Summary of PCPI Comments for Select Provisions of the Proposed Rule for the Medicare Program; CY 2020 Updates to the Quality Payment Program (CMS–1715–P)

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Promoting Interoperability		
Provision	**CMS Proposal**	**Population(s) affected**
(c) Establishing a performance period of a minimum of a continuous 90-day period within CY 2021, up to and including the full calendar year; (p. 836-837	From: *a minimum of a continuous 90-day period within the calendar year that occurs 2 years prior to the applicable MIPS payment year, up to and including the full calendar year.* To: *For the 2023 MIPS payment year, … establish a performance period for the Promoting Interoperability performance category of a minimum of a continuous 90-day period within the calendar year that occurs 2 years prior to the applicable MIPS payment year, up to and including the full calendar year (CY 2021).* Purpose: *align with the proposed EHR reporting period in CY 2021 for the Medicare Promoting Interoperability Program for eligible hospitals and CAHs*	All reporters of interoperability metrics
(B) (aa) making the Query of Prescription Drug Monitoring Program (PDMP) measure optional in CY 2020, and in the event we finalize this proposal, making the e-Prescribing measure worth up to 10 points in CY 2020;	To: *make the Query of PDMP measure optional and eligible for 5 bonus points* Purpose: *to allow additional time to evaluate the changing PDMP landscape prior to requiring a Query of PDMP measure, or introducing requirements related to EHR-PDMP integration.*	All reporters of PDMP query metric
(B) (aa) Query of PDMP Measure (p. 844-847)	To: *the measure description would remain the same (83 FR 59803), but instead of submitting numerator and denominator information for the measure, MIPS eligible clinicians would submit a "yes/no" response. A "yes" response would indicate that for at least one Schedule II opioid electronically prescribed using*	All reporters of the metric

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	CEHRT during the performance period, the MIPS eligible clinician used data from CEHRT to conduct a query of a PDMP for prescription drug history, except where prohibited and in accordance with ap*plicable law.* Purpose: *no standards-based interfaces between CEHRT and PDMPs, health care providers must manually track the number of times that they query a PDMP outside of CEHRT. We are proposing this change to reduce the burden on health care providers of having to manually keep track of information related to the measure and to mitigate the burden on health IT developers who would otherwise have to develop the measure's numerator and denominator calculations when we expect to propose changes to the measure in the near future.*	
(C) Verify Opioid Treatment Agreement Measure (p.847-850)	To: R*emove the Verify Opioid Treatment Agreement measure from the Promoting Interoperability performance category beginning with the performance period in CY 2020* Purpose: Because the measure *is vague, burdensome to measure and does not necessarily offer a clinical value to the health care providers or support the clinical goal of supporting OUD treatment.*	Eligible clinicians
(A) Proposed Modification of the Support Electronic Referral Loops by Sending Health Information measure (p.850-851)	To: *Under our existing policy (83 FR 59788), if an exclusion is claimed for the Support Electronic Referral Loops by Receiving and Incorporating Health Information measure, the 20 points associated with it will be redistributed to the Support Electronic Referral Loops by Sending Health Information measure. Under our proposal, if exclusions are claimed for both the Support Electronic Referral Loops by Receiving and Incorporating Health Information measure and the Support Electronic Referral Loops by Sending Health Information measure,*	Eligible clinicians

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	the 40 points associated with these measures would be redistributed to the Provide Patients Access to Their Health Information measure. We are proposing that this redistribution policy would be applicable beginning with the 2019 performance period/2021 MIPS payment year. Purpose: *We have chosen to redistribute the points to the Provide Patients Access to Their Health Information measure because we believe that many MIPS eligible clinicians may be eligible to claim exclusions for both measures under the Health Information Exchange objective.*	
(B) Modification of the Support Electronic Referral Loops by Receiving and Incorporating Health Information Measure (p.851-857)	To: *Any MIPS eligible clinician who receives transitions of care or referrals or has patient encounters in which the MIPS eligible clinician has never before encountered the patient fewer than 100 times during the performance period.* Purpose: *to use that same exclusion from the Request/Accept Summary of Care measure for the new Support Electronic Referral Loops by Receiving and Incorporating Health Information measure*	Eligible clinicians
(B) (f) (i and ii) Scoring Methodology -- continuing the existing policy of reweighting the Promoting Interoperability performance category for certain types of non-physician practitioner	To: *continue the existing policy of reweighting the Promoting Interoperability performance category for NPs, PAs, CRNAs, and CNSs…. physical therapists, occupational therapists, qualified speech-language pathologist, qualified audiologists, clinical psychologists, and registered dieticians or nutrition professionals, for the performance period in 2020* Purpose: *CMS is unable to determine, at this time, whether the measures currently specified for the Promoting Interoperability performance category for the 2020 performance period are applicable and available for these eligible clinicians*	Eligible clinicians

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MIPS eligible clinicians for the performance period in 2020; (p.858-861)		
(f) (iii) proposals related to hospital-based MIPS eligible clinicians and non-patient facing MIPS eligible clinicians in groups. (p. 861-863)	To: *revise the definition of a hospital-based MIPS eligible clinician under § 414.1305 to include groups and virtual groups. We are proposing that, beginning with the 2022 MIPS payment year, a hospital-based MIPS eligible clinician under § 414.1305 means an individual MIPS eligible clinician who furnishes 75 percent or more of his or her covered professional services in sites of service identified by the POS codes used in the HIPAA standard transaction as an inpatient hospital, on-campus outpatient hospital, off campus outpatient hospital, or emergency room setting based on claims for the MIPS determination period, and a group or virtual group provided that more than 75 percent of the NPIs billing under the group's TIN or virtual group's TINs, as applicable, meet the definition of a hospital-based individual MIPS eligible clinician during the MIPS determination period.* Purpose: to address concerns that *hospital medicine groups may face unique circumstances due to the nature of their practice area and the staffing practices described by stakeholders*	Eligible clinicians
(f) (iv) Non-Patient Facing MIPS Eligible Clinicians in Groups (p. 863-865)	To: *revise § 414.1380(c)(2)(iii) to also account for a group or virtual group that meets the definition of a non-patient facing MIPS eligible clinician under § 414.1305, such that the group or virtual group only has to meet a threshold of more than 75 percent.* Purpose: *to account for groups and virtual groups that meet the proposed revised definition of a hospital-based MIPS eligible clinician under § 414.1305,*	Eligible clinicians, particularly within groups or virtual groups.

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	which would only require the group or virtual group to meet a threshold of more than 75 percent instead of a threshold of all of the MIPS eligible clinicians in the group or virtual group	
Requests for Information		
Requests for Information: (g) (i) Potential Opioid Measures for Future Inclusion in the Promoting Interoperability performance category (p. 865-866)	Seeking comment on OUD prevention and treatment measures that include the following characteristics: • *Include evidence of positive impact on outcome-focused improvement activities, and the opioid crisis overall;* • *Leverage the capabilities of CEHRT where possible, including: near-automatic calculation and reporting of numerator, denominator, exclusions and exceptions to minimize manual documentation required of the provider; and timing elements to reduce quality measurement and reporting burdens to the greatest extent possible;* • *Are based on well-defined clinical concepts, measure logic and timing elements that can be captured by CEHRT in standard clinical workflow and/or routine business operations.* • *Well-defined clinical concepts include those that can be discretely represented by available clinical and/or claims vocabularies such as SNOMED CT, LOINC, RxNorm, ICD-10 or CPT;* • *Align with clinical workflows in such a way that data used in the calculation of the measure is collected as part of a standard workflow and does not require any additional steps or actions by the health care provider;* • *Are applicable to all clinicians (for example, clinicians participating as individuals or as a group, or clinicians located in a rural area,*	Eligible clinicians, EHR/EMR providers

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	designated health professional shortage area (HPSA), designated medically-underserved area (MUA), or urban area); • *Could potentially align with other MIPS performance categories; and* • *Are represented by a measure description, numerator/denominator or yes/no attestation statement, and possible exclusions.*	
Requests for Information: (g) (ii) NQF and CDC Opioid Quality Measures, (p. 867-872)	Seeking comment on: • *specific use cases for health IT implementation for the potential [CDC and NQF] measure actions.* • *modifications to the NQF and CDC measures to make the measures as applicable as possible to all participants of the Promoting Interoperability performance category* • *ways in which the two sets of measures could be correlated to support potential new measures* • *which measures might best advance the implementation and use of interoperable health IT and encourage information exchange between care teams and with patients.* NQF Measures • *Use of Opioids at High Dosage in Persons Without Cancer (NQF #2940)* • *Use of Opioids from Multiple Providers in Persons Without Cancer (NQF #2950)* • *Use of Opioids from Multiple Providers and at High Dosage in Persons Without* • *Cancer (NQF #2951)* CDC Measures New Opioid Prescription Measures	Eligible clinicians

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	• The percentage of patients with a new opioid prescription for an immediate-release opioid. • The percentage of patients with a new opioid prescription for chronic pain with documentation that a PDMP was checked prior to prescribing. • The percentage of patients with a new opioid prescription for chronic pain with documentation that a urine drug test was performed prior to prescribing. • The percentage of patients with a follow-up visit within four weeks of starting an opioid for chronic pain. • The percentage of patients with a new opioid prescription for acute pain for a three days' supply or less. Long-term Opioid Therapy Measures • The percentage of patients on long-term opioid therapy who are taking 50 MMEs or more per day. • The percentage of patients on long-term opioid therapy who are taking 90 MMEs or more per day. • The percentage of patients on long-term opioid therapy who received a prescription for a benzodiazepine. • The percentage of patients on long-term opioid therapy who had a follow-up visit at least quarterly. • The percentage of patients on long-term opioid therapy who had at least quarterly pain and functional assessments. • The percentage of patients on long-term opioid therapy who had documentation that a PDMP was checked at least quarterly.	

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	• The percentage of patients on long-term opioid therapy who the clinician counseled on the risks and benefits of opioids at least annually. • The percentage of patients on long-term opioid therapy with documentation that a urine drug test was performed at least annually. • The percentage of patients with chronic pain who had at least one referral or visit for nonpharmacologic therapy as a treatment for pain. • The percentage of patients on long-term opioid therapy who were counseled on the purpose and use of naloxone, and either prescribed or referred to obtain naloxone. • The percentage of patients with an opioid use disorder (OUD) who were referred to or prescribed medication-assisted treatment (MAT). • https://www.cdc.gov/drugoverdose/pdf/prescribing/CDC-DUIP-QualityImprovementAndCareCoordination-508.pdf	
Requests for Information: (g) (iii) a Metric to Improve Efficiency of Providers within EHRs, (p. 872-875)	CMS Requests information on the following: • *What do stakeholders believe would be useful ways to measure the efficiency of health care processes due to the use of health IT?* • *What are measurable outcomes demonstrating greater efficiency in costs or resource use that can be linked to the use of health IT-enabled processes? This includes measure description, numerator/denominator or yes/no reporting, and exclusions.* • *What do stakeholders believe may be hindering their ability to achieve greater efficiency (for example, product, measures, CMS regulations)? Please, provide examples.*	EHR/EMR Providers, Eligible Clinicians

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	• *What are specific technologies, capabilities, or system features (beyond those currently addressed in the Promoting Interoperability performance category) that can increase the efficiency of provider interactions with technology systems; for instance, alternate authentication technologies that can simplify provider logon? How could we reward providers for adoption and use of these technologies?* • *What are key administrative processes that can benefit from more efficient electronic workflows; for instance, conducting prior authorization requests? How can we measure and reward providers for their uptake of more efficient electronic workflows?* • *Could CMS successfully incentivize efficiency? What role should CMS play in improving efficiency in the practice of medicine?*	
Requests for Information: (g) (iv) the Provider to Patient Exchange Objective, (p. 875-884)	CMS is seeking comment on the following: Immediate Access • *Whether MIPS eligible clinicians should make patient health information available immediately through an open, standards-based API, no later than one business day after it is available to the MIPS eligible clinicians in their CEHRT.* • *The barriers to more immediate access to patient information.* • *Whether there are specific data elements that may be more or less feasible to share no later than one business day.* • *When implementation of such a requirement is feasible.* Persistent Access and Standards-Based APIs	Eligible Clinicians, EHR/EMR Providers

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	• *Should the proposed requirements around persistent access to APIs, which would accommodate a patient's routine access to their health information without needing to reauthorize their application and re-authenticate themselves be incorporated into the current measure for persistent access* • *If ONC's proposed FHIR-based API certification criteria is finalized, would stakeholders support a possible bonus under the Promoting Interoperability performance category for early adoption of a certified FHIR-based API in the intermediate time before ONC's final rule's compliance date for implementation of a FHIR standard for certified APIs?* Available Data Comments on alternatives to the current measures • *Do stakeholders believe that incorporating this alternative measure into the Provider to Patient Exchange objective will be effective in encouraging the availability of all data stored in health IT systems?* • *In relation to the Provider to Patient Exchange objective, as a whole, how should a required measure focused on using the proposed total EHI export function in CEHRT be scored?* • *If this certification criterion is finalized and implemented, should a measure based on the criterion be established as a bonus measure?* • *Should this measure be established as an attestation measure?* • *In the long term, how do stakeholders believe such an alternative measure would impact burden?*	

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	• *If stakeholders do not believe this will have a positive impact on burden, in what other way(s) might an alternative measure be implemented that may result in burden reduction? Please, be specific.* Other Requests for Comments • *Which data elements do stakeholders believe are of greatest clinical value or would be of most use to health care providers to share in a standardized electronic format if the complete record was not immediately available?* • *Do stakeholders believe that we should consider including a health IT activity that promotes engagement in the health information exchange across the care continuum that would encourage bi-directional exchange of health information with community partners, such as post acute care, long-term care, behavioral health, and home and community based services to promote better care coordination for patients with chronic conditions and complex care needs? If so, what criteria should we consider when implementing a health information exchange across the care continuum health IT activity in the Promoting Interoperability performance category?* • *What criteria should we employ, such as specific goals or areas of focus, to identify high priority health IT activities for the future of the performance category?* • *Are there additional health IT activities we should consider recognizing in lieu of reporting on existing measures and objectives that would most effectively advance priorities for nationwide interoperability and spur innovation?*	

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	Patient Matching • *Do stakeholders believe that CMS and ONC patient matching efforts impact burden? Please, explain.* • *If stakeholders believe that patient matching is leading to increased burden, what suggestions might stakeholders have to promote interoperability securely and accurately, without the requirement of a UPI, that may result in burden reduction? Please, be specific.*	
Requests for Information: (g) (v) Integration of Patient-Generated Health Data into EHRs Using CEHRT (p.884-888)	• *In considering how the Promoting Interoperability performance category could continue to advance the use of PGHD, we also note that a future element related to PGHD would not necessarily need to be implemented as a traditional measure requiring reporting of a numerator and denominator. For instance, in the CY 2019 PFS proposed rule (83 FR 35932), we requested comment on the concept of "health IT" or "interoperability" activities to which a health care provider could attest, potentially in lieu of reporting on measures associated with certain objectives.* Would *addressing the use of PGHD through such a concept, rather than traditional measure reporting, we could potentially reduce the reporting burden associated with a new PGHD-related element?* • *What specific use cases for capture of PGHD as part of treatment and care coordination across clinical conditions and care settings are most promising for improving patient outcomes? For instance, use of PGHD for capturing advanced directives and pre/post-operation instructions in surgery units.*	Clinicians, Patients

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	• *Should the Promoting Interoperability performance category explore ways to reward providers for engaging in activities that pilot promising technical solutions or approaches for capturing PGHD and incorporating it into CEHRT using standards-based approaches?* • *Should health care providers be expected to collect information from their patients outside of scheduled appointments or procedures? What are the benefits and concerns about doing so?* • *Should the Promoting Interoperability performance category explore ways to reward health care providers for implementing best practices associated with optimizing clinical workflows for obtaining, reviewing, and analyzing PGHD?*	
Requests for Information: (g) (vi) Engaging in Activities that Promote the Safety of the EHR. (p.888-890)	• *Ways that the Promoting Interoperability performance category may reward MIPS eligible clinicians for engaging in activities that can help to reduce the errors associated with EHR implementation, e.g., MIPS eligible clinicians would receive points towards their Promoting Interoperability performance category score for attesting to performance of an assessment based on one of the ONC SAFER Guides.* • *What alternatives to the SAFER Guides, including appropriate assessments related to patient safety, which should also be considered as part of any future bonus options* • *What other approaches might CMS to rewarding activities that promote reduction of safety risks associated with EHR implementation as part of the Promoting Interoperability performance category.*	EHR/EMR Providers, Eligible Clinicians