

October 5, 2020

Ms. Seema Verma, MPH
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD. 21244-1850

Re: CMS-1734-P; Medicare Program; CY 2021 Medicare Physician Fee Schedule and Quality Payment Program Proposed Rule

Dear Administrator Verma,

The Physicians' Electronic Health Record Coalition, PEHRC or the Coalition, is submitting our comments on the Centers for Medicare & Medicaid Services (CMS) proposed rule regarding the 2021 Medicare Physician Fee Schedule and Quality Payment Program. The Physicians' Electronic Health Record Coalition is comprised of 25 medical societies representing a nationwide community of more than 600,000 physicians who share information to support the use of health information technology.

PEHRC has been committed to providing a forum for members to collaborate and contribute to the advancement of usable, safe, and responsible patient- and provider-facing health information technology.

Provided below are PEHRC's comments regarding the CMS Medicare Physician Fee Schedule and Quality Payment Program Proposed Rule.

I. Updates to Certified Electronic Health Record Technology (CEHRT)

Timelines

CMS is proposing to require that healthcare providers participating in the Promoting Interoperability Programs or QPP use only technology certified under the ONC Health IT Certification Program according to the timelines finalized in the Cures Act final rule. This would require clinicians to use CEHRT that has been certified to the 2015 Cures Edition Update for a measure action to count in the numerator during a performance period after Aug 2, 2022.

Although the 90-consecutive day performance period for PI allows for the first PI performance period using the 2015 Edition Cures Update to be in 2023, PEHRC would like to underscore that CEHRT is required by Dec 31 of the performance year for reporting eQMs. Because of this requirement, the update would have to be completed by Dec 31, 2021.

PEHRC strongly opposes the proposed application of the ONC health IT vendor deadline to clinician implementation of these CEHRT updates. Requiring doctors to have new, updated EHR versions up and running potentially the same day as or within a few months of the vendor having the functionality certified is impractical and unsafe. We would also like to underscore that not all EHR vendors will be able to update to the new version.

Implementing EHRs in clinical practice takes more time than allowed under this proposed rule. Functionally, it is impossible to implement an EHR upgrade on the day it is released. EHR implementation in clinical settings commonly takes 16-24 months.¹ This includes preparing old records for transition, training staff, working with the vendor to create the specific build to optimize workflows, and other data-merging activities.

Moreover, many EHR vendors will likely charge high fees for this substantial update that must be purchased at an appropriate fiscal time.

Given the massive impact of the COVID-19 pandemic on the financial stability of the healthcare community, PEHRC is highly concerned about the ability of clinicians and practices to pay update fees. The healthcare sector's financial stability has been decimated by the drastic reduction or even cessation of elective procedures and a sharp decline in outpatient care since March.² It will take years for healthcare to recover financially from the pandemic. Imposing additional and potentially significant costs on clinicians during this time will worsen this crisis and, likely, lead to further increased practice closure or practices leaving Medicare. This will increase barriers to care for many patients.

¹ Chapter "Preparation: Planning Your Project." *EHR Implementation: The Definitive EHR Implementation Guide*. N.p.: HCI Group, 2015. pg 11.

² <https://www.commonwealthfund.org/publications/2020/jun/impact-covid-19-pandemic-outpatient-visits-practices-adapting-new-normal>

This timeline for clinician adoption of the 2015 Edition Cures Update should be separate from health IT vendor timeline requirements. With the strain that COVID-19 has placed on healthcare practices, **PEHRC strongly urges CMS to provide a minimum of one year between the ONC health IT vendor deadlines and the clinician deadlines.**

Removing retired criteria

PEHRC supports CMS's common-sense proposal to remove any retired criteria from the functionality requirements of the 2021 PI measures. This proposal will allow early-adopter clinicians to succeed under PI.

Adding optional new criteria

PEHRC supports CMS's proposal to add any new criteria appropriate to a PI measure as an option for functionality that can be used to fulfill the measure. This proposal will also allow clinician early-adopters to succeed under PI and get credit for their measure actions.

II. MIPS Promoting Interoperability Category

i. Proposed New Promoting Interoperability Measure

CMS proposes to add an optional alternative measure to the two current health information exchange (HIE) objective measures. This optional alternative measure, HIE Bi-Directional Exchange, would require the clinician to participate in bi-directional exchange through an HIE *for every patient seen by the eligible clinician and for any patient record stored or maintained in their EHR.*

PEHRC strongly encourages CMS to maintain this measure as an optional alternative in all future years. While the Coalition supports adding flexibility to PI and reducing reporting burden generally, we are concerned about the potential cost and burden for performing the actions required by this measure. HIE use can be expensive.

The high connectivity fees imposed by the HIE and the practice's EHR vendor can act as important deterrents to connectivity. Particularly in light of the new financial challenges associated with the COVID-19 public health emergency, practices participating in MIPS should not be penalized for having insufficient financial resources to meet an overly prescriptive Health Information Exchange measure. This impact may further drive consolidation in healthcare.

PEHRC also asks CMS for clarification on the content of information included in bi-directional exchange. It is unclear if, for example, portal messages must be included in the information exchanged with the HIE. If so, we ask for guidance on how this can be implemented for practices on a portal that does not connect to an HIE.

Attestation Statements

CMS requested comment on the attestation statements. Specifically, CMS asked if the statements reflect appropriate expectations about information exchange capabilities for eligible clinicians that engage with HIEs capable of facilitating widespread exchange with other health care providers.

The first attestation statement would require clinicians reporting this measure to attest to 100% performance to get any credit for this measure. This means that the clinician would have to exchange not only every patient seen by the eligible clinician during the performance period, but also every patient record stored or maintained in their EHR. As described above, due to the way fees are levied by HIEs, this requirement could be prohibitive for many clinicians or groups. **If CMS's goal is to encourage participation in an HIE, PEHRC suggests that CMS impose a lower threshold for performance for this measure's first year in MIPS PI.**

The second attestation statement requires the clinician or group to attest that the "HIE that I participate in is capable of exchanging information across a broad network of unaffiliated exchange partners including those using disparate EHRs, and does not engage in exclusionary behavior when determining exchange partners." Attesting to this statement will be difficult for many clinicians to do with confidence. There are not sufficient standards to allow clinicians to choose HIEs and attest to this statement with certainty.

Moreover, the HIE ecosystem is variable based on geographic location. Not all states have state-wide HIEs available or connect to a national network. In addition, some geographic locations have only regional or county-based HIEs. This wide variation in HIE networks and availability can also make it difficult and confusing for clinicians to evaluate and choose appropriate HIEs. **PEHRC encourages CMS to remove this attestation statement until there is more widespread connectivity and available information in the HIE space.**

ii. Future Direction of the PI Performance Category

Alignment with Medicare Promoting Interoperability Program

CMS states that they will consider changes to PI which support alignment with the Medicare Promoting Interoperability Program for hospitals. **PEHRC asks CMS to recognize the important differences between the MIPS PI performance category and the Medicare PIP.**

If a hospital earns at least 50 of 100 points in the program, they pass and avoid a penalty. The MIPS Promoting Interoperability category, on the other hand, comprises 25% of the MIPS Final Score. An EC may be able to achieve 50 points in the category and, given the high projected future MIPS performance thresholds, still fail MIPS. In other words, hospitals have a much larger margin for error than do ECs. **We urge CMS to allow for more flexibility in scoring the MIPS PI category.** For instance, to match the hospital PIP, clinicians that achieve 50 points in the MIPS PI performance category could be given full credit for the category.

Alignment with the 21st Century Cures Act

The timeline for physician adoption of the 2015 Edition Cures Update should be separate from health IT vendor timeline requirements. With the strain that COVID-19 has placed on healthcare practices, **PEHRC strongly urges CMS to provide a minimum of one year between the ONC health IT vendor deadlines and the providers deadlines.**

In regard to additional future changes to further align with the 21st Century Cures Act, **PEHRC urges CMS to take into account the financial viability of practices and functional ability of practices to implement future proposed changes.** For instance, **CMS could create a multi-stakeholder technical expert panel or clinical committee composed of practicing MIPS clinicians to discuss and evaluate future alignment prior to further proposed changes.**

Advancing Interoperability and the Exchange of Health Information and Promoting Innovative Uses of Health IT

The field of health information exchange (HIE) is still evolving and full interoperability has yet to be achieved. As such, **PEHRC strongly urges CMS to evaluate the cost to practices, particularly in light of the COVID-19 PHE, and the functional ability of clinicians and practices to implement future proposed changes and to allow sufficient time for clinicians to implement any proposed future changes.** As suggested above, **one option is for CMS to create a multi-stakeholder technical expert panel or clinical committee composed of practicing MIPS clinicians to discuss and evaluate future interoperability and HIE requirements prior to further proposed changes.**

III. Third Party Intermediaries

i. QCDR Measures in MVPs

The PEHRC is concerned with CMS's proposal that a QCDR measure must be fully tested at the individual clinician level to be considered for inclusion in an MVP beginning in performance year 2022. Full measure testing, as currently defined by CMS is extremely expensive and, thus, often not possible.

QCDRs are predominately run by non-profit organizations such as medical societies. Non-profit medical societies already dedicate substantial resources to quality measure development.

We would also note that this requirement is inconsistent with the proposed timeline for QCDR measures under MIPS which requires face validity for performance year 2022 and full testing for performance year 2023. **The PEHRC strongly urges CMS to make full measure testing for QCDR measures in MVPs by 2022 optional, and also to modify the definition of full measure testing using the template put forth by the Council for Medical Specialty Societies (CMSS).**

Given that QCDR measures are submitted for self-nomination after the publication of the proposed rule, **the PEHRC strongly supports CMS’s proposal to make QCDR measures in MVPs finalized in the final rule eligible for 2-year QCDR measure approval.**

ii. QCDR Measure Testing

The PEHRC applauds CMS’s decision to have a one-year delay in the previously finalized measure testing requirements in light of the COVID-19 PHE.

In this proposed rule, CMS is proposing, that beginning with the 2022 performance period, all QCDR measures submitted at the time of self-nomination must be face valid. **The PEHRC appreciates and supports this proposal.** We believe this proposal will allow QCDR measures to fill gaps in MIPS quality measurement if the measure makes sense without requiring expensive testing for the first year.

CMS also proposes that, beginning with performance year 2023, all QCDR measures must be fully tested at the clinician level, as defined by the CMS Blueprint for the CMS Measures Management System. Measure testing, as defined by the CMS Blueprint for the CMS Measures Management System, is very time-consuming and expensive and would place significant burden on QCDRs. **As such, PEHRC strongly opposes the proposal to require full QCDR measure testing.**

QCDRs are often run by non-profit specialty societies without the resources required to complete measure testing for all measures. If full testing, as defined by the CMS Blueprint and Measures Management System methodologies, is required, many QCDRs will not be able to afford to meet this new requirement without imposing or increasing participation fees on clinicians and practices. We believe that imposing requirements that would generate this outcome is counter to the statutory mandate under MACRA to encourage the use of QCDRs.

Instead, the PEHRC proposes that CMS consider alternatives to the measure testing process such as any of the following:

- **Opening the measures for public comment**
 - This will allow for evaluation of data element reliability
- **Using the template put forth by CMSS, or**
- **Providing funding to QCDRs for measure testing.**

IV. MIPS Value Pathways

i. Proposal: Apply MVP Framework Starting with the 2022 Performance Year

The PEHRC applauds CMS’s decision to delay the implementation of MVPs to performance year 2022 in light of the COVID-19 public health emergency (PHE).

ii. Availability of MIPS

In this proposed rule, CMS states that they “expect that in the future we [CMS] may propose that all eligible clinicians would be required to participate in MIPS either through an MVP or an APM Performance Pathway (APP).” **The PEHRC strongly urges to maintain the current process of MIPS reporting for all eligible clinicians and groups in all future years.**

The PEHRC would like to underscore that the MVP process should be voluntary; we are strongly opposed to mandatory assignment of MVPs for several reasons. The first of which is that we do not believe there is a reliable way for CMS to determine a clinician’s practice mix or subspecialty for MVPs. Second, **the PEHRC is concerned that there is no reliable way for CMS to determine appropriate measures to assign to clinicians.** Lastly, **assigning MVPs will further disadvantage certain specialties and small and rural practices with regard to topped out measures.** By requiring clinicians to report on specific measures, CMS may directly disadvantage particular specialties and types of practices.

iii. Proposed Changes to MVP Guiding Principles

PEHRC opposes CMS’s proposal to add the following to the MVP Guiding Principles: “MVPs should support the transition to digital quality measures.”

Many small and rural practices operate on narrow margins and cannot afford EHR costs, especially when combined with the IT and cybersecurity staff required to maintain electronic health record security. CMS has previously acknowledged this disparity and addressed it through the small practice hardship exception under the Promoting Interoperability category of MIPS. This hardship exception allows small practice clinicians to participate in MIPS and provide quality care to those who need it most. **By requiring or prioritizing eCQMs over other collection types, CMS would impose a new and substantial burden on many clinicians, particularly those in small and rural practices. We strongly urge CMS to maintain manual forms of quality measure reporting to accommodate small and rural practices.**

iv. MVP Development Criteria

Below is a selection of the proposed MVP development criteria with the PEHRC response following each proposed development criterion listed:

- MVPs should include the entire set of Promoting Interoperability (PI) measures.

PEHRC does not support this criterion as proposed. Many small and rural practices operate on narrow margins and cannot afford EHR costs, especially when combined with the IT and cybersecurity staff required to maintain electronic health record security. **At minimum, PEHRC strongly urges CMS to maintain the MIPS PI small practice hardship under MVPs.**

- For Quality measures: To the extent feasible, does the MVP include electronically specified clinical quality measures?

PEHRC opposes this criterion. Please see our discussion of the proposed MVP guiding principle related to the transition to [digital quality measures](#) (pg. 7).

- For Improvement Activities: To the extent feasible, does the MVP include improvement activities that can be conducted using CEHRT functions? The use of improvement activities that specify the use of technologies will help to further align with the CEHRT requirement under the Promoting Interoperability performance category.

PEHRC opposes this proposed criterion. As discussed above, this has the same problem of disadvantaging small and rural practices that cannot afford an EHR or cannot afford to update to the new 2015 Cures Update Edition CEHRT. In addition, this criterion would require increased screen time from clinicians without any evidence of decreased burden or improved quality. As such, PEHRC believes that this criterion is counter to the CMS Patients Over Paperwork Initiative.

v. QCDRs and the MVP Framework

PEHRC strongly urges CMS to not require full measure testing for QCDR measures in MVPs by 2022, or to modify the definition of full measure testing using the template put forth by the Council for Medical Specialty Societies (CMSS). For further discussion, please see our [Third Party Intermediaries section on QCDR Measures in MVPs](#) (pg. 5).

We appreciate the opportunity to comment on the CMS Medicare Physician Fee Schedule and Quality Payment Program Proposed Rule. If you have questions or need any additional information regarding any portion of these comments, please contact Dr. Jessica Peterson, PEHRC Chair, at jpeterson@ao.org or via phone at 202-737-6662.

Sincerely,



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Chair of the Physicians' EHR Coalition