**Comments**

1. **Increase accessibility throughout the Final Rule and tell a compelling story that is relevant to clinicians and patients.** The final rule language should explicitly communicate how the QPP requirements build on and modify existing programs, and what participants will need to do to meet program requirements, avoid penalties, and earn positive payment adjustments.
   1. CMS should clearly describe, with tables and graphics, which components of existing programs will change within MIPS, which will remain, and how the changes result in reduced burden for participants.
   2. CMS should increase understanding of the rule by including graphics/illustrations where possible to clarify the elements of the program and their inter-relationships, including:
      1. A figure that depicts the overarching goals of MACRA and how the program components achieve their objectives to transform care;
      2. A diagram mapping the current programs to MIPS and APM to highlight how the new programs provide additional flexibility, reduce burden for the eligible clinician, and improve patient-centered care; and
      3. A graphical depiction of how a clinician transitions from the MIPS program to an APM, highlighting the benefits of moving to an APM.
   3. CMS should clearly explain how participating Eligible Clinicians will be benchmarked and how the payment incentives and adjustments will be applied under the QPP, ensuring policies are clear and the scoring methodology is easy to understand.
   4. CMS technical assistance, education and outreach, and coaching efforts should extend well beyond those required in the MACRA statute and current planned efforts to ensure that eligible clinicians find the program appealing to participate in, with confidence they will succeed.

*KEY ITEMS FOR WG DISCUSSION*

1. **Further revise ACI category for clarity.** For the ACI category, while the concept of base and performance introduces incentives to do more, do not separate them because conceptually they are easier to understand when considered together. Combine the tables and scoring so that you score more when you do more in the areas that you want to incent. (see table at the end of the document as an example) I am sure that there are even simpler ways to create the chart.
2. **Provide additional clarity around CPIA Inventory.** Given the short and fairly ambiguous definitions in Table H, recommend that CMS enhance the clarity of the CPIA definitions so that providers understand more fully what they must do to qualify, to include what providers may be expected to retain as documentation and provide to an auditor where a general and non-specific definition is intentional in order to provide flexibility. (e.g. similar to CMS sub-regulatory guidance on non-percentage based measures)
3. **Provide further clarity around status of hospital-based eligible clinicians.** CMS should use the same 90 percent threshold for all the specialty types of hospital-based eligible clinicians and non-patient-facing eligible clinicians, and reweight all eligible clinicians who meet the threshold.
4. **Identify opportunities to further simplify the final rule and reduce burden for eligible clinicians.** The Quality Payment Program, as a whole and within each component, will be very difficult for many providers to put in place, and for health IT developers and others to support. Without significant preparation, education, and coordination, this Program may be too challenging for the health care market to achieve within the proposed timeframe. CMS should seek to make the program highly accessible so that all eligible clinicians gain substantial proficiency in the steps required to succeed in MIPS, APMs, and in future Other Payer APMs.
5. CMS should take every opportunity to simplify program requirements, even at risk of reduced flexibility, so that the overall burden of understanding and complying with the program is reduced. Build upon the NPRM’s stated strategic goal to “advance a program that is meaningful, understandable, and flexible for participating MIPS eligible clinicians.” [(FR 28173)](https://www.federalregister.gov/articles/2016/05/09/2016-10032/medicare-program-merit-based-incentive-payment-system-mips-and-alternative-payment-model-apm#p-274)

*KEY ITEMS FOR WG DISCUSSION*

1. **Finalize reduced set of objective measures for ACI relative to Meaningful Use Stage 3 final rule.** CMS should finalize the “primary proposal” for objectives in the ACI category. Under this proposal, CMS would remove objectives around CDS and CPOE that were finalized for Meaningful Use Stage 3 in 2018, but would retain them in an alternate proposal. ([FR 28220](http://www.federalregister.gov/a/2016-10032/p-686))
2. **Create an “on-ramp” for the ACI category that provides further flexibility for eligible clinicians that have not participated in the EHR Incentive Programs.** CMS should explore further opportunities to reduce burden on eligible clinicians that have not previously participated in the EHR Incentive Programs in 2018. CMS could consider using authority to reweight scores to allow these clinicians an additional time period when they could postpone ACI participation and only receive a MIPS score based on other categories.
3. **Extend transition period when clinicians can earn points under ACI category using either “Stage 2” or “Stage 3” framework.** Reduce program complexity and enhance feasibility of eligible clinician participation, where CMS could either maintain option of reporting MU Stage 2 Modification Objectives and Measures until 2019, OR postpone introduction of MU Stage 3 Objectives and Measures until 2019. ([FR 28219](http://www.federalregister.gov/a/2016-10032/p-670)). This would allow participants and developers time to test and prepare to meet the new requirements, while more fully engaging in other MIPS categories, such as CPIA and their chosen Quality category measures.
4. **Significantly reduce process-oriented measures in CPIA category and build on activities clinicians are already completing.** The current emphasis on the Inventory is too process-oriented and eligible clinicians will view attesting to the activities as “busy work” not connected to the program’s stated goals. Within non-CMS programs, CMS can identify surrogates that foster team-based care coordination, integration of health IT and innovative delivery methods, such as telehealth, and patient empowerment. CMS can then allow deeming of certified improvement activities (e.g., professional certification of Maintenance of Certification) as partial or complete satisfaction of CPIA requirements.
5. **More clearly integrate the use of health IT into the CPIA category.**  CMS should construct CPIA so that eligible clinicians and CMS can use the category as a “test bed” for innovation in the same way as prospective activities submitted through QCDRs may serve as a beta test, to help identify how activities will lead to improved outcomes and readiness for APM participation. CMS should, at a minimum, identify how CPIA elements relate back to capabilities in the 2015 Edition, and encourage participants to test high-impact health IT functionalities that could be considered in future APMs and certification requirements.
6. **Work with outside organizations to populate CPIA activities.** CMS should consider exercising its option to contract with entities (FR 28209) to assist in identifying activities for the CPIA category, specifying criteria, and determining whether MIPS eligible clinicians meet the criteria set. Entities for consideration include professional organizations, as part of the ABIM Maintenance of Certification Part IV development, or Bridges to Excellence, as well as patient-focusing organizations..
7. **Reduce reporting burden for providers in APMs and assist providers in decision-making around APM participation.** Develop operational solutions to prevent the burden of dual reporting by potential Advanced APM participants ([FR 28234](http://www.federalregister.gov/a/2016-10032/p-866)). For example, options may include:
   * 1. A method to deem a qualifying participant in an APM as fully satisfying the MIPS requirement for the following year so that they do not need to complete MIPS reporting.
     2. A method to allow eligible clinicians within an APM who fail to meet the QP requirement to submit data to satisfy MIPS reporting requirements through a separate targeted submission period or method subsequent to the QP determination.
     3. Convey whether new models will have Advanced APM status when they are first publicly released, so that eligible clinicians will have that information when determining participation in new models.
8. **Focus policies more distinctly and clearly on the program’s desired outcomes, especially interoperability and patient engagement.** Clearly delineate how each component within the Program aligns to drive delivery system reform.
9. Ensure that each requirement throughout each program area clearly drives behavior toward care coordination, patient engagement, and effective information sharing. Otherwise, consider eliminating the requirement to help simplify the rule.
10. Motivate clinicians to move towards advanced payment models by more strongly and clearly rewarding innovation and learning, rather than prescribing specific processes and accounting (“check the box”).
11. Focus on the outcomes that matter to patients and consumers, and incentivize measures of outcomes that are most important to them.
12. Leverage and develop as needed HIE-sensitive performance measures to reward care coordination, patient engagement, and effective information sharing.

*KEY ITEMS FOR WG DISCUSSION*

1. **Establish additional bonuses for performance on information sharing measures.** For future rulemaking, consider a scoring system that specifically rewards demonstrated electronic information sharing and patient engagement. CMS could award bonus points to be added to the composite performance score, as well as within individual MIPS performance categories, for eligible clinicians with marked improvement or achievement in these high-priority areas.
2. **Develop effective methods to reward clinicians for improvement.** For measuring improvement within MIPS in future years (see , calculate an improvement score that measures improvement towards the target threshold: % closing the gap = percentage points improved from last measure / gap between threshold target (%) and last year’s percentage score. [example: if the target is 70% and the provider achieved 50% last year and 60% this year, the % closing the gap = 10 / 70-50 = 50% closing the gap]
3. **Take further advantage of opportunities under MACRA to promote more seamless measurement and reporting infrastructure across stakeholders.** Encourage private payers to construct value-based programs that align with the QPP and to build in incentives to submit electronic clinical data using standards for data capture and format.
4. Utilize the QPP to facilitate greater partnership among providers and public and private payers to reward information sharing, by building a common infrastructure for data submission that can be used by any payer, and simplifying and standardizing quality measures.
5. Create a pathway for providers to move toward wholly electronic information collection, one that allows for equivalent information to be widely distributed to all qualified entities that request it.
6. Make sure the most important information for Quality Measurement and Improvement is submitted to QCDRs, even if this is not imported electronically. Focus on the information first, and perfect the process over time.
7. Normalize methods across domains and be clear what certified capability needs to be present

*KEY ITEMS FOR WG DISCUSSION*

1. **Increase bonuses for electronic reporting.** Increase the bonus from 5% to 10% for electronic reporting of quality measurement data derived from use of CEHRT. This percentage could be modified to a requirement rather than a bonus structure in future years if the percentage of meaningful users of CEHRT reaches 75% and the ACI category weighting is reduced. ([FR 28255-56](http://www.federalregister.gov/a/2016-10032/p-978))
2. **Clarify where certified technology is required for third party data submission methods.** CMS should clarify what constitutes a submission method that is required to be CEHRT and what does not need to be – QCDRs versus Qualified Registry methods. Affirm the EC’s prior choice and do not put new barriers on the submission methods that did not previously exist to serve their role but make it clear what that is.
3. **Increase bonus points for using eCQMs.** Increase bonus from 1 to 2 points for providers using an eCQM for the required cross-cutting measure and outcome measure, or high-priority reporting of patient safety, efficiency, patient experience, and care coordination measures, as these are deemed most critical to patient care and electronically reporting. ([FR 28255](http://www.federalregister.gov/a/2016-10032/p-975))
4. **Incentivize eligible clinicians to align measures with private payers.** Establish a process to incentivize clinicians to choose measures that are aligned with those required by private value based purchasing contracts. Such an option could reinforce efforts to reduce burden for providers and encourage measure and reporting alignment across payers ([FR 28185](http://www.federalregister.gov/a/2016-10032/p-381)).
5. **Clarify links to CMS measure development initiatives.** Directly reference language from the CMS Quality Measure Development Plan within final rule preamble language to demonstrate the breadth of changes CMS is undertaking to establish collaborative alignment between public and private payers.
6. **Allow sufficient time for developers to implement any new electronic clinical quality measures.** Based on the regulatory timeline for the Final Rule each year (by Nov. 1st), if new electronic clinical quality measures or other QPP requirements that require implementation in HIT are introduced, CMS must allow at least 18 months between the announcement of the required functionality and the expected implementation date.
7. **Explore ways to take advantage of data sources that aggregate data across payers.** As part of measuring performance improvement over time, CMS could consider taking advantage of more comprehensive data available through all-payer claims databases to modify its algorithms used to calculate the resource use, advancing care information, and clinical practice improvement activity category scores to include the use of clinical quality data tied to process improvement measures, such as clinical decision supports.
8. **Explore use of cross-cutting data in future scoring methods.** Additionally, CMS could incorporate cross cutting use of clinical quality data within the resource use, advancing care information, and clinical practice improvement activity categories by requiring continuous quality improvement protocols to demonstrate both appropriate resource use and concurrent quality and personalized care plans. ([FR 28209](https://www.federalregister.gov/articles/2016/05/09/2016-10032/medicare-program-merit-based-incentive-payment-system-mips-and-alternative-payment-model-apm#p-545) – future modifications)

| Objective | 2017 Base Score  (50 Points) | 2017 Performance Score (80 Points) | 2018 Bonus Point  (added to Base + Performance) | 2018 Base Score | 2018 Performance Score | 2018 Bonus Point |
| --- | --- | --- | --- | --- | --- | --- |
| Use CEHRT 2014 Edition or 2015 Edition | Use either |  |  | 2015 Edition |  |  |
| Do a security risk analysis or review | Required |  |  | Required |  |  |
| Attest that they are not info blocking | Required |  |  | Required |  |  |
| Have the function for implementing CDS including drug-drug, drug-allergy | Required |  |  | Required |  |  |
| Write at least 1 prescription electronically | Required |  |  | Required |  |  |
| Have the function for CPOE for medication orders | Required |  |  | Required |  |  |
| Have the function for CPOE for lab orders | Required |  |  | Required |  |  |
| Have the function for CPOE for radiology or diagnostic imaging orders | Required |  |  | Required |  |  |
| Provide access for at least 1 patient to VDT and API | Required  API (optional) | Provide access to VDT for greater than 1 patient  (10 points) |  | Required | Provide access to VDT and API for greater than 1 patient  (10 points) |  |
| Provide patient specific education for at least 1 patient | Required | Provide patient specific education for more than patient  (10 Points) |  | Required | Provide patient specific education for more than patient  (10 Points) |  |
| Ensure at least 1 patient takes action to VD or T or to use an API to access their health information | Required  API optional | More than 1 patient takes action to download, or transmit their record  (10 Points) |  | Required | More than 1 patient takes action to view, download, or transmit their record or to use an API to access their health information  (10 Points) |  |
| Send or respond to a secure message for at least 1 patient | Required | Send or respond to more than 1 secure message  (10 points) |  | **Required** | Send or respond to more than 1 secure message  (10 points) |  |
| Incorporate patient generated health data, or data from a “non-clinical” setting, for at least 1 patient | Optional | Incorporate patient generated data (or data from a non-clinical setting) for more than 1 patient  (10 points) |  | Required | Incorporate patient generated data (or data from a non-clinical setting) for more than 1 patient  (10 points) |  |
| Send an electronic summary of care document for at least 1 transition of care | Required | Send an electronic summary of care document for more than 1 transition or referral  (10 points) |  | **Required** | Send an electronic summary of care document for more than 1 transition or referral  (10 points) |  |
| Receive directly, request and receive, or query and obtain at least 1 electronic summary of care document for a transition of care received | Optional | Receive, request, or query for a summary of care document for more than 1 transition or referral  (10 points) |  | Required | Receive, request, or query for a summary of care document for more than 1 transition or referral  (10 points) |  |
| Conduct medication reconciliation or clinical information reconciliation for at least 1 transition or referral | Required | Conduct medication, medication allergy, and problem list reconciliation for more than 1 transition of care or referral or patient never before seen by the provider  (10 points) |  | Required | Conduct medication, medication allergy, and problem list reconciliation for more than 1 transition of care or referral or patient never before seen by the provider  (10 points) |  |
| Report on immunizations | Required |  | Active engagement to report data to any public health agency or specialized registry beyond immunization  Reporting  (1 point) | Required |  | Active engagement to report data to any public health agency or specialized registry beyond immunization  Reporting  (1 point) |