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August 21, 2017

Seema Verma
Administrator for the Centers for Medicare & Medicaid Services
US Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Administrator Verma,

On behalf of the 30 member companies of the Electronic Health Record Association (EHRA), we are pleased to offer our comments on the Center for Medicare and Medicaid Services' (CMS) proposed rule on the Medicare Program; CY 2018 Updates to the Quality Payment Program, which was published in the Federal Register on June 30, 2017.

Overall, we understand that clinician readiness is crucial to the success of the program and that CMS is proposing to add flexibility to help providers feel more prepared, especially for those participating in the Merit-based Incentive Payment System (MIPS). We strongly support CMS' engagement of healthcare providers in the design of this program and its intent to provide flexibility in various aspects of the QPP program reflecting the wide range of provider-types and levels of readiness.

While recognizing CMS' desire to add such flexibility, we do have concerns that repeated delays in program implementation timelines, as we have seen over several regulatory cycles, as well as a continued lack of clarity around requirements, may discourage clinicians from adequately preparing for MIPS' future performance periods.

Similar patterns have been seen with Meaningful Use and ICD-10, and repeated delays and changes to prior levels of expected compliance can condition providers to delay implementing necessary and beneficial changes in technology and its use in clinical practice. We note that many provider organizations and developers have invested in significant technical upgrades and process improvements. Being unable to realize a return on those investments because deadlines are moved creates disincentives to aggressive participation in future years.

Overall, this pattern can inhibit the broader adoption of health IT, a necessary component to the transition to value-based care.

In making these comments, we are not arguing against specific proposals made by CMS in the proposed rule but rather highlighting the need to “get it right” as early as possible by heeding input from providers and developers in QPP program design to minimize the need for mid-course corrections that can waste stakeholder time and resources.

In our comments below, we’ve identified some areas where the proposed additional flexibility requires further clarity to ensure that CMS expectations are fully understood by affected stakeholders.

Virtual Groups:

With the addition of the virtual group option for reporting to MIPS 2018, there remains uncertainty as to how data can and should be submitted for these groups. Many providers in small practices who may opt to form virtual groups will be using different EHR systems, which will require them to combine data prior to submission. Although many EHR systems have the ability to exchange clinical data, combining it for purposes of meeting quality or advancing care information (ACI) measures for MIPS is more complex.

We urge CMS to set clear expectations as to how virtual groups should submit data across categories and from multiple systems while ensuring their information is aggregated and reported correctly to maximize the group’s composite performance score. We understand there must be a Virtual Group identifier on reports submitted by virtual groups, so we encourage CMS to provide more details about this as soon as possible, so we can be prepared to implement the identifier and support eligible clinicians (EC) reporting in this manner.

MIPS – Improvement Activities:

CMS has proposed adding appropriate use criteria (AUC) for all advanced diagnostic imaging services (CT, MRI, PET, echocardiography) as an improvement activity in 2018. We support this additional improvement activity (IA) but ask CMS to shift from a requirement that “all” advanced imaging services must involve AUC consultation. Such a de facto 100% performance threshold is unworkable, even more restrictive than ACI measures, and will create significant measurement challenges for ECs and vendors. In general, with such a quantitative approach to the AUC IA, EHR vendors will need clarity from CMS as to how EHRs should measure adherence to appropriate use criteria in order to support providers submitting this as an IA. Furthermore, as we have stated in previous comments, adequate time is needed to assess whether standards can support the requirements; update the standards as necessary; update systems to support the new/updated standards; test the access/exchange; and roll out the updated software to the relevant stakeholders. Each of these steps takes time and effort, so sufficient time for preparation and execution is essential.

This same comment is also applicable to other newly proposed IAs for 2018, several of which have a 75% performance threshold. We urge CMS not to move toward a percentage-based measurement approach to IAs.

Also, we encourage CMS to refrain from creating a health IT subcategory of improvement activities and cancelling the opportunity for providers to earn bonus points in the ACI category for submitting improvement activities requiring health IT. Introducing a separate category of health IT activities could create measures that are difficult for EHRs to support, which again contradicts the goal of the improvement activities category. Rather than create a separate category of health IT activities, we urge CMS to clarify which activities cannot be repeated each year so eligible clinicians can plan accordingly.

MIPS – Advancing Care Information:

The proposed rule allows flexibility for the required edition of certified EHR technology (CEHRT) for reporting advancing care information and electronic clinical quality measures (eCQMs) in MIPS, though it suggests awarding 10 ACI bonus points to eligible clinicians who use 2015 CEHRT. We encourage CMS to consider awarding 20 bonus points to eligible clinicians using 2015 CEHRT in 2018 as it would provide stronger incentive for them to upgrade and implement the 2015 edition for 2018 use, thereby expanding the availability of 2015 edition enhancements, such as the new open APIs.

Also, we ask CMS to clarify that during 2018, as in 2017, ECs can use either transition or regular ACI objectives and measures regardless of which CEHRT edition(s) they use for ACI. The recently finalized IPPS Final Rule for 2018 permits clinicians to use either the Modified Stage 2 or Stage 3 objectives and measures in 2018, regardless of the CEHRT edition used, so we ask for the same clarity for ACI in MIPS.

Furthermore, we urge CMS to be as clear as possible regarding the required edition of CEHRT across regulatory programs and alternative payment models (APM) and to harmonize the calendar year 2018 requirement across the various QPP-relevant payment models. Many alternative payment models, for example, point to the definition of CEHRT as outlined in the Meaningful Use (MU) or the Quality Payment Programs. Not only do we urge CMS to create consistency across these two programs via rulemaking, we suggest it publish guidance to clarify which APMs align with the finalized QPP definition of CEHRT and use of CEHRT for specific activities, or whether they have their own, such as what appears to be the case for the Comprehensive Primary Care Plus (CPC+) program.

MIPS – Cost:

CMS has proposed weighting the cost category at zero percent of eligible clinicians' MIPS composite score in 2018 and introducing new episode-based measures for the 2019 performance year. If this proposal is finalized, we urge CMS to release the new episode-based measures as soon as possible in 2018 so providers have sufficient time to prepare, especially since the cost category is weighted at 30% beginning in 2019. It will be important for clinicians to understand exactly how they will be measured from a cost standpoint prior to the beginning of the performance year. Because the weight of the Cost category will jump dramatically from zero to 30% between 2018 and 2019, it is essential that ECs receive significant information and support regarding the role of the episode-based measures, clinician attribution assumptions, and general guidance regarding the types of actions, including use of health IT, that could improve cost performance consistent with providing high quality care.

MIPS – Quality:

In the proposed rule, CMS proposes allowing multiple submission methods for reporting quality (and other) measures to MIPS. While we understand the request and need for such flexibility, we want to highlight that it does add complexity to how EHR vendors are able to provide visibility into eligible clinicians' MIPS scores. Many vendors are working diligently to calculate and give visibility to MIPS scores at the group and individual level so clinicians understand where they fall prior to submitting their QPP data to CMS. Lack of visibility to measures submitted via other methods, such as a qualified clinical data registry, will make the calculations for the quality category incomplete. Ideally, the API CMS is working to deploy will be able to aggregate data across submission methods; however, until that is available for EHR vendors to implement, it will be challenging to calculate MIPS scores that are 100% accurate due to this nuance in the quality category.

Performance improvement scoring is another proposal that could present challenges in calculating the quality score. Such calculations could be particularly difficult if clinicians switch EHR systems or are migrating from paper. We ask CMS to clarify how the performance improvement score will be calculated in these circumstances.

Finally, we urge CMS to be clear that, given the proposed data completeness threshold, clinicians could meet the full year quality reporting requirement for a measure with less than a full year of data, and this could be met with 2014 edition, 2015 edition, or a combination of the two, regardless of which edition is used for ACI so long as the Spring 2017 eCQM specifications are used and CEHRT (2014 or 2015 edition) is used for reporting.

Alternative Payment Models:

We are very pleased that CMS is proposing to allow CPC+ to count as an advanced APM in 2018 for practices participating in round one of the program regardless of the size of their parent organization. We felt it was unfair and inappropriate to practices owned by large organizations that were accepted into the program last year to not be able to count CPC+ as an advanced APM given all of the requirements they must meet. Additionally, we are glad that CMS has proposed expanding the definition of a patient-centered medical home for IAs to include CPC+ given the similarity in requirements.

In conclusion, we encourage CMS to provide clarity around reporting via virtual groups; maintain simplicity in the improvement activities category; ensure consistency regarding use of CEHRT across programs and alternative payment models; and, avoid adding complexity to the quality category in the MIPS program. We applaud CMS' efforts in making the Quality Payment Program more flexible in several areas and expanding opportunities for clinicians to participate in advanced alternative payment models.

We look forward to continuing to work with CMS and other stakeholders to advance the goals of the Quality Payment Program and appreciate this opportunity to provide feedback on this important rule. EHRA representatives would be happy to engage in further discussion; please reach out to our Program Manager, Sarah Willis-Garcia at swillis@himss.org.

Sincerely,



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About the EHR Association

Established in 2004, the Electronic Health Record (EHR) Association is comprised of 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.