June 27, 2016

The Honorable Andy Slavitt, Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS–5517-P
P.O. Box 8013
Baltimore, MD 21244–8010

Dear Administrator Slavitt,

On behalf of the Healthcare Billing and Management Association (HBMA), we appreciate the opportunity to provide observations and comments about the proposed rules for the Merit-based Incentive Payment System (MIPS) and the requirements for approval as an Advanced Alternative Payment Model as required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

HBMA

The Healthcare Billing and Management Association (HBMA), a non-profit professional trade association, is a major voice in the revenue cycle management industry in the United States. HBMA members collectively submit a significant percentage of all initial medical claims to the country's governmental and commercial payors. Those claims not submitted by HBMA member companies are usually submitted directly by the provider.

HBMA membership includes some of the nation's largest revenue cycle management companies (1,000+ employees submitting millions of claims), however, the typical HBMA member is a small to medium sized business. Nearly half of HBMA members have clients in multiple states.

HBMA is a recognized revenue cycle management (RCM) authority by both the commercial insurance industry and the governmental agencies that regulate or otherwise affect the U.S. healthcare system.

General Observations

Properly considering all the implications of moving from a purely fee-for-service payment system with annual adjustments based on medical inflation and productivity to a fee-for-service payment model that links payment to quality represents an overhaul to the entire operational aspect of the claim adjudication and reimbursement process. The methodology, relevancy and specific metrics selected for quantification is critical to the long-term availability of healthcare, and must be consistent with CMS's objective to promulgate rules devoid of either discriminatory intent or discriminatory effect.

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Any change in the approach to how Medicare compensates a medical practice creates a multitude of diverse operational challenges. The magnitude of the changes contemplated in this proposed rule are voluminous and implementing these operational changes, as presently drafted, is daunting. Most physician practices are, essentially, small businesses. Even seemingly large practices with more than 50 providers are small when compared to a local big box retailer, fast food restaurant, chain pharmacy or grocery store. Like all businesses, practices must make financial commitments for rent, utilities, payroll, infrastructure, medical and business supplies and all of the other typical business expenses. And, like all businesses, there is some degree of risk of lost sales, changes in customer preferences, traffic patterns, while there are also opportunities for growth through new services and increased demand for existing services.

One of the most important factors in operating a successful small business is predictability, both from self-awareness (past performance, budgets, demographic changes, referral patterns, business plans, etc.) and from having a reliable way to forecast practice income.

HBMA member companies work with thousands of practices and tens of thousands of providers in every state and many territories, covering virtually every specialty and subspecialty. Many of our members' clients count on their billing company to not only help them comply with increasingly complex contracting, billing and payment systems, they also rely on those companies to provide periodic (annual, semi-annual or quarterly) forecasts of the practices' income based on typical service mix, payer mix, payment rates and adjudication turnaround times.

When additional reporting requirements were imposed, such as Physician Quality Reporting System (PQRS), Meaningful Use (MU), etc. these reporting methods often required additional or new software or program support; additional data collection, data entry and reporting; results reporting; and a wide variety of additional support activities. Often, those additional tasks produced little, if any, additional income for the practice and, in fact, for some their Medicare income declined in spite of complying with the additional requirements.

Predictability

We are concerned that the overall effect of the aggressive timetable, complexity and extraordinary variability of the myriad new proposed requirements will render preparation of any reliable income forecasts virtually impossible. Despite the flawed and ultimately unsuccessful Sustainable Growth Rate formula (SGR) regulating provider payments, it was – predictable. Even when it was launched two decades ago, the "moving parts" of SGR allowed providers and their support teams a means of confidently predicting their financial future.

Until this NPRM was published, providers could mostly understand how the Medicare payment system worked, how annual changes in the Conversion Factor, Relative Value Units and even coverage policies such as MPPR would affect their bottom line on a per-service, per-provider or monthly basis. The proposed changes in payment models, qualifications – and disqualifications, intricate formulae, thresholds (often indexed to external sources with no published or accessible historic data) and other proposals will make preparing any dependable forecast untenable.

We are concerned that one of the most important aspects of the Medicare program – patient access – will be at significant, material risk.

Small businesses are vulnerable to the aforementioned risks, as well as to unplanned or unanticipated negative financial outcomes, particularly when the "rules of the game" are vague, subject to change, reinterpretation or "clarification". Ironically, both MIPS and APMs seek to shift some level of financial risk to the physician/medical practice when experience demonstrates that physicians in private practice are risk-averse. As small business owners, they have financial obligations and a duty to their patients to stay in business and be available to care for their patients.

For some physicians, the most reliable way to minimize their business and financial risks may be to dramatically reduce the number of Medicare patients in the practice. This could be accomplished through rationing the number of appointments, the number of "high dollar risk" patients, the services offered to Medicare patients or other forms of financial risk reduction.

We have no way to anticipate whether the heavy weight of the proposed regulations will increase the already growing number of Medicare providers to opt-out entirely, but it is logical to think that those who can, will.

We fully recognize that there are certain statutorily mandated effective dates which CMS feels it cannot ignore. However, we are very concerned that unless CMS allows sufficient time to properly and thoroughly test the various requirements prior to implementing the MIPS initiative, many clinicians will experience severe cash-flow disruptions when the MIPS payment adjustments begin in 2019.

The following comments are intended to prevent as many unintended consequences from occurring as possible.

- **Delay Actionable MIPS reporting until October 1, 2017**

Although many of the MIPS reporting requirements are built on the existing framework (PQRS, EHR Meaningful Use and Value Modifiers), each of these programs will undergo changes as part of the move to MIPS. These changes, no matter how small will present significant operational challenges for RCM companies, clinicians as well as EHR systems, claim clearinghouses and other vendors, as well as for CMS.

As a result, for the benefit of all parties, there is tremendous value in providing additional time to successfully phase in the implementation and associated reporting mechanisms. We believe additional time should be provided – at least for year one – for proper implementation and reporting.

For the 2017 performance period, we anticipate that CMS will issue the required announcement as close to November 1, 2016 as possible. This means that the provider community (physicians, PAs, NPs, etc.) and the third-party revenue cycle management companies, practice managers, practice management software vendors, EHR vendors, coders, coding software vendors and

clearinghouses will have two months to make all of the changes necessary to meet the reporting requirements should CMS opt to mandate MIPS reporting on January 1, 2017.

We appreciate the enormity of the task given to CMS, and the amount of work that went into the nearly 1,000 page proposed rule. However, unlike similarly long proposed rules changes to the existing physician fee schedule, this is a brand new payment model that will impact the entire healthcare system for years to come. History has shown us that even small annual changes can create problems for many months. Such broad sweeping overhauls will certainly require an unparalleled investment in time and resources by the entire industry to minimize and control disruptions.

The MACRA statute mandates that Merit-based Incentive Payments apply to "…payments for items and services furnished on or after January 1, 2019." The statute does not, however, mandate when or how long the "performance period" upon which those adjustments are based must occur.

Based on the successful elements of prior implementation as experienced with ICD-10, robust external testing of MIPS data reporting testing must occur prior to actionable reporting to ensure that the MIPS data are being properly captured and accurately reported back to the clinicians prior to the "go live" date. We believe this is an imperative step in order to ensure physicians and practitioners are aware of how they are performing and to allow time to make necessary corrections. Perhaps more importantly, if software or programming should fail, the Eligible Clinician may not know in time to rectify the problem.

CMS is proposing to expand the use of episode-based reporting under the Resource Use category of MIPS. CMS traditionally uses general total per capita resource use measures for this purpose. HBMA believes that there needs to be adequate time to prepare for significant changes in resource use measurement such as those in this proposal. Many of these measures are new and relatively untested. HBMA believes that CMS needs to develop a program for conducting outreach and education to the provider community on this major shift in resource use measurement.

While MACRA mandates that CMS provide clinicians with feedback reports in 2017, MACRA does not mandate that a full year of 2017 quality measure data be utilized to assess adjustments for 2019 payments. As such, it is to CMS's and the industry's advantage to use as many months in 2017 as feasible for testing purposes, yet retaining as many of the remaining months in 2017 to assure statistical validity for the submission of data on which 2019 reimbursement will be based.

Adequate time for education, program modifications, system revisions, training and testing was the key to successful ICD-10 implementation. CMS listened to the industry and sought valuable input to identify and avoid the potential ICD-10 issues. That collaborative approach and lessons learned should serve as a roadmap for MIPS.

Recommendation

The HBMA recommends allowing MIPS eligible clinicians to begin voluntary MIPS reporting January 1, 2017 but delay actionable reporting until October 1, 2017. This will allow CMS and vendors to test the systems using real data and address any issues or problems during the nine month testing period. This approach would still allow CMS to comply with the feedback reporting requirement in MACRA.

HBMA believes the proposed episode-based reporting measures proposed in Table 4 and 5 in the proposed rule should be delayed until the 2018 reporting year. This will maintain consistency with the Value-based Modifier (VM) program for the first year of the transition.

- **Timing of Implementation Deadlines**

Maintaining continuity of claim adjudication and disposition is essential for Medicare patients, CMS and the clinicians. When multiple programming changes occur concurrently, this continuity is subjected to disruption resulting in unnecessary denied claims and rework by all parties involved.

Between October 1st and the end of each calendar year there are numerous and significant changes directly related to CMS. These updates and changes require changes to billing processes, practice management software and claims management. For example:

- October 1, 20XX - new ICD-10 codes will take effect which must be loaded onto the electronic claims processing systems of both payers and providers;
- November, 20XX - CMS releases the physician fee schedule updates that must be loaded onto the electronic claims processing systems of CMS, clinicians and their supporting systems;
- November/December, 20XX – additions, deletions and changes to CPT codes for the subsequent calendar year are announced;

This annual process will be exacerbated in 2016 as CMS will be making adjustments to ICD-10 claim processing edits on October 1 due to the code freeze related to ICD-10 implementation delays. These changes to the edit process typically result in additional claim rejections and a need for additional practice management software reprogramming to prevent such rejections.

Recommendation

We encourage CMS to establish a national program update calendar to identify annual data management updates or reprogramming that is recurring and make a reasonable effort to adjust regulatory change dates to spread-out the data collection, modifications or updates so that they do not all occur during the last quarter of the calendar year.

- **MIPS Eligible Clinicians**

For the first two years of MIPS, the MIPS eligible clinicians will include:

- Physicians,
- Physician Assistants (PAs),
- Nurse Practitioners (NPs),
- Clinical nurse specialists,
- Certified registered nurse anesthetists.

A number of MIPS Eligible Clinicians should be excluded from MIPS participation because the sub-specialty or sub-sub-specialty in which they practice is so narrow that it would be virtually impossible for them to have sufficient quality measures, CPIA or Resource Use data to report. It is conceivable that depending upon where CMS sets the low-volume threshold, these clinicians could be subject to MIPS if they had claims higher than the low-volume threshold.

CMS correctly identifies many of these as non-patient facing clinicians and provides examples of these types of providers (radiology, pathology, nuclear medicine, anesthesiology, etc.). CMS specifically states that there are potentially other specialties that could qualify. For example, Dermatopathologists are Pathologists who practice a specialized form of Dermatology. The specialty does not know if they are going to be designated as Dermatologists or are they Pathologists?

CMS proposes to "define a non-patient-facing MIPS eligible clinicians as an individual MIPS eligible clinician or group that bills 25 or fewer patient-facing encounters during a performance period." CMS considers a patient-facing encounter as an instance in which the MIPS eligible clinician or group billed for services such as general office visits, outpatient visits, and surgical procedure codes under the PFS.

CMS proposes to provide "zero weight" to a particular category for which the clinician qualifies. CMS maintains that it does not have the discretion to exempt clinicians from MIPS. However, CMS has the authority to classify these specialists as "low-volume" under an alternative definition and allow them to be exempt from MIPS.

The relevant portion of MACRA states:

The Secretary shall select a low-volume threshold to apply for purposes of clause (ii) (III), which may include one or more or a combination of the following:

(I) the minimum number (as determined by the Secretary) of individuals enrolled under this part who are treated by the eligible professional for the performance period involved.
(II) the minimum number (as determined by the Secretary) of items and services furnished to individuals enrolled under this part by such professional for such performance period.
(III) the minimum amount (as determined by the Secretary) of allowed charges billed by such professional under this part for such performance period.

The statute provides the Secretary broad discretion to designate the non-patient facing clinicians as low-volume providers creating a special category for them based upon their claims/billing history.

If CMS exercises its authority and raises the low-volume threshold, many of these sub-specialists will be exempt based upon their low-volume and not inadvertently and inappropriately subjected to MIPS penalties.

Recommendation

HBMA recommends the threshold be raised to a minimum of 200 encounters annually, per individual clinician (less than one Medicare patient per day); and we ask that CMS clarify the threshold in its calculation.

CMS should provide a list of clinicians, who, due to the highly specialized nature of their practice, may not qualify for a low-volume exception but who are unlikely to have sufficient reporting options to avoid MIPS penalties.

The non-patient-facing encounter threshold is vague. It is not clear whether this applies to individuals or the group. CMS should clarify the non-patient facing threshold.

- **Low-Volume Exception**

MACRA provides CMS with the authority to classify certain MIPS Eligible Clinicians as "low volume" providers. Low-Volume providers would be exempt from MIPS and not subject to MIPS penalties or payment enhancements. CMS has proposed that Eligible Clinicians who, during the performance period, have Medicare billing charges less than or equal to $10,000 and provide care for 100 or fewer Part B-enrolled Medicare beneficiaries, would be exempt from MIPS.

We believe the MIPS threshold is too low and would result in thousands of truly low volume providers being subject to MIPS (mostly penalties) and could result in these low-volume providers discontinuing their participation in the Medicare program.

For many of these low-volume providers, the decision to participate in MIPS will be largely financial using a very simple business equation. Cost of compliance v. cost of non-compliance.

CMS must consider that the cost to simply be able to report the requested data will, on average be $30,000 - $40,000. This cost is primarily the cost to purchase, install and maintain an EHR.

For a physician with $20,000 in total Medicare claims during a performance period, the total possible financial exposure during the first year of MIPS will be $20,000 X .04 = $800.00. It is not reasonable for CMS to expect a clinician to spend $30,000 (low end of compliance cost) to either avoid an $800 reduction or receive an $800 bonus.

It is our understanding that of the 40% of clinicians who were subject to a PQRS negative payment adjustment in 2015 roughly 98 percent did not even attempt to report data. While the numbers for 2016 were somewhat better, it should be noted that those not even attempting to report was over 80%. We presume that many of these physicians were not opposed to reporting and likely saw some clinical value but based upon the cost-benefit calculations they performed,

determined that participation could cause severe financial harm to the practice. In short, the cost of participating was greater than the benefit, if they participated.

PQRS reporting was relatively easy compared to MIPS. Therefore we can only conclude that similarly high percentages of physicians will be unable to participate increasing the need for a reasonable low-volume exception.

Recommendation/Questions

Raise the low volume threshold to $50,000 in Medicare claims during the performance period and remove any reference to the number of claims.

It is not clear what happens to Medicare payments for low-volume clinicians who are exempt from MIPS in that there is no fee schedule update for those not in MIPS or APMs. HBMA requests clarification as to how MIPS eligible clinicians who meet the low-volume threshold will be reimbursed during the five year period 2019 – 2024? Will MIPS exempt clinicians receive any payment update between 2019 and 2024 or will their payments be effectively frozen during this time period?

- **Quality Performance Reporting Threshold**

Current PQRS rules provide for reporting on 50 percent of patients to avoid the PQRS reporting penalty. CMS is proposing that individual MIPS eligible clinicians submitting data on quality measures data using Medicare Part B claims, would report on at least 80 percent of the Medicare Part B patients seen during the performance period to which the measure applies.

Raising this reporting threshold is inappropriate at the very time physicians and other clinicians will be attempting to just become familiar with the MIPS process. Adopting a higher reporting threshold may be appropriate at a later date but it is not appropriate during the first two years of MIPS reporting.

Again, according to information included in the recently released report - PQRS Reporting Experience – approximately 40% of physicians were subject to PQRS penalties in 2015 and 2016 and of those, a very high percentage did not even attempt to report PQRS data. To expect that these physicians (and other clinicians who have not been required to do PQRS reporting) will be able to suddenly begin doing quality reporting at such a high level is unrealistic. This will only serve to increase the likelihood that these providers will be subject to negative payment adjustments.

The proposed increase to 80 or 90 percent is not necessary to obtain a valid sample size and will be extremely difficult for many physicians to meet. Such high reporting levels will disproportionately impact those in small practices who are still striving to become proficient in reporting of quality measures.

Recommendation

We recommend that CMS maintain the 50 percent threshold.

- **Reporting and Benchmarking of Quality Measures**

While we appreciate that CMS has proposed to reduce the number of reportable quality measures (QMs) from nine to six, and to eliminate the required domains, many Clinicians, particularly those in certain specialties, simply do not have a sufficient number of meaningful measures to report, resulting in the reporting of measures that have little relevance to their practice. In these instances, the Eligible Clinicians are reporting for reporting's sake.

Until such time as there are sufficient quality measures within a physician's specialty to allow them to report a minimum number, physicians should not be forced to report for the sake of reporting.

Until this situation can be remedied through the adoption of meaningful measures, we believe even six measures is too many and we ask that the number be reduced.

We also believe that if quality reporting is to result in the desired improvements in quality, physicians must receive more timely information on where they stand in relation to performance benchmarks.

While it is laudable that CMS intends to provide quarterly reports on the individual reporting of an Eligible Clinician, the EC will not know where he/she stands relative to other physicians until just prior to the beginning of the payment adjustments. Because the benchmark will be based upon overall reporting (thus using a curve methodology) a physician may be under the mistaken impression that he/she had scored well on a measure only to learn that he/she is in a low decile compared to all other physician's reporting in a particular category.

A two year lag between performance and benchmark reporting is too long. We are also concerned that the performance benchmarks for measures are being based on data that will be four years after the payment year. We urge that CMS set benchmarks on more current data.

Recommendation

HBMA recommends the number of Quality Measures an EC must report be reduced; as well as shorten the timeframe between when the Quality Measures are reported and CMS announces the benchmark for the Quality Measures.

Use the reporting period rather than a baseline period for setting benchmarks. This allows flexibility for setting benchmarks if a reporting period is shortened.

- **Claims Based Reporting**

We commend CMS for retaining the Claims based reporting capability but it seems clear that over time, CMS would like to eliminate this option and move to registry based reporting.

We recognize that the quality of information that can be obtained via registry-based reporting is far more robust than what can be obtained from claims-based reporting. We urge CMS to recognize the significant cost to the provider for registry-based reporting. HBMA members routinely report that the per-clinician reporting cost for registry-based reporting can be $300 - $400 per clinician annually. Many Registries not only charge on a per-clinician basis, but also charge an additional fee for additional sites.

Depending upon the size of the practice and the volume of Medicare claims, the cost of Registry-based reporting can be higher than the positive payment adjustment the clinician could receive!

Recommendation

We strongly urge that CMS retain the claims-based reporting option as a cost-effective and effective alternative to more expensive registry-based reporting.

- **Feedback to Physicians/MIPS Data Submission and Reporting**

CMS is proposing Quarterly reporting over the 12 month reporting period. As noted earlier, we recommend for 2017, the reporting period be three months from October 1, 2107 to December 31, 2017.

To achieve maximum compliance and benefit to CMS, frequent updates to clinicians will be beneficial to assess their comparative performance with other MIPS eligible clinicians reporting in the same categories.

HBMA and others have previously pointed out the problem with physicians receiving timely feedback and urged CMS to improve the information in the performance reports. Sadly, CMS is often unable to provide information in a timely fashion or make more timely updates to information shared electronically with physicians because CMS operates on an outdated computer platform. CMS should do all it can to update its computer system to allow it to produce reports that are timely and contain information that can truly help physician's improve their practice and patient care.

Moving to a MIPS or APM environment will require quality, timely data.

CMS should consult with stakeholder groups, particularly groups such as HBMA that are heavily invested in the operational aspects of the medical practice, to determine the most meaningful format for sharing ongoing, actionable performance feedback with physicians and practices. It is critical that CMS take a proactive approach to improving the way performance information is disseminated to physicians and practices.

In the proposed rule, CMS proposes to provide feedback reports for MIPS on the quality and resource use performance categories in the performance feedback but states it will consider providing feedback on the CPIA and ACI categories in the future. HBMA believes that it is imperative that eligible clinicians are able to understand their MIPS performance status in order

to identify where to direct their finite resources to improve the aspect of their practice to achieve the goals of MIPS.

CMS states in the proposed rule that MIPS eligible clinicians who participate in APM Entities will receive performance feedback as "technically feasible". HBMA believes this is a grossly inadequate and vague proposal. Eligible clinicians who are attempting to qualify as a full, or partial QP in Advanced APMs are likely to rely on our members to track their revenue and patient attribution status for meeting the QP threshold. Eligible Clinicians would value knowing that CMS's data is consistent with their own data.

In the proposed rule, CMS expresses its intent to work with stakeholders on which data fields to include in feedback reports. HBMA looks forward to participating in that process. The proposed rule also expresses CMS' intent to broaden feedback reporting so that it is more detailed and comprehensive across all four categories in the future.

HBMA supports CMS' intent to broaden and enhance feedback reporting data across all four performance categories. HBMA also supports the use of a single, web-based portal facilitated by CMS for feedback reporting. While individual registries may provide feedback reports to their users, those reports only reflect the data within that registry while ignoring the data from other registries and reporting mechanisms. A single, CMS-facilitated web portal for communicating feedback reports is the only way to guarantee eligible clinicians have an accurate report on how their performance compares to that of all other eligible clinicians that they will be measured against.

In the proposed rule, CMS states its intention to develop resources to assist eligible clinicians understand their feedback reports, such as help desk and other educational resources. HBMA is glad that CMS will provide such resources but cautions CMS against the delegation of these duties to the Medicare Administrative Contractors (MAC). HBMA members have experienced frequent enough inconsistencies with responses from MACs, as well as difficulties obtaining written responses from them to support their decision. HBMA believes CMS should use its own staff to troubleshoot and educate providers on feedback reporting.

Along with other stakeholder groups, HBMA encourages CMS to move towards a more iterative process where physicians and vendors submit data more routinely to CMS. This will allow CMS to produce more frequent feedback information in terms of how a physician is performing throughout MIPS, including their composite score and not just with quality.

HBMA has previously expressed concerns about the ability of physicians (or their surrogates) to access feedback reports due to the overly complicated log-in process. We urge CMS to improve the log-in process for accessing reports to ensure it is simple and user-friendly. CMS must also recognize that it is rarely the physician/Eligible Clinician who accesses these reports and as part of making the system more "user friendly" simplify the process for surrogates (either in-office staff or third party partner) to access and download the Eligible Clinician's data.

Eligible Clinicians (and their surrogates) must be provided adequate notice that feedback reports are available. ECs must be given sufficient time to review the data. To expect ECs to access, review, and contest data in less than 90 days is unrealistic.

As technology improves, we support allowing MIPS Eligible Clinicians to submit more frequently than Quarterly. This would allow Eligible Clinicians to receive feedback more frequently throughout the performance period.

Recommendation

HBMA strongly believes that MIPS feedback reports should include information on all four categories of MIPS and have a process in place for stakeholders to contact CMS to clarify any disagreements or misconceptions regarding the information contained in the feedback report. The feedback reports should include information and estimates on the benchmarks for the clinician's specialty's quality measures, the eligible clinician's CPS if it were to be calculated at that time, and suggestions for improving performance. Though CMS acknowledges it intends to move from yearly to more frequent feedback in the future, we encourage CMS to move to quarterly feedback reports as soon as possible.

HBMA recommends that MIPS data reporting be quarterly with a minimum of quarterly updates. This will allow MIPS Eligible Clinicians to see how they are doing and how they compare to other clinicians in the same category.

Over time, as technology improves, Clinicians should be given the opportunity for voluntary monthly reporting with the incentive that they would receive monthly reports from CMS.

- **Measure Applicability Validation (MAV) process**

CMS states that it intends to develop a MIPS validation process to review and validate a MIPS EC's quality performance, and that the process will function similar to the MAV process. We urge CMS to consult with organizations such as HBMA, as well as physician stakeholders as it develops the new validation process.

Our members have considerable experience with the MAV process and would welcome the opportunity to work with CMS to improve the operational part of this process. We would note that since the CMS Provider Enrollment staff established a "Users Group" a few years ago, there has been tremendous improvement in the Medicare enrollment process. These improvements have led to greater accuracy, timely updates and the improvements have saved time and money for both Medicare and physicians. We believe similar opportunities exist and would welcome the opportunity to be involved in any "User Group" that may be established.

- **Advancing Care Information**

HBMA does not agree with CMS' proposal to require all eligible clinicians to use 2015 CEHRT beginning in the 2018 reporting year. CMS acknowledges the many barriers to greater utilization of EHRs and HBMA believes that it is incredibly unlikely that improvements will be made to

address those barriers before the 2018 reporting year. HBMA supports the use of technology as a means to improve patient care and feels that most of the barriers to better utilization are confined to the vendors and beyond the control of providers. HBMA believes there is a need for improvements in interoperability, functionality and cost before CMS will see the utilization rates of EHRs that it desires, especially among 2015 CEHRT products.

Additionally, HBMA supports having a process in place for hardship exemptions in the Meaningful Use program.

Recommendation

HBMA believes that the hardship exemption process in the Meaningful Use program should be carried over into MIPS. Providers who receive a hardship exemption would have their ACI reporting category weighted at 0%.

For the 2017 reporting year, HBMA believes the weighting for the ACI category should be reduced to 15% while the Clinical Practice Improvement Activity category should be weighted at 25% to offset the reduction. HBMA believes that the use of EHRs will be one of the largest burdens to eligible clinicians in MIPS. Reducing the ACI category's weight will help mitigate that burden.

HBMA believes that the use of 2015 CEHRT should not be a requirement of the Advancing Care Information category by 2018. We suggest making use of the most recent CEHRT an item in the Clinical Practice Improvement Activity list instead.

Lastly, HBMA supports the proposed exemption for hospital-based clinicians from the ACI category as they generally do not have control over the EHR technology they use.

- **Outreach to Power User Groups**

Given the fact that it is highly unlikely that the eligible clinician will be doing a significant portion of the tracking and reporting of data required under MIPS and that in many cases they will delegate that work to our members, HBMA believes it is critical that CMS consults with the actual end users of the reporting mechanisms required to satisfy MIPS reporting. For similar initiatives, CMS has convened "power user" groups to provide feedback and best practice advice to the Agency.

HBMA urges CMS to create power user groups for MIPS.

- **Alternative Payment Models**

We are very concerned that if CMS moves ahead with the proposed requirements for approval of alternative payment models as "Advanced APMs" it will have a chilling effect on the development of truly creative and valuable alternative payment models.

The irony is that there appear to be a number of specialty specific initiatives under way that hold significant promise for improving patient outcomes and saving money for both patients and providers.

Unfortunately, CMS has chosen to develop a framework for approval of APMs that seems more driven by achieving various process measures and far less attention to actually evaluating a proposal on its ability to improve care (and incidentally lower costs).

We believe that by improving care outcomes, in particular investing in payment models that aim to keep patients out of the hospital, avoid unnecessary Emergency Room visits and improve the patient's quality of life, CMS can and will save money. But saving money should be a residual benefit of improving care delivery, not its purpose.

As with so many of the "quality measures" CMS is putting greater emphasis on "process" and not enough emphasis on "outcomes".

CMS is proposing that an Advanced APM model must meet three criteria:

1. Comparable Clinical Quality Measures
2. EHR Utilization
3. More than nominal risk

We disagree with the proposed definition of "more than nominal risk".

While Congress mandates that as a condition for approval of an APM, the clinician's participating in that model must be at "more than nominal risk," CMS has broad latitude in how to define this financial risk.

Reports of medical practices declaring bankruptcy have been on the rise which suggests that simply operating a medical practice in the current economic climate represents "more than nominal risk".

We believe CMS has made it too difficult for many creative and innovate payment models being developed by specialty societies to qualify as APMs. We encourage CMS to review and adopt the recommendations put forward by the American Medical Association as it relates to modifications of the APM process as well as the AMAs comments and recommendations as they related to the definition of "nominal risk".

CMS proposes to gradually increase the requirements for the certification of an APM as an Advanced APM. For example, the use of CEHRT increases from 50% to 75% over time. CMS does not anticipate very many providers qualifying as full or partial participants in Advanced APMs in 2017. HBMA believes that rather than increasing the criteria for Advanced APM certification as proposed, that CMS should apply the same timeline of increasing the Advanced APM criteria beginning with the first year an Advanced APM Entity is approved.

An Advanced APM model that cannot meet the criteria for an Advanced APM in the first year will only have a more difficult time meeting the requirements in future years. Applying the same timeline for the Advanced APM Model requirements but beginning with the first year a model is certified will make it easier for more Advanced APMs to be certified and would therefore increase participation in Advanced APMS.

Additionally, the threshold for QP status increases over the first few years. It is clear that MACRA intends to incentivize the transition of clinicians from MIPS to APM participation. For example, the Payment Amount threshold for QP Status increases gradually from 25% in 2019 to 75% by 2023.

Recommendation

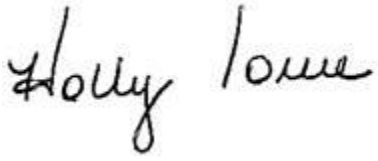
We believe CMS should remove the specific years of this gradual increase and instead apply this same gradually increasing threshold for both Payment amount and Patient Count beginning with the first year of QP or partial QP status between the years 2019 and 2023. This will allow a provider who transitions from MIPS to APMs to have an easier time qualifying and adjusting to the new reimbursement methodology.

HBMA recommends that CMS provide, on a quarterly basis, feedback reports to eligible clinicians stating the current data CMS has regarding each eligible clinicians status towards meeting the Advanced APM Threshold for QP status.

Your consideration of these comments is appreciated.

Please do not hesitate to contact us if you have any questions.

Sincerely,



Holly Louie, CHBME
President
Healthcare Billing and Management Association