HCMS
Harris County Medical Society

August 21, 2017

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–5522–P, P.O. Box 8013
Baltimore, MD 21244–8013

Filed Electronically

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

RE: Medicare Program; CY 2018 Updates to the Quality Payment Program

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 "Medicare Program; CY 2018 Updates to the Quality Payment Program Proposed Rules" published in the *Federal Register* on Friday, June 30, 2017.

PLATFORM BEHIND OUR COMMENTS
HCMS represents grass root physicians in all medical and surgical specialties who transact with all of the Medicare payment policies on a daily basis. Our comments are reflective of the feedback we receive from our members and their staff. Harris County Texas with a population of approximately five million people contains approximately 450,000 Medicare patients.

Our primary concern has been the lack of EHR interoperability, which will have a large impact into the success of the Quality Payment Program. Interoperability is the only way to improve financial inefficiencies and quality improvement in the Medicare system.

The Congressional intent for the MACRA law was to simplify EHR and quality reporting on physicians. Yet, it will take reviewing 490 pages of the Updates to the 2018 QPP Proposed Rules and 253 pages of the 2018 Medicare Physician Fee Schedule Proposed Rules just to determine payments and requirements may be in the year 2018. In October and November, the two final rules will be published and the hundreds of pages of final rules will need to be reviewed to set up a budget for the physician's medical business in 2018. No other profession must go through this extremely complex annual budget forecasting process.

The MACRA law promised an annual update of .5% to the physician conversion factor (CF) until 2019, which has not come to fruition because other laws created negative offsets. In 1998, according to CMS,

the physician CF was $36.6873. In 2017 the physician CF is $35.8887 (Exhibit A). The US Bureau of Labor Statistics reports that the Consumer Price Index has increased 47.8% between 1998-2017 (Exhibit B). As physician Medicare payments have decreased over a twenty-year span, physician costs have vastly increased.

OFFICIAL COMMENTS

Comment - HCMS would encourage CMS to continue a transition period as in 2017 until such time EHR interoperability and usability are established and the program can move forward in a more successful pathway. Interoperability is scientifically proven to improve quality and lower cost. None of the other requirements in the QPP are proven to do the same.

Low-Volume Threshold

Comment - HCMS supports CMS's proposal to increase the low-volume threshold to less than or equal to $90,000 in Medicare Part B allowed charges or less than or equal to 200 Medicare Part B patients.

HCMS recommends that the low-volume threshold be increased for the MIPS performance year 2019 and future years as well. Our rationale for this increase is due to the requirement that the Secretary set the performance threshold for the 2021 MIPS payment year (2019 performance year) to the mean or median of the MIPS final scores for all MIPS eligible clinicians from a previous period. This mean or median will be a much higher threshold than most small practices could manage to meet due to having a larger portion of the score made up of larger and more well equipped practices that were above the low-volume threshold. By increasing the low-volume threshold in 2019 and beyond small practices will not have to compete with larger practices with more resources at their disposal for top tier quality reporting.

Additionally, HCMS recognizes that this increased threshold may inhibit an increased number of smaller practices and eligible clinicians from participating in MIPS and receiving incentive payments. We believe that CMS should offer an opt-in policy starting in 2018 to allow those that fall below the threshold to participate in MIPS and be eligible for incentives. This opt-in system could be built like or alongside the registration system for CAHPS and the CMS Web Interface. Creating this opt-in selection is important for many physicians who without this opportunity for an incentive payment, are seeing flat Medicare payment rates. (Exhibit C).

Performance Score Threshold

Comment - HCMS accepts CMS' recommendation to set the scoring threshold at 15 points. This can be accomplished by reporting Quality measures and/or Clinical Practice Improvement Activities (CPIAs). HCMS opposes any increase in points in future years that mandate reporting for Advancing Care Information (ACI) until such time EHRs are interoperable and proficient in contributing to the success of the QPP.

Category Performance Periods

Comment - HCMS opposes the CMS proposal to increase the Quality category reporting period to a full 12 months. Results from the 2017 transition year need to be evaluated before any increase in the performance period can be determined.

Quality Data Submission Criteria – Data Completeness

Comment - HCMS agrees with CMS's proposal to maintain the 50% data completeness criteria for the 2018 performance year, but disagrees with the proposal to increase this to 60% for program year 2019.

We strongly believe that the data completeness criteria for the Quality category should not increase to 60% and needs to be consistently maintained at 50%. As a medical society that works directly with physicians and practices at the grass roots level our members have made us very aware of how difficult and time consuming it presently is to meet the 50% threshold, especially now that most reporting mechanisms require all-payer data, making this task even more burdensome.

In addition, many of these practices are unable to report directly through their CEHRT due to lack of available measures or the extremely high cost of the service through their EHR vendor. Therefore, most practices are left with the option of reporting through claims or direct manual entry through qualified registries. This process of pulling and entering data is very time consuming and strenuous. It is important to keep the threshold at 50% to allow practices to work on both meeting their data completeness criteria and improving their performance results.

Further, HCMS opposes the CMS proposal to provide only one point for each quality measure that is submitted by the larger practices that fall below the data completeness criteria until such time that the 2017 data can be evaluated. We support continuing the original three points provided during the 2017 transition year into 2018 for all size practices.

Cost Category Weight
Comment - HCMS agrees with CMS's proposal to maintain the Cost category weight at zero percent for 2018, although also understands the dilemma physicians will face in 2019 when this weight jumps up to 30% as required by statute. Until there are proven cost measures with a track record that are properly risk adjusted, HCMS will urge CMS and work with our congressional delegation to maintain cost at a zero percent weight in future comments.

Support for Health Information Exchange (HIE) and Prevention of Information Blocking
Comment - CMS should not require physicians to attest to support for HIE and the prevention of information blocking. Rather, CMS should require EHR vendors to design systems that are interoperable and can compile needed health information to improve patient safety and meet all reporting requirements. Physicians should not be penalized based upon failures of the EHR vendors. CMS should not allow EHR vendors to charge physician practices any add-on fees for information required by CMS.

HCMS supports the Texas Medical Association's request to CMS in its comments to this proposed rule "that CMS conduct a cost study of fees required by EHR vendors and HIEs to determine 1) connection fees, 2) ongoing maintenance fees, 3) transaction fees, and 4) subscription fees."

Deferment of 2015 CEHRT Requirement
Comment - HCMS commends CMS for proposing a deferment of the EHR 2015 CEHRT requirement in 2018. We strongly support this decision and encourage CMS to extend this deferment into all future program years until EHR interoperability and proper certification testing standards are put in place without extraneous costs to physicians and proper oversight to EHR companies.

In addition to the significant cost of upgrading and training staff to the new CEHRT product, the change in ACI base measures between those required for 2014 CEHRT and 2015 CEHRT does not justify a 2015 CEHRT requirement. As shown in the chart below, the bold area shows the difference in base measures is negligible and would not benefit patient care unless there was true interoperability between EHR systems. Receiving or sending summary of care measures do not live up to their intended purposes unless automated incorporation into patients' electronic medical records is achieved, and the manual process is no longer needed.

Comparison of 2014 & 2015 CEHRT ACI Base Measures		
2014 CEHRT MEASURE	**2015 CEHRT MEASURE**	**MEASURE DESCRIPTION**
e-Prescribing	e-Prescribing	At least one permissible prescription written by the MIPS eligible clinician is queried for a drug formulary and transmitted electronically using certified EHR technology.
Provide Patient Access	Provide Patient Access	At least one patient seen by the MIPS eligible clinician during the performance period is provided timely access to view online, download, and transmit to a third party their health information subject to the MIPS eligible clinician's discretion to withhold certain information.
Security Risk Analysis	Security Risk Analysis	Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI data created or maintained by certified EHR technology in accordance with requirements in 45 CFR164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the MIPS eligible clinician's risk management process.
Health Information Exchange		**The MIPS eligible clinician that transitions or refers their patient to another setting of care or health care clinician (1) uses CEHRT to create a summary of care record; and (2) electronically transmits such summary to a receiving health care clinician for at least one transition of care or referral.**
	Request/Accept Summary of Care	**For at least one transition of care or referral received or patient encounter in which the MIPS eligible clinician has never before encountered the patient, the MIPS eligible clinician receives or retrieves and incorporates into the patient's record an electronic summary of care document.**
	Send a Summary of Care	**For at least one transition of care or referral, the MIPS eligible clinician that transitions or refers their patient to another setting of care or health care provider-(1) creates a summary of care record using certified EHR technology; and (2) electronically exchanges the summary of care record.**

CMS must focus first on fixing the basic foundations necessary for data exchange and on increasing the functional interoperability between HIT vendors and among vendors and registries to ensure the ACI aspect of MIPS is achievable, meaningful, and not another unnecessary regulatory burden on physicians.

Significant Hardship Exception for Small Practices – Advancing Care Information
Comment - HCMS supports the proposal to provide a significant hardship exception for the ACI category for small practices. We ask that CMS clarify what type of documentation is necessary to demonstrate overwhelming barriers that prevent complying with ACI requirements, as well as examples of what CMS considers "overwhelming barriers".

CPIA Group Credit Requirement
Comment - Regarding CMS's request for comment concerning 'if a minimum threshold of clinicians should be established to complete an improvement activity for the entire group (TIN) to receive credit in the improvement activities performance category in future years', HCMS opposes a minimal threshold be established for future years. HCMS supports the present minimal threshold as adequate for future years.

Additional Advanced APM Participant Snapshot
Comment - We are in support of the proposal for a fourth snapshot date of December 31 being added for the purpose of determining participation in full TIN MIPS APMs to apply the APM scoring standard. However, HCMS also encourages CMS to use this date as an additional assessment date for QP

determinations. By doing this CMS will be able to bridge the gap between the previous snapshot of August 31 and the end of the year allowing for any and all new physicians to be considered for Advanced APM participation.

Conclusion
We appreciate the opportunity to comment. With physician burnout being a very real liability to Medicare patients, we encourage CMS to make the QPP more efficient by requiring EHR interoperability, and cost conscience on physicians.

Sincerely,

Lisa Ehrlich, MD
President