August 21, 2017

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

RE: RIN 0938-AT13

Dear Administrator Verma:

Health IT Now (HITN) is pleased to submit our comments in response to the proposed rule entitled *Medicare Program; CY 2018 Updates to the Quality Payment Program*. HITN is a diverse coalition of health care providers, patient advocates, consumers, employers, and payers who support the adoption and use of health IT to improve health outcomes and lower costs.

General Comments

With the passage of the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA), Congress recognized the promise of technology to transform the health care system, with the recognition that we have yet to reach that goal.

One of the main barriers to reaching this goal is the lack of widespread interoperability of health technologies. MACRA requires widespread interoperability by December 31, 2018, but as that date quickly approaches, it is becoming more apparent that this is yet another deadline that will not be reached. While the implementation of the *21st Century Cures Act* will make great strides toward reaching interoperability, there is much work left to be done to ensure data can flow seamlessly through the health care system.

Reaching interoperability is crucial for the success of the Quality Payment Program (QPP) as providers' success in the program hinges on providing high-quality care. In order to do accomplish this, providers must be able to access their patients' health information and patients must be able to share their information between providers. CMS must prioritize incentivizing interoperability to ensure success of the QPP.

Specific Comments

Advancing Care Information

HITN is concerned that CMS, working with the Office of the National Coordinator for Health Information Technology (ONC), is missing an opportunity by merely delaying the requirement for eligible providers to report using electronic health record (EHR) technology certified to the 2015 requirements. While we support the delay as it is important to reduce provider burden in the program, we believe that CMS, in coordination with ONC, should not simply delay for the sake of delay – rather, use this time to revisit certification requirements and ensure that every requirement is critical to providers' success and reduces provider and vendor burdens under the QPP. Since the *2015 Edition Health Information Technology (Health IT) Certification Criteria, Base Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications* rule was proposed, two major laws impacting EHRs have been signed into law – MACRA and the *21st Century Cures Act*. Coupled with rapid advances in technology, this necessitates a review of requirements that are now over two years old. We look forward to working with CMS to ensure health technology is another tool in the toolbox for providers and not a burdensome requirement.

Virtual Groups

Health IT Now is pleased that CMS is moving forward with implementing virtual groups. As we have stated in letters to Secretary Price, we believe this is an important tool for providers to succeed under the QPP. Virtual groups were established by Congress to allow varying providers in different physical locations to associate as a group for reporting. The model is intended to allow innovative IT companies to partner with providers who might otherwise have difficulty reporting on meaningful measures under MIPS. Providers with limited direct patient interaction, providers in rural areas, and those who are not able to report on full sets of measures might benefit from this technology-supported reporting option.

While we are generally supportive of CMS' proposals, we do have specific feedback in a number of areas. First, we believe the December timeline for providers to elect into a virtual group is very short. We support this timeline for providers who are able to elect on such a short timeframe; however, we expect that participation will be very low in the first year due to this. Therefore, we encourage CMS to continue building virtual groups throughout 2018 even if participation is low at first.

To further alleviate provider concerns with virtual group participation, CMS should allow those who elect into a virtual group to switch out after an election is made. Providers should have the option to report individually if they feel they would be more successful doing so. In the proposed rule, CMS aligns virtual group policies with group policies, except in this case. As individual providers are able to leave a group, we believe they should also be able to leave a virtual group.

We are also concerned that virtual groups will not have the capacity for data aggregation for the purposes of reporting to CMS in 2018. We urge CMS to align this policy with other programs and perform data aggregation in the first years of the program. Alternately, CMS should not apply a negative MIPS adjustment to virtual groups who are not able to aggregate data. Moving forward, CMS should allow third party vendors to perform the necessary data aggregation. While these tools are not readily available now, if CMS made it clear this is the direction the virtual group is headed, along with making necessary policy changes, this would go a long way towards ensuring the success of virtual groups. In order to allow third-party data aggregation moving forward, CMS must make a number of regulatory changes:

- Allow third-party aggregators to access CMS claims data for beneficiaries attributed to the virtual group.

- Aggregators must be explicitly and uniformly required to comply with all applicable HIPAA requirements.
- Stark, Anti-Kickback Statute (AKS) and anti-trust waivers are needed to alleviate concerns when providers are sharing savings and maintaining a coordinated referral network.

Health IT Now is very supportive of virtual groups and is looking forward to working with CMS to grow this important aspect of the QPP moving forward.

Performance Feedback

We support CMS' effort to utilize health IT to provide performance feedback. We appreciate CMS recognizing the role third party intermediaries play in helping providers aggregate data from disparate sources and across the continuum of care in order to maintain a competitive advantage and provide better health outcomes. As a business partner, third party intermediaries have an opportunity to support providers and practices by providing one point of entry, timely feedback to address gaps in care, and remove reporting burden. The same mechanisms used to support reporting can also be utilized by CMS to provide performance feedback. However, in order to fully recognize the potential of third party intermediaries, information blocking must be ended once and for all. We acknowledge HHS' efforts to address information blocking and interoperability as required by the *21st Century Cures Act,* and we encourage CMS to continue to work with HHS to help address information blocking given that it impedes on the ability of providers to fully utilize health IT to succeed under the QPP.

Qualified Clinical Data Registries

Qualified Clinical Data Registries help providers to monitor and manage their quality of care and patient outcomes and can lead to more successful outcomes and less expensive care. However, there is no eligible measure applicability (EMA) process for QCDR or EHR reporters. Health IT Now urges CMS to apply the EMA process to QCDR and EHR reporters so that these providers are not unfairly disadvantaged under the MIPS program.

Health IT Now recognizes the flexibility that CMS has built into the 2018 proposed rule. One point of concern is the proposal to allow providers to submit measures through multiple submission mechanisms with each performance category amounts to a substantial increase in burden for many providers. As the EMA process does not apply to QCDR or EHR submissions, those who submit via these mechanisms will be required to submit via a second or third mechanism if they cannot find six germane measures which disincentivizes QCDR-and EHR-based submission of quality measures.

We applaud the simplifications of ACI in this proposed rule, however, ACI reporting remains burdensome for providers. This, combined with the lack of interoperability and tangible patient care improvements under EHR requirements, is a significant contributor to the high rate of provider burnout. QCDRs have the ability to reduce regulatory burden for eligible providers by providing a meaningful tool for quality improvement. We encourage CMS to create an alternative pathway to success by providing full ACI credit to providers participating in a provider-led QCDR via CEHRT.

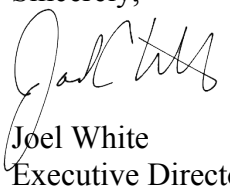
Registries advance improvements in quality and patient outcomes by providing actionable feedback to participating providers related to their performance on key quality metrics in real-time. Providers participating in a QCDR can compare their patient outcomes, professional performance and care

processes against other participating providers across the country. We encourage CMS to award 50% of the Quality Category score to active engagement in a QCDR.

Conclusion

Health IT Now appreciates the opportunity to provide comments on the *Medicare Program; CY 2018 Updates to the Quality Payment Program* proposed rule. We look forward to continuing to work with CMS on this important program.

Sincerely,



Joel White
Executive Director