



72810 Hedgehog Street • Palm Desert, CA 92260 • 858/538-2220 • 858/538-2209 (FAX)
info@hln.com • http://www.hln.com/

September 6, 2018

Administrator Selma Verma
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1693-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Comments on Proposed Rule-CMS-1693-P

Dear Administrator Verma,

HLN Consulting, LLC is pleased to submit the following comments on the recently-released CMS QPP NPRM, CMS-1693-P. HLN is a leading public health informatics consulting company. With that in mind, we read documents like the NPRM through a public health lens, and confine our comments to that important context.

Here are some specific comments which echo many of those submitted by the American Immunization Registry Association (AIRA):

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Page 35912	“However, beginning with the performance period in 2019, MIPS eligible clinicians must use EHR technology certified to the 2015 Edition certification criteria as specified at § 414.1305. As discussed in this section, we continue to believe it is appropriate to require the use of 2015 Edition CEHRT beginning in CY 2019.”	<p>We support the requirement to use only 2015 Edition Certified EHR Technology beginning in 2019, as it better meets standards and interoperability needs across both clinical medicine and public health.</p> <p>However, one subtlety that affects public health needs to be corrected. For several public health interoperability measures the 2015 edition CEHRT does not define the precise standards that are required for implementation. In the past, public health registries that implemented these standards were allowed to continue to operate and the standards-in-use were “grandfathered” into the rule making. It</p>

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		appears uncertain whether this situation will be allowed to continue, and public health registries run the risk that their transactions will not qualify through no fault of their own (they are not using <i>incorrect</i> standards, just <i>unselected</i> standards). We feel strongly that this situation must be corrected.
Page 35874	“...we propose to amend § 495.24(d)(8)(i)(B)(2), EP Objective 8 (Public health and clinical data registry reporting), Measure 2 (Syndrome surveillance reporting measure), to amend the language restricting the use of syndromic surveillance reporting for meaningful use only to EPs practicing in an urgent care setting. We propose to include any EP defined by the state or local public health agency as a provider who can submit syndromic surveillance data.”	We support the inclusion of these other EPs in the set of eligible Syndromic Surveillance reporters.
Table 35, page 35914	“Additionally, we want to align the requirements of the Promoting Interoperability performance category with the requirements of the Medicare Promoting Interoperability Program for eligible hospitals and CAHs as we have proposed in the FY 2019 IPPS/LTCH PPS proposed rule (83 FR 20518 through 20537).”	We support the alignment of requirements across settings and provider groups.
Page 35914-35915	“Finally, the Public Health and Clinical Data Exchange objective supports the ongoing systematic collection, analysis, and interpretation of data that may be used in the prevention and controlling of disease through the estimation of health status and behavior. The integration of health IT systems into the national network of health data tracking and promotion improves the efficiency, timeliness, and effectiveness of public health surveillance. We believe it is important to keep these core goals,	We appreciate and support the continued prioritization of public health measures, and the recognition of the ways public health supports interoperability and coordinated clinical care.

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	<p>primarily because these objectives promote interoperability between health care providers and health IT systems to support safer, more coordinated care while ensuring patients have access to their medical data.”</p>	
Page 35915	<p>“We also considered an alternative approach in which scoring would occur at the objective level, instead of the individual measure level, and MIPS eligible clinicians would be required to report on only one measure from each objective to earn a score for that objective. Under this scoring methodology, instead of six required measures, the MIPS eligible clinician total Promoting Interoperability performance category score would be based on only four measures, one measure from each objective.”</p>	<p>We strongly support the requirement for clinicians to report on at least two public health measures. The proposed alternative would seem to reduce the number of required measures to just one per objective. Therefore, we do not support the consideration of this alternative approach.</p>
Page 35915	<p>“In the event that a MIPS eligible clinician meets the criteria and claims the exclusion for the e-Prescribing measure in 2019, the 10 points available for that measure would be redistributed equally among the two measures under the Health Information Exchange objective:</p> <ul style="list-style-type: none"> • Support Electronic Referral Loops By Sending Health Information Measure (25 points) • Support Electronic Referral Loops By Receiving and Incorporating Health Information (25 points).” 	<p>We recommend reconsideration of the distribution of points for a provider that claims an e-Prescribing exemption. It may be more beneficial to require that he/she must meet an additional PH reporting measure (if an additional one is available to them) rather than just giving points to another measure the clinician will need to meet anyway.</p>
Page 35916	<p>“The measures under the Public Health and Clinical Data Exchange objective are reported using “yes or no” responses and thus we are proposing to score those measures on a pass/fail basis in which the MIPS eligible clinician would receive the full 10 points for reporting two “yes” responses, or for submitting a “yes” for one measure and claiming an exclusion for another.”</p>	<p>It is not clear whether an EC can claim exclusion from two public health measures when capable of participating in another measure as a way to avoid public health measures altogether, and we recommend the language around this issue be clarified to not allow avoidance of public health measures. As currently written, it seems possible for a provider to claim an exclusion rather than implementing a public health reporting measure available to them. We</p>

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		<p>recommend a clarification that if two PH reporting measures are available to the provider, he/she must implement those measures rather than claim an exclusion for one of the other measures.</p> <p>Furthermore, before an EC should have public health points redirected to the consumer access measure, we recommend that that <i>all</i> possible public health reporting measures should be exhausted.</p> <p>We are also concerned that there is no incremental increase in scoring for clinicians who report to multiple public health measures; we recommend an increase in scoring or elimination of the 10 percent/10 point cap to further incentivize these important data exchange functions.</p>
Table 36, Page 35917	<p>“Choose two of the following: Immunization Registry Reporting. Electronic Case Reporting. Public Health Registry Reporting. Clinical Data Registry Reporting. Syndromic Surveillance Reporting.”</p>	<p>We appreciate and support that all five public health measures are proposed to be equal in scoring and able to be selected by clinicians in both 2019 and 2020 performance periods.</p>
Table 37, Page 35917	<p>“Health Information Exchange, Maximum Points =40 points, Provider to Patient Exchange, Maximum Points =35 points, Public Health and Clinical Data Exchange, Maximum Points =10 points). We are seeking public comment on whether these measures are weighted appropriately, or whether a different weighting distribution, such as equal distribution across all measures would be better suited to this program and this proposed scoring methodology. We are also seeking public comment on other scoring methodologies such as the alternative we considered and outlined earlier in this section.”</p>	<p>We are concerned that the scoring for public health data exchange measures is minimal in comparison to other areas. Given the importance of public health in assuring and protecting all individuals, we recommend revisiting of the balance of scoring, and a revision to better emphasize and incentivize public health data exchange.</p>

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Page 35920	“Finally, we are proposing to rename the Public Health and Clinical Data Registry Reporting objective to Public Health and Clinical Data Exchange...”	We support renaming this objective, as “Public Health and Clinical Data Exchange” is more representative of the dynamic nature of EHR-IIS interfaces than “registry reporting.” As mentioned above, most IIS now respond to provider queries, as well as submissions, so “exchange” is a more accurate term. We also recommend renaming the Immunization Registry Reporting measure to Immunization Registry Data Exchange, since this measure includes both submission to and query from an immunization registry, or immunization information system (IIS).
Page 35929	“We continue to believe that public health reporting is valuable in terms of health information exchange between MIPS eligible clinicians and public health and clinical data registries. For example, when immunization information is directly exchanged between EHRs and registries, patient information may be accessed by all of a patient’s health care providers for improved continuity of care and reduced health care provider burden, as well as supporting population health monitoring.”	We appreciate and support the recognition that IIS improve care and reduce provider burden. We strongly support the requirement for the selection of two public health measures.
Page 35930	“In addition, we intend to propose in future rulemaking to remove the Public Health and Clinical Data Exchange objective and measures no later than CY 2022, and are seeking public comment on whether MIPS eligible clinicians will continue to share such data with public health entities once the Public Health and Clinical Data Exchange objective is removed, as well as other policy levers outside of the Promoting Interoperability performance category that could be adopted for continued reporting to public health and clinical data registries, if necessary.”	We strongly advocate that incentives that promote public health and clinical data exchange continue beyond 2022. Incentive programs have fueled significant increases in interoperability between clinical medicine and public health, supporting both reporting to IIS as well as use of IIS data at the point of care and for population health. This availability of accurate, complete data increasingly lowers provider burden while improving patient health. However, there is much room to improve before IIS reach 100% data capture across the lifespan, and even once that milestone is achieved, data quality assurance to support accuracy and completeness is an ongoing activity and challenge. In addition, opportunities abound for using

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		<p>the data to meet population health needs (e.g., calculating clinic rates, analyzing population coverage rates, addressing pockets of need), and these will benefit from incentives for clinicians and public health alike.</p> <p>We also recommend that core public health objectives – such as those related to disease prevention – are included in any new CMS constructs (such as public health priority sets).</p>
Table A.8, Page 36100	<p>“We are proposing to adopt this measure because there are no measures currently in MIPS that address shingles vaccination for patients 60 years and older as recommended by the CDC.”</p>	<p>Table A.8 references a denominator of “patients 50 years of age” and older but the Rationale section below discusses “patients 60 years and older”. Given the most recent ACIP recommendations for recombinant shingles vaccine, we recommend that the rationale should reference “50 years and older” as well.</p>

I hope you will give our comments ample consideration.

Sincerely,



Noam H. Arzt, PhD
President