to donate these technology and services to prescribers who are

working under a research protocol, than to prescribers not working under such a protocol. However, we seek comment on such an assumption.

We believe that, to the extent this is an accurate assumption, such donations further decrease the burden for prescribers working under a research protocol. It is for these additional reasons that we have declined to propose an exception for those working under a research protocol. We seek comment on this decision.

The EHR Association suggests CMS consider the specifics of existing Anti-Kickback Statute and Stark Law regulations and whether there exists a need for amendment to reflect the specific dynamics described.

c. Cases of Recognized Emergencies and Extraordinary Circumstances

We are proposing two exceptions to the EPCS requirement.

The first exception is for prescribers who are prescribing during a recognized emergency, such as a natural disaster, a pandemic, or a similar situation where there is an environmental hazard.

The second exception is for prescribers who request and receive from CMS a waiver, which CMS would grant to prescribers who are facing extraordinary circumstances that prevent them from electronically prescribing a controlled substance to a Part D beneficiary, but who are not in an emergency or disaster area.

The EHR Association is in agreement with these exceptions, and asks that CMS provide clear guidance to allow providers to identify and attest to these exceptions. We understand that it is in such extraordinary times that prescribing practices often change, and while prescribers certainly benefit from burden reduction during these events, monitoring remains valuable for the benefit of public health.

8. Penalties

We propose that with respect to compliance from January 1, 2023 through December 31, 2023, CMS compliance actions will consist of sending letters to prescribers that we believe are violating the EPCS requirement during that period of time. These letters will consist of a notification to prescribers that they are violating the EPCS requirement, information about how they can come into compliance, the benefits of EPCS, an information solicitation as to why they are not conducting EPCS, and a link to the CMS portal to request a waiver. We will re-evaluate whether further compliance actions will be necessary and what those compliance actions will be in future rulemaking.

The EHR Association strongly urges CMS to require EPCS compliance, and enact penalties for violating prescribers, as of the original deadline of January 1, 2022 in order to begin to impact the opioid epidemic. EHR technology has long been prepared for this to take effect.

IV. Summary of the Quality Payment Program Proposed Provisions

A. CY 2022 Updates to the Quality Payment Program

1. Executive Summary

b. Summary of Major Provisions

(1) Major MIPS Provisions

(b) MIPS Value Pathways and APM Performance Pathway

Proposed: A delay to the CY 2023 MIPS performance period/CY 2025 MIPS payment year: MVP implementation and subgroup reporting timelines. Beginning in the CY 2025 MIPS performance period/CY 2027 MIPS payment year, multispecialty groups would be required to form subgroups in order to report MVPs

The EHR Association appreciates the delay. Additional time might be necessary; as the transition to MVPs is clarified, stakeholders can give more specific feedback on necessary transition timelines.

CMS may need to prioritize where EHR developers focus their attention between changes to traditional MIPS, MVPs, and the dQM transition. Simultaneous changes in all areas would be burdensome and delay adoption.

(c) Other MIPS and APM Policies

As discussed in section IV.A.3.h. of this proposed rule, for Third Party Intermediaries, we are proposing to modify third party intermediary requirements, remedial actions and termination policies. Specifically, beginning with the 2023 MIPS performance period/2025 MIPS payment year, QCDRs, qualified registries, and health IT vendors must support MVPs that are applicable to the MVP participants on whose behalf they submit MIPS data. QCDRs, qualified registries, and health IT vendors may also support the APP. We also propose to require QCDRs, qualified registries, health IT vendors, and CMS-approved survey vendors to support subgroup reporting beginning with the 2023 MIPS performance period/2025 MIPS payment year.

What is meant by “applicable MVP participants”?

(4) Changes Under Consideration to Advance Digital Quality Measurement: Potential Actions in Four Areas to Transition to Digital Quality Measures by 2025

(a) Leveraging and Advancing Standards for Digital Data and Obtaining all EHR Data Required for Quality Measures via Provider FHIR-based APIs

We are considering targeting the data required for our quality measures that utilize EHR data to be data retrieved via FHIR-based APIs based on standardized, interoperable data.

Today, quality measures are primarily reported through eQMs, a standard familiar to most EHR developers and organizations. The industry should move to dQMs if such a move will lead to other efficiencies, such as alignment of all measures required by various CMS programs. If CMS were to move to dQMs, a number of prerequisites would be necessary.

First, the necessary building blocks of such measures, such as HL7(R) FHIR(R) R4, would need to be widely adopted by program participants. Then, the implementation of QI Core would be required for quality reporting with dQMs.

CMS should only adopt mature and piloted IGs for quality reporting standards into regulatory programs. Because of this, 2025 is an overly ambitious goal for a conversion to dQMs.

CMS will need to provide a robust set of testing and validation tools to allow developers to ensure their implementation of the capabilities is consistent and accurate. Also, CMS should allow developer access to test-submission portals so they can provide better support to their clients.

If CMS intends to aggregate quality data in the dQM framework, they should provide API(s) to allow for real-time performance feedback and reporting from their measure calculation system, back to the EHR so clinicians can understand how to improve. For transparency, CMS should continue to publish specifications and logic for dQMs in how hospital performance is evaluated.

Does CMS intend to replace all eQMs with dQMs?

(b) Redesigning Quality Measures to be Self-Contained Tools

We seek comment on the suggested functionalities and other additional functionalities that quality measure tools should ideally have particularly in the context of the possible expanding availability of standardized and interoperable data (for example, standardized EHR data available via FHIR-based APIs).

Currently, there is overlap in the MVP and dQM implementation timelines, which causes concern. The EHR Association would suggest that until FHIR specifications have matured sufficiently to make it viable for widespread development, this should not be included in the development roadmap.

(c) Building a Pathway to Data Aggregation in Support of Quality Measurement

Using multiple sources of collected data to inform measurement would reduce data fragmentation (or, different pieces of data regarding a single patient stored in many different places). Additionally, we are considering expanding and establishing policies and processes for data aggregation and measure calculation by third-party aggregators that include, but are not limited to, HIEs and clinical registries.

In this regard, the EHR Association has particular concern with accurate patient matching, as well as the proposed timeline.

We seek feedback on aggregation of data from multiple sources to inform measurement and potential policy considerations.

We note that using FHIR-based APIs to gather the input data and deploying a common tool to calculate the measures has strong appeal. However, considering the volumes of data to be extracted from the EHR, maturity of the necessary technologies, and questions regarding CMS's ability to provide immediate data insights, this proposal is not yet an agreed approach for the EHR Association. We do recognize the value of clear definitions using a common language to express measures, such as FHIR and CQL, to promote substantial consistency.

We also seek feedback on the role data intermediaries can and should play in CMS quality measure reporting in collaboration with providers, and how we can best facilitate and enable aggregation.

The EHR Association is concerned with the consistency of data aggregation and measure reporting across different developers, as they take different approaches to data collection. We suggest that clear standards using HL7 FHIR-based CQL expressions can substantially address undesired variations in measure quality, while maintaining flexibility in solutions on how to aggregate large data sets using FHIR-based APIs.

To improve data aggregation, CMS should focus on the barriers that current HIPAA regulations present today. Specifically, while Business Associate Agreements and HIPAA control disclosure back to the patient and third parties, they leave whether to use PHI to support Public Health Activities or to allow for de-identification up to the health system's discretion. Many health systems are restrictive with their BAAs and refuse to permit a developer to engage in such activities. CMS should address these privacy barriers prior to engaging data intermediaries in how they can play a role in facilitating data aggregation.

(5) Solicitation of Comments

(b) Use of FHIR for Current eCQMs

Do you agree that a transition to FHIR-based quality reporting can reduce burden on health IT vendors and providers? Please explain if you do not agree.

It is important to distinguish the measure definition vs. the actual data access and reporting mechanisms using FHIR-based approaches. For measure definition, aligning on a common definition (FHIR) that is used for measures and the source data reduces ambiguity. Using FHIR for the actual reporting is not well matured to understand the ability to reduce burden. While the resulting measure report can very reasonably be expressed using FHIR (i.e., the FHIR MeasureReport), whether FHIR APIs are the best data access method for all variations in provider organizations and EHRs without compromising performance for the support of patient care delivery, is not yet well understood. Connectathon-level efforts are very promising, but do not approximate the large volumes of data involved in real-world environments. FHIR Bulk Data as the format does not address the challenge of gathering all the relevant data while individual data class level FHIR APIs are not necessarily an appropriate substitute for that either. We suggest to focus on measure definitions and measure reports to drive the necessary consistency and clarity using FHIR as the common language to align with all other forms of data exchange and access, while exploring how FHIR based solutions similar to those being pursued by HL7 SANER and CDC's

electronic case reporting approach could take advantage of FHIR based access/gathering and generating the measure reports in high-volume environments.

We note that this exploration should include privacy and security considerations as to when and whether identifiable patient data, or even de-identified patient level data considering advancements in re-identification algorithms, should leave the provider's IT infrastructure for purposes of external measure generation rather than aggregated measure reports. That still may involve measure reporting tools that can be deployed within a provider's infrastructure using emerging FHIR based API capabilities, or utilize other techniques. CMS' approach regarding the HL7 Da Vinci's Prior-Authorization reference implementation guides can be very informative on how to establish a common technique that can be implemented in a variety of configurations, including SMART Apps and/or embedded capabilities.

In what ways could a CMS FHIR Reporting IG be crafted to reduce burden on providers and vendors?

Good implementation guides are characterized by clearly defined requirements that are testable (testing is built in) and validated through real world experience in settings that the implementation guide applies to, before it is deployed at scale. In order to reduce burden and drive consistency, it is important to include definitions and implementation guidance on all fronts, with particular attention paid to defining measures, measure reports, and the necessary underlying APIs where external tools are to be consistently deployed. Expressing these definitions in FHIR and CQL will further decrease challenges in interpretation, and therefore reduce burden on providers and EHR developers.

However, HL7 FHIR is not sufficiently mature at this time to fully address all aspects of the reporting process as also indicated in response to the prior question. Using FHIR to define measures and the resulting measure reports has progressed substantially, while the use of FHIR based APIs to externalize measure data extraction and measure report generation lack implementation experience at scale to understand viability or need to solely support such an approach. We recognize it has potential benefits but may not be suitable, thus required, in all settings. The EHR Association supports further efforts and exploration of alternative reporting architectures before a single method is established, if even appropriate.

3. MIPS Program Details

b. Transforming MIPS: MIPS Value Pathways

(d) MVP and Subgroup Implementation Timeline

(i) MVP Implementation Timeline

We request public comments on this incremental timeline to transition to mandatory MVP reporting, including the timing of the sunset of traditional MIPS. Specifically, are there concerns with this timeline? Is there an alternative timeline we should consider and why? In addition, what factors should CMS monitor to determine stakeholders readiness to sunset traditional MIPS and transition to MVPs? We understand that some clinicians who participate in MIPS practice in highly specialized clinical areas and subspecialties, where they may believe there is not an MVP applicable to their highly specialized practice. Therefore, we also request comment on what should happen in instances where highly specialized clinicians cannot identify an applicable and relevant MVP.

This is a particular concern for highly specialized groups who have challenges in the current MIPS structure. While a traditional MIPS platform may not improve things for them, creating new measures that focus on those subspecialties could prove equally challenging. The EHR Association supports a delay in the sunset of traditional MIPS until a suitable option can be found for those subspecialties, whether that be an exception or another option yet to be defined.

Additionally, we ask CMS to consider that highly specialized measures, although part of the MIPS program today, are not currently supported by all developers due to their complexity and limited use case by clients. In cases where highly specialized measure sets are not available, we ask CMS to consider allowing clinicians to report through the traditional MIPS pathway (individual or group) as they do today until a better alternative is identified. If CMS were to require all developers to support all measures, the additional development resources required to accommodate this would force users to license software that is more expensive because it includes irrelevant measures.

(f) Catalyst for Reporting MVPs

(3) Subgroup Composition

(c) Definitions of a Single Specialty Group, Multispecialty Group, Subgroup, and Special Status

(ii) Proposed Subgroup Definition

We propose to define a subgroup at § 414.1305 as a subset of a group which contains at least one MIPS eligible clinician and is identified by a combination of the group TIN, the subgroup identifier, and each eligible clinician's NPI.

A majority of EHR developers would require technical implementations in order to apply these subgroups. Therefore, the EHR Association would ask for an adequate timeline to ramp up to this.

MIPS eligible clinicians in groups who do not have an MVP available and applicable to their practice would participate in MIPS through group reporting or as an individual. If their group reports through traditional MIPS or an MVP, the clinicians could receive their group's score, if their group submits data. If the group chooses not to report, a MIPS eligible clinician can report as an individual and receive their individual score.

While subgroup reporting of MVPs would be voluntary through the CY 2024 MIPS performance period/CY 2026 MIPS payment year, groups will continue to report to MIPS for the eligible clinicians (as identified by NPI) under their TIN, including clinicians reporting through subgroups, which is discussed in section IV.A.3.b.(2)(d)(i) of this proposed rule. We request public comment on this proposal.

The EHR Association would recommend a delay of MVP implementation until the following criteria is met and developers have had an opportunity to validate all necessary changes.

- Currently there is a lack of subspecialties, CMS needs to introduce more prior to release.

- Subgroup reporting will require changes in our reporting systems, because of this CMS should offer more time for developers to update, deliver and install changes.
- Require developers to add to their number of offered measures, because third party intermediaries are proposed to require all measures offered in the MVP to their clients. We EHR developers will need more time to onboard additional measures.
- Under the proposed model, developers who are not 3rd party intermediaries are left without an option to support clients.
- dQMs are also a major lift for developers. Since CMS proposes to transition to them only a couple years after optional MVP, we recommend a delay to align with dQMs.

(d) Subgroup Eligibility

(iii) Subgroup Composition Limitations

We request comment from stakeholders on the options for multispecialty groups to participate as subgroups for reporting MVPs for the first year of voluntary subgroup reporting, beginning in the CY 2023 MIPS performance period/2025 MIPS payment year.

The EHR Association believes that this timeline is inadequate as our clients would expect this functionality in 2022 to prepare, which is insufficient for EHR developers to make modifications and allow clients to implement these changes.

(iv) Proposed Subgroup Inclusions and Exclusions

(bb) Proposed Subgroup Eligibility - Participants in MIPS APMs

We seek comment on whether there are strategies that CMS should consider to allow the formation of subgroups for clinicians in APM Entities comprised of multiple billing TINs.

APM Entities composed of multiple billing TINs will not be an issue for many EHR developers. The EHR Association does request a minimum one-year notice for applicable development to be completed by developers and for clients to implement the required functionality.

(h) Future Vision of Subgroups

(ii) Vision for Data Granularity

We envision an end state where technology will allow for the submission of discrete data elements and allow us to calculate measure performance for clinicians, subgroups, groups, and APM Entities, rather than having measure performance aggregated and calculated at a group or subgroup level prior to reporting more granular data will be available for patients, clinicians, and other stakeholders through a three pronged approach of mandatory subgroup reporting, broad use of standards-based APIs that leverage the FHIR standard within EHR And the creation and use of dQMs.... We believe this would give patients specific and meaningful information which can better inform their choices when selecting a clinician and offer more targeted feedback to clinicians. We request information on the vision for data granularity.

Concerns for patient privacy and data security, in light of cyber threats and unintended uses of data, the EHR Association questions whether the API will access only needed data, or will it access full patient data? Further, does this data include only CMS beneficiaries or all patients? We would be in favor of additional details regarding the proposed program changes.

(iii) 2023 MIPS Performance Period (2025 MIPS Payment Year)

We seek public comment on our proposals to maintain the data completeness criteria threshold of at least 70 percent for the 2021 and 2022 MIPS performance periods (2023 and 2024 MIPS payment years), and increase the data completeness criteria threshold from at least 70 percent to at least 80 percent for the 2023 MIPS performance period (2025 MIPS payment year).

If CMS chooses to maintain the 80 percent requirement, we suggest a leniency for clinicians who are transitioning between EHRs during the year, as the de-duplication and aggregation process can be challenging.

TABLE Group C: Previously Finalized Quality Measures Proposed for Removal in the CY 2022 MIPS Performance Period/2024 MIPS Payment Year and Future Years

Proposed Removal of 2 eQMs, [including] CMS 22 Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented, because this measure does not align with the Meaningful Measures Initiative as it is low-bar and a frequently performed assessment. This is a process measure that only requires a blood pressure to be taken and if abnormal a follow-up plan of care be documented; however, the documented follow-up includes referring the patient to a primary care physician and does require confirmation of follow-up.

We do not support the removal of CMS 22 as it is a widely used measure that also has broad application to a number of providers, who may otherwise struggle to find measures applicable to their practice.