HCMS
Harris County Medical Society

June 27, 2016

Centers for Medicare & Medicaid Services
Department of Health and Human Services
CMS–5517–P, P.O. Box 8013
Baltimore, MD 21244–8013

Filed Electronically

To: Centers for Medicare & Medicaid Services (CMS), HHS

Re: Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models; Proposed Rule

INTRODUCTION

On behalf of over 11,500 physician and medical student members of the Harris County Medical Society (HCMS), thank you for the opportunity to participate in commenting on the proposed rule regarding the "Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models" published in the *Federal Register* on Monday, May 9, 2016.

PLATFORM BEHIND OUR COMMENTS

HCMS represents grassroot physicians in all medical and surgical specialties who transact with all of the Medicare compliance processes on a daily basis. Our comments are reflective of the feedback we receive from our members and their staff. Our 5 million patient area of Houston Texas contains approximately 360,000 fee-for service Medicare patients. One of our primary concerns is dropout of primary care Medicare providers. Our comments reflect this concern and ways to mitigate the migration out of Medicare.

PRIORITY COMMENTS

First, HCMS would like to request a delay in this program of at least six months. Final rules are scheduled to be published in November which only gives two months to prepare for this new system. This is an undue burden on physicians and will interrupt care being given to Medicare patients as seen when initially implementing PQRS and EHR Meaningful Use (MU).

The complexity of the Quality Payment Program (QPP) and the cost to implement are more than Congress intended. The intent of this legislation was to establish objective and timely quality measurement and reporting systems that are simpler and less costly than those currently required. This has not been accomplished and we fear frustrated physicians will simply not participate as there are no clear improvements.

Since the Clinical Practice Improvement Activity (CPIA) is a new category, HCMS would like to propose initially having CPIA as an option for "extra credit" to be added to the total points of the other three categories to prevent physician alienation.

HCMS questions the scoring and transparency of the different categories. The scoring needs to be simplified so physicians are clear on the weight of each measure and threshold.

A one year performance period does not give CMS enough time to give physicians timely feedback on performance reports. This is a dilemma in the present programs. A performance period of 90-days is sufficient for CMS to measure, incentivize or penalize an Eligible Clinician (EC). It will also make tracking physician progress more efficient from period to period.

CMS has stated several times it wants collaboration with physicians. We appreciate that commitment and hope that you will specifically address the needs of small practices. Approximately 54% of our members are in practices of under 10 physicians.

Small practices' inability to fulfill what is needed to accomplish MIPS scoring due to the high cost and complexity will highly likely lead to a negative outcome. Hence, the smaller practices' penalties will be supporting the large group bonuses. Texas, being a state that has a large number of small practices could be subsidizing other states that have a majority of large groups. This is an unbalanced threshold that needs further review and revisions to be a fair process. Exempt physicians who have no possibility of covering the cost to report data, and do not force physicians into unacceptably risky payment models. We specifically ask that CMS raise the 100 patient and $10,000 exemption threshold, which is discussed in more detail below.

Regulators and physicians have hoped market forces would drive EHRs to interface and there would be a meaningful exchange of meaningful patient data. Unfortunately this has not occurred. Every time physicians must make a change to their EHR system there is an immediate and uncompensated increase in IT costs. The proposed rules require many changes to existing EHR systems. The burden must fall on EHR vendors to build and maintain products that meet federal specifications rather than forcing physicians to purchase and constantly upgrade expensive and often balky systems.

HCMS supports an exemption level higher that the proposed 100 patients and $10,000 ceiling. We have great concern that many physicians will limit their practices to this level to avoid the cost of compliance and the penalties. That would cause a huge access problem for Medicare

patients. As mentioned above, there are approximately 5 million people in the Houston area, including approximately 360,000 fee for service Medicare beneficiaries. There are approximately 2.3 million people with commercial insurance. We have approximately 1 million uninsured patients, many whom pay cash for primary care services. The rest of the population are Medicaid and CHIP. Our area has a shortage of primary care physicians. There are enough commercial insured and cash patients to fill their practices. Only about 30% of our physicians see Medicaid patients. We could have a large decline in physicians seeing Medicare patients above the exemption level. Consequently, the amount should be calculated based upon Medicare allowed charges, not billed charges.

ADDITIONAL COMMENTS

Quality Payment Plan (QPP) Ultimate Goal

As stated in the proposed rule, the main goal of the Quality Payment Program is to "**encourage more MIPS eligible clinicians to participate in Advanced APMs, which link quality and value to payment**"

- It is clear that CMS intentions in the proposed rules are to move from "fee for volume" to "fee for value" by ultimately moving all fee for service payments through an advanced APM. However, it is also clear that most physicians will need to initially go the MIPS pathway. As written, the MIPS is an unbalanced stepping stone to advanced APMs as seen through our comments below. Thus making it difficult for CMS to accomplish its ultimate long term goal. Allow physicians who want to shift to value-based care enough time to make this transition in a way that actually benefits their patients and does not cause undue collateral damage to their practices.

Merit-based Incentive Payment System (MIPS)

- HCMS does appreciate the removal of the "all or nothing" mandate in the MIPS pathway. However, as MIPS was supposed to be the unity of PQRS, EHR Meaningful Use and the Valued Based Modifier, we are disappointed to see that there is no harmony between these three programs. Even of more concern, CMS added a fourth category, the Clinical Practice Improvement Activity (CPIA), which is unbalanced regarding the 'high' and 'medium' categories. This category needs to be studied further, therefore HCMS would support CPIA as an "extra credit" to be added to the composite performance score total from the other three categories.

- HCMS requests that CMS allow physicians who are participating in the Medicaid EHR MU be exempt from the MIPS by submitting a waiver of participation to CMS.

- HCMS encourages CMS to take into consideration patient non-compliance when calculating scores in the MIPS program.
- MIPS should not use measures based on economic data rather than evidence-based, scientifically sound medical data.

- The Congressional Budget Office (CBO) financial burdensome estimates are incorrect because it does not include the number of patients physicians see each day and the amount of time it takes to report on each of those patients. If CMS is going to require physicians to report on information from all payers, this will increase the physician cost even more.

- In the past, the CBO estimates have been way lower than actual physician expenditure. As physicians have not even had a cost of living increase in over 10 years, the cost is becoming more unsustainable especially for small to midsize practices. An MGMA study published in September 23, 2015 announced "Physician-owned, multispecialty practices responding to the MGMA Cost and Revenue Survey reported a 12.02% increase in spending on total operating costs per full-time-equivalent (FTE) physician since 2010. Physician owned, multispecialty practices reported an 11.87% increase spent on operating costs associated with technology since last year, spending $20,693 per FTE physician in 2014. Since 2010, this number has increased by **33.92%,** showing how much impact the technology boom and mandated electronic health records has had on individual practices. A recent published study in *Health Affairs* estimated the ongoing labor cost of reporting quality data to payers at more than $50,000/physician/year. Please note that this is a stark contrast to CMS' estimate of the burden, which ranges from $18 to $1,294/reporting mechanism/eligible clinician/year as noted in Tables 48-51 of the proposed rule.

- Allow physicians who want to shift to value-based care enough time to make this transition in a way that actually benefits their patients and does not cause undue collateral damage to their practices. As proven by the history of the implementation of the EHR MU and PQRS programs (See Exhibits 1, 2, 3 and 4) the statistics show not even 50% are successfully participating in PQRS nationally. In Texas, the EHR MU success rates have declined as shown in Exhibits 2 & 3. Exhibit 4 shows Eligible Professionals (EP) in Texas rotating in and out of the EHR incentive program.

(Exhibit 1) National PQRS Participation Statistics for Eligible Professionals (EPs)

Pymt Year	Total Eligible	Of Total Eligible Participants (Count, %)		Of Total Eligible Non-Participants (Count, %)		Of Total Eligible Participants Amount Successful (Count, %, $$ Rcvd)			Of Total Eligible Participants Amount Unsuccessful (Count, %)	
2009	688,329	103,938	15%	584,391	85%	55,244	53%	$ 36,000,669	48,694	47%
2010	964,196	154,271	16%	809,925	84%	85,481	55%	$136,769,600	68,790	45%
2011	1,006,833	210,428	21%	796,405	79%	120,665	57%	$234,282,572	89,763	43%
2012	1,042,595	268,990	26%	773,605	74%	194,278	72%	$391,635,495	74,712	28%
2013	1,101,773	320,616	29%	781,157	71%	266,740	83%	$261,733,236	53,876	17%
2014	1,201,362	436,094	36%	765,268	64%	367,228	84%	$167,815,193	68,866	16%
**2015	1,253,599	641,843	51%	611,756	49%	494,619	77%	$218,930,348	147,224	23%
2016	1,322,529	822,613	62%	499,916	38%	585,037	71%	$224,088,411	237,576	29%

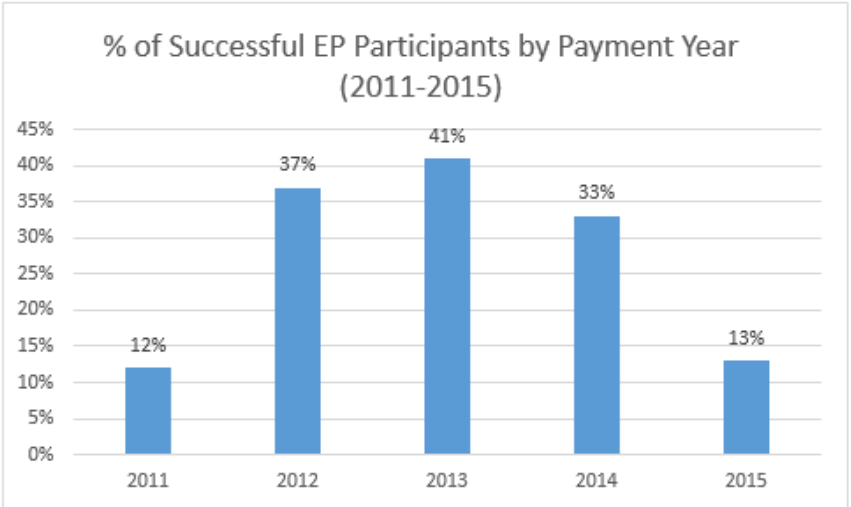
**** Penalty Initiated***

(Exhibit 2) Meaningful Use Statistics - Texas

Payment Year	Calculation of Texas Medicare Providers w/ EHR Technology**	Total EPs Receiving Incentive Payments	% of Successful EP Participants	Total $ Amount of Incentive Payments
2011	28,196	3,491	12%	58,903,798
2012	29,772	11,012	37%	170,704,149
2013	33,274	13,630	41%	152,686,719
2014	41,914	13,937	33%	116,457,310
2015	45,767	6,176	13%	31,679,480
2016	48,335	no data	unknown	no data

**Calculated based on Physician Compare data of Medicare providers in Texas multiplied by HealthIT.gov data of national percentages of physicians using EHR technology.*

(Exhibit 3) Meaningful Use Statistics – Texas Percentage of Successful EPs (2011-2015)



(Exhibit 4) Texas physicians rotating in and out of Electronic Health Record (EHR) Meaningful Use (MU)

Texas EPs Paid from Jan. 2011 - Dec. 2014	31,136	
Unique Texas EPs that Participate in MU from Jan. 2011 - Dec. 2014	**17,255**	
Unique Texas EPs that participated in MU for 1 year	6,785	39%
Unique Texas EPs that participated in MU for 2 years	7,362	43%
Unique Texas EPs that participated in MU for 3 years	2,805	16%
Unique Texas EPs that participated in MU for 4 years	303	2%
25 out of 11,419 EPs changed EHRs		
EPs starting MU in 2011	**3,692**	
Unique Texas EPs that participated in MU for 1 year	459	12%
Unique Texas EPs that participated in MU for 2 years	713	19%
Unique Texas EPs that participated in MU for 3 years	2,217	60%
Unique Texas EPs that participated in MU for 4 years	303	8%
EPs starting MU in 2012	**8,188**	
Unique Texas EPs that participated in MU for 1 year	1,563	19%
Unique Texas EPs that participated in MU for 2 years	6,037	74%
Unique Texas EPs that participated in MU for 3 years	588	7%
EPs Starting MU in 2013	**4,234**	
Unique Texas EPs that participated in MU for 1 year	3,622	86%
Unique Texas EPs that participated in MU for 2 years	612	14%
EPs Starting MU in 2014	**1,141**	

Top Ten Specialties Participating in Meanignful Use (MU)	
FAMILY PRACTICE	1947
INTERNAL MEDICINE	1509
CARDIOLOGY	784
ORTHOPEDIC SURGERY	548
OPTOMETRY	474
OPHTHALMOLOGY	451
OBSTETRICS/GYNECOLOG	436
GENERAL SURGERY	431
GASTROENTEROLOGY	342
NEUROLOGY	335

Participation by Group Size	
1-10	4605
11-20	714
21-50	901
51-100	889
100+	4573

*5573 EPs did not report grp size

Participation by Group Size MU for 3 or 4 years	
1-10	813
11-20	117
21-50	247
51-100	142
100+	739

Advancing Care Information (ACI) (Formerly known as Meaningful Use (MU)

- As of April 2016, 308,218 Medicare Eligible Professionals (EPs) received payments of $8,067,422,429 for participating in Stage 1of the EHR Incentive Program. Stage 2 has 144,261 EPs participating with incentive payments at $932,609,354 (See Exhibits 5 & 6). Almost $9 billion dollars has been paid out to EPs to assist in covering the cost of EHR hardware and software, but yet this does not cover all the cost. Additionally, the amount of incentive payments are dropping year to year as shown in Exhibit 7. As EHR prices and maintenance are going up, and incentive payments go down, this program may become financially unsustainable for physicians over time. Therefore, will negatively affect the composite performance score.

(Exhibit 5)

April 2016
EHR Incentive Program

Medicare Provider Count & Payment Summary by Stage Number

	Stage 1 - Program to Date		Stage 2 - Program to Date	
	Count of Unique Providers	Payments	Count of Unique Providers	Paymemts
Medicare Eligible Professionals	308,218	$ 8,067,422,429	144,261	$ 932,609,354

(Exhibit 6)

April 2016
EHR Incentive Program

Payment Summary

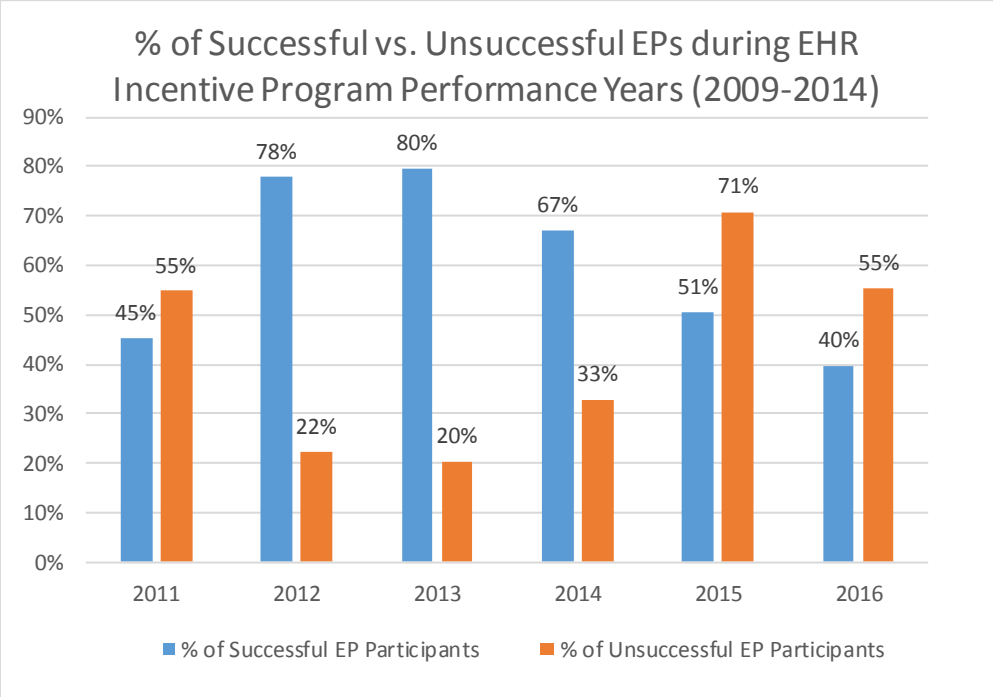
Program Year	Amount Paid
2011	$ 937,929,710
2013	$ 2,864,338,438
2013	$ 2,580,252,729
2014	$ 1,886,444,625
2015	$ 731,066,280
2016	$ -
Total Paid	$ 9,000,031,783

- HCMS thanks CMS for giving credit for work completed instead of only an "all or nothing" option.
- CMS did not allow the Immunization Registry Reporting as an option or name exemptions in the proposed rule. There are presently exemptions to this reporting measure as not all physicians give immunizations to patients. HCMS supports "optional" or exemptions be added to this reporting measure.
- As stated in Goal # 1 of the QPP goal list "CMS would like for the QPP to lead Medicare patients to better, smarter, and healthier care." EHR MU has not proven to accomplish this goal, therefore it is projected that the ACI is set up to do the same.
- HCMS does thank CMS for recognizing the importance of EHR usability and operability in the proposed rule. HCMS would support requiring EHR vendors to build and maintain products that meet federal specifications rather than forcing physicians to purchase and constantly upgrade expensive and often-balky systems.
- The proposed rule emphasizes interoperability and information exchange. It requires practices to use policies and technologies to assure that their EHR is interoperable and compliant with the Office of the National Coordinator for Health IT (ONC) standards. Patients must be given timely access to their information electronically. Their EHR must allow for the exchange of structured health information with other health care providers (including unaffiliated providers) using different EHR vendors. The amount of work and the high cost for physicians to accomplish this starting January 1, 2017 is extremely unreasonable.
- HCMS appreciates CMS delaying implementation of the ACI in the Medicaid Program.
- CMS requested comment on how to consider how best to incorporate Part D costs into resource use – physicians do not control drug costs and should not be measured on this benchmark. Their job is to diagnose and treat with the best drug that will assure resolution or minimize ailment.
- 2017 will be the first year of the new program that EHRs, QCDRs, and qualified registries would be able to submit EHR Incentive Program objectives and measures. Plus, for the first time the ability to report data through a CMS Web Interface is an option. Many Health IT vendors, QCDRs and qualified registries will still not have this capability on January 1, 2017 – basically still left with attestation as the only option. With the proposed scoring mechanism, this will have a negative impact on the total composite score.
- Scoring for ACI needs to be as simplified as possible. As the trend on EPs registering for the EHR MU program, the success rates are decreasing (See Exhibits 7 & 8). Implementing a complex scoring mechanism may divert this category in the MIPS, hence it will negatively affect the total composite performance score.

(Exhibit 7) National Stats on EHR MU

Program Year	# of Active EP Registrations to Date	# of New EP Registrations	# of EPs Receiving Incentive Payments	% of Successful EP Participants	Total $ Amount of Incentive Payments	# of EPs Receiving Negative Payment Adjustments	% of Unsuccessful EP Participants	Total $ Amount of Payment Adjustments
2011	123,923	123,923	55,997	45%	$938,849,044	no adjustment	55%	n/a
2012	240,695	116,772	187,222	78%	$2,861,135,644	no adjustment	22%	n/a
2013	291,368	50,673	231,856	80%	$2,568,304,442	no adjustment	20%	n/a
2014	339,991	48,623	228,023	67%	$1,879,814,509	no adjustment	33%	n/a
2015	362,586	22,595	183,387	51%	$1,445,613,658	257,000	71%	average over $250,000,000
2016	377,000	14,414	150,106	40%	$722,425,973 (as of April 2016)	209,000	55%	average over $600,000,000

(Exhibit 8) Graph showing Exhibit 8 information



Clinical Practice Improvement Activities (CPIA)

- HCMS would like to propose initially having CPIA as an option for "extra credit" to be added to the total points of the other three categories.

- Some of the medium-weight activities proposed demand a lot of time to accomplish and should be at the high-weight level. For instance, regarding the medium-weight activity of checking the PDMP. In Texas, physicians use the Prescription Access of Texas (PAT) System. Once access has been granted, through a difficult initial set-up, it takes about 5-7 minutes per patient to look thru the data. Many times physicians catch a narcotic prescription given by a different provider such as a dentist. When this happens, the physician has to call the patient to assure he/she understands that this is a narcotic and must be reported to their physician when a narcotic prescription is given by another provider. Additionally, the State of Texas includes a urine drug test which is approximately 2-3 hours of unfunded mandate per patient per year.

- HCMS appreciates CMS wanting to give credit for activities already incorporated into the practice, however most of the activities are not affordable to smaller and midsize practices.

- CMS requested a comment on "What type of information should be reported on physician compare" in the proposed rules. HCMS' reply - whatever CMS publishes it has to be accurate, valid and consistent among physicians.

Resource Use (Old Value-based Modifier (VBM)) = COST

- HCMS recommends that CMS base the assessment score on paid claims and not include claims that have been denied, pended or rejected in accessing the performance category score.

- HCMS strongly encourages CMS to only assign the allowed charge minus any overpayments made inadvertently by CMS to the eligible clinician and/or facility.

- HCMS recognizes CMS's desire to track cost through an 'episode of care'. However, HCMS strongly encourages CMS to only use resource/claims data for circumstances in which the eligible clinician has the ability to control the cost. In most circumstances eligible clinicians cannot control the hospital or pharmaceutical costs. If CMS is going to attribute resource costs to eligible clinicians, CMS will need to ensure that eligible clinicians are granted rights to allow for them to identify the cost through price transparency.

- HCMS would encourage CMS to only contribute Resource Use to eligible clinicians if the eligible clinician was directly able to control the patient's choice to obtain services.

Quality

CMS' proposal to decrease quality performance category requirement from 9 measures (under PQRS) to 6 measures is appreciated. However, CMS is not taking into consideration the population measures physicians (See Exhibit 9) will be scored on through administrative claims. This increases the measure count to 13.

(Exhibit 9) Comparing PQRS to MIPS Quality measures

PQRS Measures	MIPS Quality Performance Category Measures
Measure #1	Measure #1
Measure #2	Measure #2
Measure #3	Measures #3
Measure #4	Measure #4
Measure #5	Cross-Cutting Measure
Measure #6	Out-come/High Priority Measure
Measure #7	Population-Based Measure: Acute Conditions Composite – Bacterial Pneumonia
Measure #8	Population-Based Measure: Acute Conditions Composite – Urinary Tract Infection
Cross-Cutting Measure	Population-Based Measure: Acute Conditions Composite – Dehydration
	Population-Based Measure: Chronic Conditions Composite – Diabetes
	Population-Based Measure: Chronic Conditions Composite – COPD or Asthma
	Population-Based Measure: Chronic Conditions Composite – Heart Failure
	All-cause Hospital Readmission Measure
TOTAL: 9 Measures	**TOTAL: 13 Measures**

- CMS is proposing to increase requirements for reporting outcome measures over the next several years which would make the total measure count even higher. (increase to 2 or 3 measures).
- CMS is proposing to increase requirement for reporting on appropriate use, patient experience, safety and care coordination measures as well.

Global and Population-Based Measures

- HCMS cannot support CMS's proposed evaluation of eligible clinician quality measures on administrative claims for acute and chronic composite measures without risk adjustments occurring from Day 1 of the new program.

- HCMS recognizes these measures have been determined to be reliable with a minimum case size of 20 and with an average range of 0.64 to 0.79. However, HCMS does not support this recommendation and request that CMS not implement this criterion until a risk adjustment can be implemented. HCMS recognizes that the .64 to .79 is statistically reliable, however, since this criteria will apply to the eligible clinician's quality measure calculation anything less than .90 is unreliable and unacceptable and should not be used when the potential outcome could adversely impact the total composite performance.

- HCMS supports reducing the quality reporting thresholds from the proposed 80-90 percent of patients back to the current 50 percent per measure. Failure to meet the 50-percent threshold under PQRS is one of the main reasons physicians currently fail quality reporting. Under MIPS, any physician who fails to meet the threshold for any reason will get a zero score per measure and thus receive lower scores for the quality performance category. The first year of MIPS implementation is not the time to raise the bar and increase the degree of difficulty of meeting quality reporting requirements.

- Performance Criteria for Quality Measures for Groups Electing to Report Consumer Assessment of Healthcare Providers and Systems (CAHPS) for the MIPS Survey - HCMS strongly encourages CMS to allow for voluntary participation in CAHPS. If CMS wants to encourage the use of CAHPS then HCMS would recommend CMS offer bonus points for eligible clinicians who choose to participate in the program, especially since the program is being paid for by the eligible clinicians/group/or facility.

Data Completeness Criteria

- HCMS recognizes CMS' need to ensure the completeness of data. However, we strongly discourage the proposed reporting criteria that would require eligible clinicians to report at least 90 percent of a particular measures denominator criteria *regardless of payer*.
- Under the MIPS, CMS is proposing to require all payer data for the qualified registry, qualified clinical data registry (QCDR), and EHR reporting mechanisms, but only Medicare Part B data for the claims, web interface, and Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey reporting mechanisms. Medicare populations are very different from those covered by other payers. Having some

practices submitting data that represent all payers and others providing Medicare only, coupled with the fact that quality benchmarks are based solely on Medicare data, will result in an inequitable assessment of quality performance. Additionally, this requirement will significantly increase the volume of data needed per measure and make it more difficult to meet the threshold requirements which will negatively affect the total composite performance score.

Topped Out Measures

- HCMS strongly objects to CMS not recognizing measure scoring for those measures that have been implemented into the physician work process over time called "Topped Out" measures. Since overall performance is so high (near 100 percent) CMS denotes that the measures are no longer meaningful to collect and report. As physicians will focus on measures that will increase their points, "topped out" performance measures are processes that are important to patient care and may decline in performance over time. HCMS suggests the use of quality metrics that capture those activities that are under the physician's control and have been shown to improve quality of care, enhance access-to-care, and/or reduce the cost of care. The focus should be on metrics that are most meaningful to a practice and its patients, not on what will result in the best "score."
- The scoring methodology should be unified amongst measures, deciding which measures are "topped out" measures is not a science and, as stated by CMS, may be measures that are used by specialties that may otherwise not have enough applicable measures. This creates an unfair bias towards these specialties by limiting the number of points they can receive.

Virtual Groups

- HCMS supports having a process that allows for eligible clinicians to elect to participate in Virtual Groups.
- HCMS is requesting consideration to extend the election time frame from June 30 of a performance period to Nov. 30 of the calendar year prior to the beginning of the next performance period. This would allow ample time for physicians to apply to CMS to participate as a virtual group. This change would also provide CMS sufficient time to collect and analyze the data prior to providing feedback reports.

Alternative Payment Models and Advanced Alternative Payment Models

- HCMS recognizes CMS' effort in encouraging Alternative Payments Models and supports these efforts. However, HCMS calls for CMS to develop a more simplistic approach. In order to cultivate the continued growth of APMs, HCMS would like to encourage CMS to allow for new APMs to be considered Advanced APMs for the first three years of operations by offering a waiver from the nominal amount criteria without

taking a high 30% financial risk. In order for organizations to implement and develop APMs there are huge expenses and debt that is incurred to build these models. Given the fact that Medicare certified APMs are designed to achieve cost savings, it is recommended that CMS allow for these APMs to submit a request for approval to be recognized as an advanced APM initially, be exempt from the nominal amount requirement, and to allow all MIPS eligible clinicians who are participating in the APM to be exempt from the MIPS.

- HCMS requests CMS to allow APM Entities to be an APM without requiring an additional layer. The current proposal requests that APM Entities develop an APM so the APM Entity can be assigned to the APM and the Eligible Clinicians (EC) can be assigned to the APM Entity. This requirement will be an administrative hassle. HCMS encourages CMS to allow APM Entities to submit a list of ECs who are participating in the entity. It is further requested that CMS allow these ECs to be MIPS exempt, and to forfeit developing a Qualified APM Professional (QP) and partial QPs therefore reducing the complexity of the overall APM structure.

- HCMS does not support the development of APM Identifiers as this requires another layer of administrative complexity. It would appear that CMS could identify APM Entities by the APM Tax ID and ECs NPI numbers that are submitted to CMS. Once identified, exemption to the MIPS pathway can then occur.

- HCMS could support other payers' participation in the CMS APM requirements to align quality measures. However, we cannot support other payers following the full requirements of an APM until administrative simplification is fully embraced by EHR vendors, and CMS resolves convoluted compliance mandates which is not shown in this proposed rule.

- HCMS request that CMS allow eligible clinicians who are participating in an APM who choose/have to withdraw from the APM prior to the end of the performance period to be exempt from participating in MIPS for that performance period. Failure to do so is going to hinder physicians from being able to transition between employment thus forcing them to potentially stay in an APM that is not conducive to their practice model or patient type/care. In addition, HCMS request that CMS develop a wavier to allow physicians who are transitioning in employment to be exempt from participating in MIPS for that performance period.

- HCMS requests, prior to CMS applying any type of adjustment that the EC be given the option to review and dispute any discrepancies in the data. HCMS recommends that the dispute process be an expedited appeals process where the decision is made by a non-biased entity made up of the eligible clinician's peers.

If you have any questions about our comments, please call Ms. Pat Harris, Senior Vice President, at 713-524-4267. You may also email Ms. Harris at *pat_harris@hcms.org*.

These issues are very important to the physicians in Harris County, Houston Texas. Thank you for taking our comments into consideration.

Sincerely,

Kimberly E. Monday, MD
President

CC: Senator John Cornyn
Senator Ted Cruz
Congressman Kevin Brady, Chair, House Ways and Means Committee
Congressman Michael McCaul, Chair, House Homeland Security Committee
Congressman Brian Babin
Congressman John Culberson
Congressman Al Green
Congressman Gene Green
Congresswoman Sheila Jackson Lee
Congressman Pete Olson
Congressman Ted Poe
Congressman Randy Weber
Congressman Michael Burgess, MD