August 21, 2017

The Honorable Seema Verma
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5522-P

Submitted electronically http://www.regulations.gov

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

Dear Administrator Verma:

The American Medical Informatics Association (AMIA) appreciates the opportunity to provide input on the CY 2018 Updates to the Quality Payment Program (QPP) proposed rule.

AMIA is the professional home for more than 5,400 informatics professionals, representing frontline clinicians, researchers and public health experts who bring meaning to data, manage information and generate new knowledge across the health and healthcare enterprise. As the voice of the nation's biomedical and health informatics professionals, AMIA plays a leading role in advancing health and wellness by moving basic research findings from bench to bedside, and evaluating interventions, innovations and public policy across settings and patient populations.

Given the degree of digitization in healthcare, CMS is, perhaps, poised to become one of the most data-heavy government agencies in our federal bureaucracy. In comments submitted to CMS in 2016 regarding proposals for Year 1 of the QPP, we stated, "AMIA believes CMS has an unprecedented opportunity to learn which components of these legacy programs [PQRS, MU, and VBM] will effectively support our healthcare system in moving toward the triple aim."

Following nearly a year of program experience, we see important progress in many areas, as well as, the need to continue work in others. The flexibilities offered by CMS to acclimate MIPS ECs to a new payment and performance measurement paradigm were much needed. We see additional flexibilities proposed for Year 2 of the QPP as helpful. For instance, AMIA supports the process outlined to determine "topped-out" quality measures and we are encouraged by CMS questions related to feedback loops for comparison and benchmarking purposes. We also are pleased that CMS has proposed a series of exemptions and policies intended to help small and under-resourced practices.

Perhaps most importantly, we see progress in addressing a fundamental challenge facing CMS in crafting a set of MIPS policies that mitigate the effects of having ECs comply with four separate programs. AMIA commends CMS for expanding the list of potential Improvement Activities (IAs) that are eligible for the Advancing Care Information (ACI) performance category bonus score if completed using CEHRT functionality. **We recommend CMS continue to identify MIPS requirements that are mutually reinforcing across Performance Categories.**

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With the sunset of Meaningful Use for Medicare, we view MIPS and APM requirements as a primary mechanism to incentivize continued investment and use of Certified EHR Technology (CEHRT) among ambulatory providers. **It is important that CMS continue to view CEHRT as a means to encourage adoption and maintenance of modern information and communication technology in care delivery, and focus on making the use of such systems easier for clinicians.** Without CEHRT, there is a higher likelihood that systems will not interoperate because there is very little else compelling the market to standardize around medical vocabularies, content templates, or transport mechanisms. Data from care delivery settings that do not have CEHRT and were not afforded incentives to adopt EHRs provide a useful control group.[1, 2] CEHRT and associated standards are important vehicles by which other incentives – such as risk-based sharing and value-based payment – will be successful. At the same time, it is essential that both CEHRT criteria and MIPS policies not contribute to overly prescriptive requirements for providers and vendors, impairing functionality and workflows.

AMIA views proposals that encourage adoption of CEHRT, such as the bonus score available to MIPS ECs who use the 2015 Edition, as important. And while we understand the hesitancy to require upgrades to the 2015 Edition for all MIPS ECs in 2018, **we ask CMS to clearly state its intentions to require 2015 Edition CEHRT in 2019 for QPP participation**. This will signal to industry that they must continue investments in CEHRT, and prepare clinicians for a nationwide upgrade to 2015 Edition products to better support interoperability across the care continuum.

The 2015 Edition includes more robust technology in the form of (1) standardized common clinical data set summary records; (2) application program interfaces (APIs); (3) data elements for social, psychological and behavioral data, and implantable devices; (4) technical standard that allow providers to flag sensitive health information, while still enabling that data to be included in an electronic data stream; and (5) a criterion meant to improve the performance of consolidated CDA creation. These advances are fundamental to the next iteration of health informatics-supported patient care, and CMS must acknowledge the important role its policies play in moving the industry forward.

At the same time, AMIA encourages CMS to work with ONC to ensure that the Federal Certification Program focuses on conformance to technical standards and allows for third-party

[1] Rates of electronic sharing with long-term care, behavioral health, and home health providers were lower than rates of electronic sharing with ambulatory care providers. These settings do not have requirements for CEHRT, nor do they have agreed-upon standards for vocabulary, content, or transport of health information. Heisey-Grove D, Patel V, Searcy, T. Physician electronic exchange of patient health information, 2014. ONC Data Brief, No. 31. Office of the National Coordinator for Health Information Technology: Washington DC. 2015. Accessed August 2017. https://www.healthit.gov/sites/default/files/briefs/oncdatabrief31_physician_e_exchange.pdf

[2] The same is true for acute care settings. Swain M, Charles D, Patel V, Searcy T. Health Information Exchange among U.S. Non-federal Acute Care Hospitals: 2008-2014. ONC Data Brief, No.24. Office of the National Coordinator for Health Information Technology: Washington DC. 2015. Accessed August 2017. https://www.healthit.gov/sites/default/files/data-brief/ONC_DataBrief24_HIE_Final.pdf

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developed functions. As stated in our detailed comments, CEHRT that continues a focus on numerator/denominator automated measure calculations will continue to have usability challenges.

And while we fiercely believe health informatics tools are a necessary component to modern practice, we also must insist that evidence supports the use of such tools. AMIA supports the CMS Blueprint for the Measurement Management System,[3] and we encourage development of similar processes for the MIPS ACI and IA Performance Categories. To this end, **AMIA recommends that CMS measure and determine the value of ACI measures with as much vigor as it does quality measures.** If the measures are not seen as demonstrating value, they should be considered for removal. AMIA's members are particularly well-versed in evaluating technological interventions, and should be seen as a source for such research.

We hope our comments, attached below, are helpful as you undertake this important work. Should you have questions about these comments or require additional information, please contact Jeffery Smith, Vice President of Public Policy at jsmith@amia.org or (301) 657-1291. We look forward to continued partnership and dialogue.

Sincerely,

Douglas B. Fridsma, MD, PhD, FACP, FACMI
President and CEO
AMIA

Thomas H. Payne, MD, FACP, FACMI
AMIA Board Chair
Medical Director, IT Services, UW Medicine
University of Washington

Enclosed: AMIA Detailed Recommendations on Select QPP Year 2 NPRM Proposals

[3] CMS Blueprint for the Measurement Management System, Version 13, May 2017
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/Blueprint-130.pdf

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Quality Performance Category

II.C.6.b.(3)(b) Data Completeness Criteria

CMS proposes to revise the data completeness criteria for the quality performance category that provides that MIPS eligible clinicians and groups submitting quality measures data using the QCDR, qualified registry, EHR, or Medicare Part B claims submission mechanisms must submit data on at least 50 percent of the individual MIPS eligible clinician's or group's patients that meet the measure's denominator criteria, regardless of payer, for MIPS payment year 2020. They further propose that MIPS eligible clinicians and groups submitting quality measures data using the QCDR, qualified registry, or EHR or Medicare Part B claims submission mechanisms must submit data on at least 60 percent of the individual MIPS eligible clinician or group's patients that meet the measure's denominator criteria, regardless of payer for MIPS payment year 2021.

AMIA Recommendation: AMIA supports keeping the data completeness criteria at the current level, as proposed in this rule, for 2018. However, members express serious concern over current policy regarding data completeness for group reported quality measures. The goal of increased data completeness and improved data quality is incredibly important. However, the current methodology requires a denominator of all patients billed under a certain code, regardless of whether the physician is responsible for managing the condition billed under said code.

As an example, Dermatologists may report diabetes in their billing, as the patient may have a rash related to that condition, but they are not responsible for managing the patient's diabetes control. Current methodology, however, requires this patient to be part of the denominator of eligible patients to consider whether their diabetes is controlled. This approach contributes to faulty data reporting and negatively impacts organizations that submit the diagnosis in a claim, but do not manage that condition. In the example of diabetes, to be truly reflective of performance, the only diabetes patients that should be in the denominator should be by clinicians who manage the disease, and in this case, should be limited to Endocrinologists, Family Medicine, and Internal Medicine and the 50% (future 60%) rule applies to these physician's patients, not the totality of patients in that organization.

AMIA requests that CMS clarify the data completeness and actual measure computation policy for group reporting to allow for specific omissions of specialists who may bill for a particular condition, but are not responsible for managing the condition. Further, we recommend CMS garner more input on MIPS ECs' experience before moving beyond 60 percent.

II.C.6.c.(1) Policies for the Call for Measures and Measure Selection Process

CMS will accept quality measures submissions at any time, but only measures submitted during the timeframe provided through the pre-rulemaking process of each year will be considered for inclusion in the annual list of MIPS quality measures for the performance period beginning 2 years

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after the measure is submitted. This process is consistent with the pre-rulemaking process and the annual call for measures, which are further described at (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Pre-Rule-Making.html). CMS does not seek to change the measure development and selection process.

AMIA Recommendation: AMIA supports CMS's outlined approach and also supports the MAP process and encourages CMS to continue a regular, predictable and transparent measure selection process. AMIA reiterates the stated CMS goal to preference outcome measures when and where they are available and appropriate.

II.C.6.c.(2) Topped Out Measures

CMS proposes a 3-year timeline for identifying and proposing to remove topped out MIPS measures. After a measure has been identified as topped out for three consecutive years, CMS may propose to remove the measure through comment and rulemaking for the 4th year. Therefore, in the 4th year, if finalized through rulemaking, the measure would be removed and would no longer be available for reporting during the performance period. QCDR measures that consistently are identified as topped out would not be approved for use in year 4 during the QCDR self-nomination review process, and would not go through the comment and rulemaking process.

AMIA Recommendation: We view this proposed process as reasonable, regarding the timeline and notice-comment rulemaking. We note, however, that there may be cases where individual measures have value, even if topped out, or that there may be a risk of "back sliding" due to a shift in resources from topped-out measure to a new measure(s). AMIA recommends that CMS monitor and evaluate how behaviors may change when measures are removed through this process.

II.C.7.a.(2)(g) Incentives to Use CEHRT to Support Quality Performance Category Submissions

CMS is not proposing changes to policies related to bonus points for using CEHRT for end-to-end reporting in this proposed rule. However, they are seeking comment on the use of health IT in quality measurement and how HHS can encourage the use of certified EHR technology in quality measurement as established in the statute. What other incentives within this category for reporting in an end-to-end manner could be leveraged to incentivize more clinicians to report electronically? What format should these incentives take? For example, should clinicians who report all of their quality performance category data in an end-to-end manner receive additional bonus points than those who report only partial electronic data? Are there other ways that HHS should incentivize providers to report electronic quality data beyond what is currently employed? CMS welcomes public comment on these questions.

AMIA Recommendation: AMIA commends CMS for seeking information on how to incentivize end-to-end electronic reporting using CEHRT. However, we note that the availability of structured

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data sources that are not CEHRT, but that are electronic (such as a specialty-focused HIT solution), should be taken into account and allowed as part of end-to-end reporting that uses either a registry or CEHRT, in whole or in part. We recommend that CMS focus on end-to-end electronic, not only end-to-end CEHRT. We could envision quality reporting pathways that originate or rely on CEHRT, but have additional data sources for certain measures, such as non-EHR specialty focused HIT that may not be CEHRT. CMS would better incentivize end-to-end electronic (and CEHRT) reporting by focusing efforts to broaden the corpus of electronically-specified quality measures.

II.C.9.a.(2) Mechanisms

CMS is also seeking comment on how health IT, either in the form of an EHR or as a supplemental module, could better support the feedback related to participation in the Quality Payment Program and quality improvement in general. Specifically -

- Are there specific health IT functionalities that could contribute significantly to quality improvement?
- Are there specific health IT functionalities that could be part of a certified EHR technology or made available as optional health IT modules in order to support the feedback loop related to Quality Payment Program participation or participation in other HHS reporting programs?
- In what other ways can health IT support clinicians seeking to leverage quality data reports to inform clinical improvement efforts? For example, are there existing or emerging tools or resources that could leverage an API to provide timely feedback on quality improvement activities?
- Are there opportunities to expand existing tracking and reporting for use by clinicians, for example expanding the feedback loop for patient engagement tools to support remote monitoring of patient status and access to education materials?

CMS welcomes public comment on these questions.

AMIA Recommendation: AMIA appreciates CMS looking to support timely, accurate feedback to MIPS ECs. We recommend that CMS focus its energies on making sure that QPP data is available and accurate. The notion of developing and supporting API(s) for timely feedback is aligned with our recommendations, for example. We envision that de-identified or aggregated data made available for comparison purposes and benchmarking could be a powerful motivator for some MIPS ECs.

AMIA does not support CMS' endeavors to develop its own dashboards, or otherwise mandate specific health IT requirements along these lines.

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Improvement Activity Performance Category

II.C.6.e.(1) Improvement Activity Criteria

CMS considers the use of health IT an important aspect of care delivery processes described in many of the proposed new improvement activities and those finalized in the CY 2017 Quality Payment Program final rule. In that same final rule, they finalized a policy to allow MIPS eligible clinicians to achieve a bonus in the ACI performance category when they use functions included in CEHRT to complete eligible activities from the Improvement Activities Inventory. Although CMS is not proposing any specific new policies, CMS seeks comment on how they might provide flexibility for MIPS eligible clinicians to effectively demonstrate improvement through health IT usage while also measuring such improvement.

AMIA Recommendation: AMIA continues to support CMS policies that encourage use of health IT in carrying out Improvement Activities (IAs).

To provide greater flexibility for MIPS ECs demonstrating improvement through health IT usage while also measuring such improvement, we recommend CMS draw on American Board of Medical Specialties (ABMS) standard Maintenance of Certification (MOC) IV activities. ABMS MOC IV activities focus on "Improvement in Medical Practice," and require data-based reports on individual or group physician practice assessments. The assessments will conform to the three -stage process that is the Hallmark of the performance or quality improvement plan. In stage A, a data pull of patient data indicates an area for improvement. In stage B, the physician or team engages in an educational intervention addressing the area. In stage C, a second data pull is compared to the first. The individual or group compare the two sets of days to discover if there has been improvement in the area under investigation. If there has not been improvement, the individual or team must consider limitations or barriers that prevented improvement. The 3-stage process must take place over a minimum of 90 days.

AMIA members board certified in Clinical Informatics have relevant experience in leveraging health IT for their MOC IV activities, and CMS could view MOC IV activities of this kind as another potential linkage between ACI and IA performance categories. Further, we see this kind of IA as helping non-physician ECs have options for which they too could participate. MOC IV activities would also serve to reinforce team-based initiatives in patient safety and quality improvement, or to engage either as individuals or as groups in three-part assessment initiatives that follow MOC-IV requirements.

II.C.6.e.(3)(c) Required Period of Time for Performing an Activity (pg. 161)

In the CY 2017 Quality Payment Program final rule, CMS specified at that MIPS eligible clinicians or groups must perform improvement activities for at least 90 consecutive days during the

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performance period for improvement activities performance category credit. CMS is not proposing any changes to the required period of time for performing an activity for the improvement activities performance category in this proposed rule.

AMIA Recommendation: AMIA supports the current policy of "at least 90 consecutive days during the performance period for improvement activities performance category credit." We see this as an appropriate floor for most IAs, allowing for balanced engagement in multiple IAs over a reporting year, while giving MIPS ECs the flexibility to determine if the IA can or should be implemented for more than 90 days. We do urge CMS to provide clarification regarding how the 90-day minimum is to be interpreted across the range of types of measures, what documentation must be retained, and also to be explicit that certain measures actually require more than 90 days (e.g., Annual registration in the Prescription Drug Monitoring Program – ECs must participate for a minimum of 6 months.

II.C.6.e.(8) Approach for Adding New Subcategories

CMS is not proposing any changes to the approach for adding new subcategories for the improvement activities performance category in this proposed rule. However, they are proposing that in future years of the Quality Payment Program they will add new improvement activities subcategories through notice-and-comment rulemaking. CMS is seeking suggestions on how a health IT subcategory within the improvement activities performance category could be structured to afford MIPS eligible clinicians with flexible opportunities to gain experience in using CEHRT and other health IT to improve their practice. Should the current policies where improvement activities earn bonus points within the ACI performance category be enhanced? Are there additional policies that should be explored in future rulemaking? CMS welcomes public comment on this potential health IT subcategory.

AMIA Recommendation: AMIA does not recommend development of a health IT subcategory for the IA performance category. As stated previously, AMIA supports CMS efforts to encourage health IT use by way of the IA performance category. However, we note that the use of health IT should not be an IA unto itself – this is the domain of the ACI performance category. Further, we see the IA performance category, and subcategories, appropriately focused on outcomes, and we do not view health IT as an outcome. Improved outcomes for patients is and should remain the sole purpose of IAs, and health IT, when used as a means for improved outcomes, should be encouraged. Rather, were CMS to develop a subcategory, they should consider broad concepts, such as "Preventative Care." This would create opportunities for technology, such as telemedicine or syndromic surveillance to aid preventative care activities, for example.

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II.C.6.f.(2)(b) Performance Score

CMS is proposing that if a MIPS eligible clinician fulfills the Immunization Registry Reporting Measure, the MIPS eligible clinician would earn 10 percentage points in the performance score. If a MIPS eligible clinician cannot fulfill the Immunization Registry Reporting Measure, they are proposing that the MIPS eligible clinician could earn 5 percentage points in the performance score for each public health agency or clinical data registry to which the clinician reports for the following measures, up to a maximum of 10 percentage points: Syndromic Surveillance Reporting; Electronic Case Reporting; Public Health Registry Reporting; and Clinical Data Registry Reporting. A MIPS eligible clinician who chooses to report to more than one public health agency or clinical data registry may receive credit in the performance score for the submission to more than one agency or registry; however, the MIPS eligible clinician would not earn more than a total of 10 percentage points for such reporting. CMS further proposes similar flexibility for MIPS eligible clinicians who choose to report the measures specified for the Public Health Reporting Objective of the 2018 Advancing Care Information Transition Objective and Measure set.

AMIA Recommendation: We support these changes to afford MIPS ECs additional flexibilities. We do suggest that CMS clarify that an EC can simply determine that immunization registry reporting is not the best approach for his or her practice rather than requiring any sort of documented inability to submit to an immunization registry. In these cases, we suggest CMS consider providing the full 10 percentage point credit for those clinicians for participation in other registries, with the ability to earn the additional 5 percentage points for each public health agency or clinical data registry.

II.C.6.f.(2)(c) Bonus Score

CMS is proposing that a MIPS eligible clinician may only earn the bonus score of 5 percentage points for reporting to at least one additional public health agency or clinical data registry that is different from the agency/agencies or registry/or registries to which the MIPS eligible clinician reports to earn a performance score. CMS is proposing that for the ACI Objectives and Measures, a bonus of 5 percentage points would be awarded if the MIPS eligible clinician reports "yes" for any one of the following measures associated with the Public Health and Clinical Data Registry Reporting objective: Syndromic Surveillance Reporting; Electronic Case Reporting; Public Health Registry Reporting; or Clinical Data Registry Reporting. They are also proposing that for the 2018 ACI Transition Objectives and Measures, a bonus of 5 percent would be awarded if the MIPS eligible clinician reports "yes" for any one of the following measures associated with the Public Health Reporting objective: Syndromic Surveillance Reporting or Specialized Registry Reporting.

AMIA Recommendation: We support these changes to afford MIPS ECs additional flexibilities.

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Advancing Care Information Performance Category

II.C.6.f.(2)(d) Improvement Activities Bonus Score under the Advancing Care Information Performance Category

In the CY 2017 CMS adopted a policy to award a 10 percent bonus for the ACI performance category if a MIPS eligible clinician attests to completing at least one of the improvement activities it has specified using CEHRT. In this proposed rule, CMS is proposing to expand this policy beginning with the CY 2018 performance period by identifying additional improvement activities that would be eligible for the ACI performance category bonus score if they are completed using CEHRT functionality.

AMIA Recommendation: AMIA supports the expansion of potential IAs that are eligible for the ACI performance category bonus score if completed using CEHRT functionality.

AMIA strongly recommends that CMS avoid percentage-based measures for IAs. For example, several of the proposed IAs mention a threshold of 75 percent. Measuring thresholds for such activities is a non-trivial task, and as we mentioned in our opening comments, measurement can have a profound and often negative or limiting impact on how technology is designed and how workflows are implemented, potentially reducing usability and usefulness. We also note that placing thresholds on IAs will be difficult to document for audit purposes.

Also, we note that one of the IAs is related to the Medicare AUC Program. While we support inclusion of this IA and see it as a way for certain MIPS ECs to garner experience with that program, we note that in order to be successful in the IA referencing the Medicare AUC Program would require far more than the referenced program. The phrase "for all advanced imaging diagnostic services ordered" is excessive and is, in effect, a 100% binary performance threshold. In addition, it is not likely that such measurement can be supported by an EC's EHR..

II.C.6.f.(3) Performance Periods for the Advancing Care Information Performance Category

CMS has stated for the first and second performance periods of MIPS (CYs 2017 and 2018), they will accept a minimum of 90 consecutive days of data and encourage MIPS eligible clinicians to report data for the full year performance period. CMS is maintaining this policy as finalized for the performance period in CY 2018, and will accept a minimum of 90 consecutive days of data in CY 2018. CMS is also proposing the same policy for the ACI performance category for the performance period in CY 2019, Quality Payment Program Year 3, and would accept a minimum of 90 consecutive days of data in CY 2019.

AMIA Recommendation: For 2018, we support a continued 90-day reporting period along with the increase in the MIPS score threshold from 3 to 15. This represents a reasonable accelerated continuation of the current "pick your pace" paradigm, and members indicate that MIPS ECs have

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planned around the need to report for at least 90 days in 2018. A 90-day reporting period would also facilitate adoption of the 2015 Edition, which includes more robust technology in the form of (1) standardized common clinical data set summary records; (2) application program interfaces (APIs); (3) data elements for social, psychological and behavioral data, and implantable devices; and (4) a criterion meant to improve the performance of consolidated CDA creation.

For CY 2019, AMIA is generally supportive a 90-day reporting period for the ACI performance category.

II.C.6.f.(4) Certification Requirements

CMS is proposing that MIPS eligible clinicians may use EHR technology certified to either the 2014 or 2015 Edition certification criteria, or a combination of the two for the CY 2018 performance period. CMS notes that to encourage new participants to adopt certified health IT and to incentivize participants to upgrade their technology to 2015 Edition products which better support interoperability across the care continuum, they are proposing to offer a bonus of 10 percentage points under the ACI performance category for MIPS eligible clinicians who report the ACI Objectives and Measures for the performance period in CY 2018 using only 2015 Edition CEHRT. Specifically, they intend this bonus to support new participants that may be adopting health IT for the first time in CY 2018 and do not have 2014 Edition technology available to use or that may have no prior experience with meaningful use objectives and measures.

AMIA Recommendation: AMIA supports the proposal to allow MIPS ECs to use either 2014 Edition or 2015 Edition CEHRT in CY 2018 for the rationale provided by CMS. We also support the proposed bonus for using 2015 Edition CEHRT only for ACI, which is meant to incentivize continued investment in technology that will update standards and functions to support interoperability.

Lastly, AMIA strongly recommends that CMS very clearly state its intentions to require 2015 Edition CEHRT in 2019. This will signal to industry that they must continue investments in CEHRT, and prepare them for a nationwide upgrade to 2015 Edition products, which better support interoperability across the care continuum. Accordingly, we request CMS align hospital CEHRT requirements to what is required of MIPS.

II.C.6.f.(6)(a) Advancing Care Information Objectives and Measures Specifications

CMS is proposing to maintain for the CY 2018 performance period the ACI Objectives and Measures as finalized in the CY 2017 Quality Payment Program final rule with some modifications.

AMIA Recommendation: AMIA supports CMS's proposal to maintain 2017 ACI Measures and Objectives for CY 2018. This approach will provide year-to-year consistency for MIPS ECs

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diligently working to improve scores within various measures. We also support the continued option for MIPS ECs to report on transitional measures should they choose to use 2014 Edition CEHRT or a combination of 2014 and 2015 CEHRT and ask that CMS clarify that this option exists as it did very clearly in the recent IPPS Final Rule.

AMIA requests clarity on two issues: (1) Immunization options and (2) transitional ACI measures. First, we seek information on what supporting information MIPS ECs need to support their claim that they are unable to report on immunization data. As indicated above, we suggest that CMS simply allow ECs the option of reporting to an immunization registry or alternatively, to two other registries as proposed. Second, we suggest that CMS clarify, as it did in the IPPS Final Rule, that an EC can use the transition measures even if they have fully or partially implemented the 2015 edition.

II.C.6.f.(6)(c) Exclusions

Proposed Exclusion for the E-Prescribing Objective and Measure
In the CY 2017 Quality Payment Program final rule, CMS established a policy that MIPS eligible clinicians who write fewer than 100 permissible prescriptions in a performance period may elect to report their numerator and denominator (if they have at least one permissible prescription for the numerator), or they may report a null value. CMS is proposing to change this policy beginning with the CY 2017 performance period and propose to establish an exclusion for the e-Prescribing Measure. If a MIPS eligible clinician does not claim the exclusion, they would fail the measure and not earn a base score or any score in the ACI performance category.

AMIA Recommendation: We support this exclusion.

Proposed Exclusion for the Health Information Exchange Objective and Measures
CMS is proposing to add exclusions for the measures associated with the Health Information Exchange Objective. Stakeholders have expressed concern through public comments on the CY 2017 Quality Payment Program proposed rule and other inquiries to us that some MIPS eligible clinicians are unable to meet the measures associated with the Health Information Exchange Objective, which are required for the base score, because they do not regularly refer or transition patients in the normal course of their practice. As they did not intend to disadvantage those MIPS eligible clinicians and prevent them from earning a base score, they are proposing the exclusions.

AMIA Recommendation: We support this exclusion.

II.C.6.f.(6)(c)(v) Exception for MIPS Eligible Clinicians Using Decertified EHR Technology

The 21st Century Cures Act allows the Secretary to exempt eligible clinicians if he determines that compliance with the requirement for being a meaningful EHR user is not possible because the CEHRT used by such professional has been decertified under ONC's Health IT Certification

Program. CMS is proposing that a MIPS eligible clinician may demonstrate through an application process that reporting on the measures specified for the ACI performance category is not possible because the CEHRT used by the MIPS eligible clinician has been decertified under ONC's Health IT Certification Program. CMS also proposes that if the MIPS eligible clinician's demonstration is successful and an exception is granted, a zero percent weighting to the ACI performance category in the MIPS final score for the MIPS payment year would be applied.

The exception would be subject to annual renewal, and in no case may a MIPS eligible clinician be granted an exception for more than 5 years. CMS further proposes this exception would be available beginning with the CY 2018 performance period and the 2020 MIPS payment year. MIPS eligible clinician may qualify for this exception if their CEHRT was decertified either during the performance period for the MIPS payment year or during the calendar year preceding the performance period for the MIPS payment year. In addition, MIPS eligible clinician must demonstrate in their application and through supporting documentation if available that the MIPS eligible clinician made a good faith effort to adopt and implement another CEHRT in advance of the performance period. CMS proposes that a MIPS eligible clinician seeking to qualify for this exception would submit an application in the form and manner specified by CMS by December 31st of the performance period, or a later specified date.

AMIA Recommendation: We support the provisions of this exclusion per the statute.