September 13, 2021

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD. 21244-1850

Re: CMS-1751-P; Medicare Program; CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-payment Medical Review Requirements.

Dear Administrator Brooks-LaSure,

MarsdenAdvisors (MA) is submitting our comments on the Centers for Medicare & Medicaid Services (CMS) proposed rule regarding the 2022 Quality Payment Program. MA is an EHR consulting and software company that helps small to medium sized specialty practices implement and manage EHR technology and comply with QPP requirements. We support over 1,000 clinicians in QPP compliance and reporting nationwide.

Our experience with reporting for clinicians nationwide has given us significant insight into how changes to the MIPS program impact practices each year.

Provided below is a summary of the key points from our comments on the Quality Payment Program portion of the proposed rule. These comments are more fully developed in the body of this letter along with other issues and comments not highlighted in our summary.

Quality Payment Program Executive Summary

Quality Measures Removals

Many of our clients are in dermatology or ophthalmology practices. Currently, under MIPS, there is already a dearth of quality measures available for specialists or subspecialists, this is particularly true in dermatology. There are currently only nine benchmarked MIPS quality measures that are relevant to dermatology. In this proposed rule, CMS is proposing to remove several important measures, including two of the only four benchmarked dermatology measures that are not 7-point capped.

MA understands that CMS wants to ensure that the measures that clinicians report on are truly meaningful, however, by eliminating specialty-specific measures every year, we have seen the opposite effect. Without sufficient specialty-specific measures to report on, clinicians are forced to report on measures that are outside of their scope-of-practice and meaningless to their quality of care. **MA urges CMS to take this into account and to maintain sufficient specialty-specific MIPS quality measures.**

Promoting Interoperability (PI) Public Health and Clinical Data Exchange Objective

We strongly recommend including QCDRs as an option in the required measure set for this objective as the points earned in measure have been a driving factor in our practices choosing to join a QCDR. Moreover, **QCDRs have been instrumental in identifying symptoms and sequelae of COVID-19**, as demonstrated by CMS's continued inclusion of the COVID-19 registry reporting improvement activity.

Multiple PI Scores

Every year, there are clinicians and practices that are impacted by having multiple PI scores submitted. When this happens, CMS has been giving the clinician or group 0 points for the entire PI category, rather than using one of the two available scores. **MA is opposed to this scoring practice. As such, we strongly urge CMS to give clinicians impacted by multiple PI submissions to receive the highest PI category score of their submissions.**

Low-Volume Claims Reporters

MA applauds CMS's proposal to only calculate a group-level Quality performance category scores from Medicare Part B Claims measures if the practice submitted data for another performance category as a group. We have heard several stories from practices with clinicians who do not exceed the low-volume threshold and had no intent to report MIPS, but the practice's billing software reported QDCs. Because of this, low-volume clinicians received payment penalties. **MA recommends that CMS not only finalize this proposal but also release**

an interim final rule allowing practices in this situation to submit a targeted review for this reason beginning with the results of the 2020 MIPS performance year.

Mid-Level Providers Who Do Not Provide Primary Care

In both the Cost and Quality performance categories, there are several measures that are attributed only to certain specialties. These measures classify mid-level providers – NPs, PAs, and CCNSs – as primary care providers. This is problematic for specialty practices that employ mid-level providers.

While we understand the thought process behind this designation, we represent multiple practices that employ NPs or PAs but provide no primary care. For instance, we have a dermatology practice that employs PAs and NPs who bill under the practice TIN. Under current and proposed policies, this designation of mid-levels as primary care only would inappropriately score specialty practices on primary care measures. **We urge CMS to address this problem before finalizing any additional measures that rely on these designations or to allow these clinicians and practices to submit targeted reviews to show that they are not providing primary care.**

MVPs

MA strongly recommends that CMS reevaluate this timeline for sunsetting traditional MIPS. We do not believe that there will be sufficient specialty- and subspecialty-specific MVPs by 2028 to allow for appropriate measurement of all MIPS clinicians.

The issue of mid-level provider designation as primary care providers is also a problem for future MVP implementation. CMS discusses limiting participation in MVPs to clinicians who provide relevant care and limiting subgroup participation to ECs in the same or related specialties. As noted above, although PAs and NPs are often labelled as primary care providers, many work in specialty care-only practices. It is important that CMS be able to determine the specialty of care provision of mid-level providers before mandatory subgroups are implemented.

Detailed Comments of MarsdenAdvisors: Contents

I. SPECIFIC ISSUES ON THE QUALITY PAYMENT PROGRAM

A. General Eligibility, Reporting, Scoring, and Adjustments

i. Reporting: Reporting Periods

MA appreciates the consistency provided by retaining the 90-day reporting period for the Promoting Interoperability and Improvement Activities performance categories and in the calendar year reporting period for the Quality and Cost performance categories.

ii. Reporting: Web Interface Reporting

We understand the need to delay the removal of the Web Interface collection type by one year due to the continued COVID-19 public health emergency (PHE). We also applaud CMS's continued commitment to remove the CMS Web Interface collection type. There remains a need for specific-specialty information from large multispecialty groups. Under the current MIPS program, these large multispecialty groups report only primary care measures on a limited number of patients under the Web Interface reporting method, leading to a lack of meaningful participation for specialists.

iii. Performance Thresholds

MA supports the proposed performance thresholds. We believe that this will more clearly differentiate high performers and provide more meaningful payment adjustments. Given significant changes to the MIPS program, however, we urge CMS to continue to monitor changes in mean and median performance year-over-year as future thresholds are determined.

iv. Final Scoring: Category Weights and Bonuses

1. Category Weights

MA supports the proposed performance category weights as the proposed changes are as required by law. Despite our support, we remain concerned that the Cost category has not yielded predictable results based on practice patterns and best practices.

2. Small Practice Bonus

MA appreciates the continued acknowledgement of the unique challenges faced by small practices participating in MIPS through the maintenance of the MIPS Quality Score small practice bonus.

3. Complex Patient Bonus

MA supports the proposal to extend the increased complex patient Final Score bonus to performance year 2022. These bonus points have helped to level the field for practices that treat high-risk and complex patients. The increase in these bonus points during the COVID-19 pandemic have helped to account for the significant impact of the PHE on patient health and outcomes.[1]

MA is, however, concerned with the proposal to limit the bonus to clinicians who have a median or higher value for at least one of the two risk indicators (HCC and dual eligible status). These indicators fail to fully capture the desired risks of medical comorbidities and social determinants of health. Specifically, the list of HCC medical comorbidities still does not capture many important factors that increase risk or complexity for many specialties' patients. The HCC risk scores were developed for inpatient hospital diagnosis related groups (DRGs) and have never been validated for outpatient care. **Therefore, we encourage CMS to push for rapid identification and incorporation of additional risk factors that influence how patients respond to care.**

B. Targeted Reviews

We ask CMS to allow clinicians impacted by multiple PI submissions to submit a targeted review. As the deadline will likely be prior to the issuance of the final rule, we ask that submission for this reason be allowed after the deadline. This would allow ECs to receive the PI category score from the highest scored collection type as required under CMS-finalized policy.[2] We also ask that CMS allow those who previously submitted a targeted review due to this issue and were denied appropriate PI scoring to resubmit the targeted review. For further discussion, please see our comments on this issue in the PI Scoring section (pg. 18).

C. Extreme and Uncontrollable Circumstances

MA appreciates that CMS is continuing to accept EUC applications for issues arising from COVID-19. As we all know, this PHE is, unfortunately, far from over. We would, however, request that CMS allow EUC applications to be submitted until the end of the submission period (March 31 following the performance period). We often encounter issues with vendors accurately reporting data after the end of the performance period and, for us and our clients

[1] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00350
[2] 83 FR 59452

that are impacted by this, it can often be extremely difficult or impossible to correct these issues. Allowing for limited EUC applications for issues related to submission of data that occur during the submission period would, we believe, fulfill the intent of the EUC for vendor issues. As such, **we urge CMS to allow for limited EUC applications for issues related to the submission of data that both outside of clinician control and occur after the performance period but prior to the submission deadline.**

D. Category Reweighting

i. Redistributing Weight to Cost Category

MA strongly supports CMS's proposal to continue its policy to not to redistribute weight to the Cost performance category except for when only Cost and IA are scored. We **strongly urge CMS to maintain this policy in all future years**. With the continued addition of new cost episode groups to MIPS, a large percentage of Cost measures are in their first or second year of use and, therefore, untested. Additionally, the Cost Category is only able to measure short-term costs rather than long term cost savings through high quality care and care improvements, and largely ignores a substantial component of cost: Part D drugs.

Given the stronger focus on care quality in the remaining categories, we believe it would be inappropriate to redistribute the weight of any of the remaining three performance categories to the Cost Category.

ii. Performance Category Redistribution Proposals for Small Practices

MA strongly supports CMS's proposal to limit the weight distributed to the Quality performance category for small practices. We agree that small practices have fewer resources and more limited ability to succeed in the Quality category than do larger practices.

E. Small Practices

MA strongly supports CMS's proposals to account for the increased strain faced by small practices participating in MIPS. Specifically, we strongly support the proposal to establish automatic reweighting for the Promoting Interoperability category and the proposed establishment of the revised category redistribution policies for small practices. We believe that these proposals will help to level the playing field for small practices operating on narrow margins.

Small practices are more likely to be unable to afford increasing EHR maintenance and upgrade costs, especially when combined with the IT and cybersecurity staff required to maintain electronic health record security. By giving such practices an automatic hardship exception

from the Promoting Interoperability category, small practice clinicians can continue to participate in MIPS and provide quality care to those who need it most.

As stated above, MA agrees with CMS that small practices have more limited ability to succeed in the Quality category than do larger practices. Part of the reason for this emanates from more limited access to EHRs. In addition, small practices are more likely to be single sub-specialty than are larger practices. Because of this, these practices are more reliant on MIPS CQMs and Part B Claims-based measures than are larger practices. As such, **MA is concerned that CMS's proposals to eliminate many non-eCQM ophthalmology and dermatology measures that our clients rely on** to have sufficient germane measures on which to report. For further discussion, please see our comments on the Quality measure removal proposals (pg. 13).

Finally, MA strongly supports the maintenance of the quality measure 3-point floor for small practices and the 6-point small practice bonus in the Quality category.

F. Quality Category

i. Category Weight and Category Reporting

MA appreciates the measured and gradual redistribution of weight from the Cost category to the Quality category over the past several years. Of course, we support the proposal to comply with statutory requirements for Cost and Quality weight.

1. Web Interface Reporting

We understand the need to delay the removal of the Web Interface collection type by one year due to the continued COVID-19 public health emergency (PHE). We also applaud CMS's continued commitment to remove the CMS Web Interface collection type. For further discussion, please see Reporting: Web Interface Reporting section above on pg. 6.

2. Claims Reporting

MA applauds CMS's proposal to only calculate a group-level Quality performance category scores from Medicare Part B Claims measures if the practice submitted data for another performance category as a group (signaling their intent to participate as a group). We have heard several stories from practices with clinicians who do not exceed the low-volume threshold and had no intent to report MIPS, but the practice's billing software reported QDCs. Because of this, low-volume clinicians received payment penalties.

This is not a new problem and has been a voiced concern since the 2018 interim final rule discussing EUC hardships. Given the automatic EUC for COVID-19 in 2019 and 2020 for those who did not report, **MA recommends that CMS not only finalize this proposal but also release an interim final rule allowing practices in this situation to submit a targeted review for this reason beginning with the results of the 2020 MIPS performance year.**

ii. Data Completeness Threshold

CMS proposes to maintain the current data completeness threshold of 70% for the 2022 performance year and to increase the threshold to 80% for the 2023 performance year. **MA supports the maintenance of the current data completeness threshold** but opposes the proposal to increase the data completeness threshold to 80% in 2023.

MA is concerned about the potential impact on manual reporters if the data completeness threshold is increased in future years. This would have a disproportionate impact on small and rural practices, which are significantly less likely to have an EHR. Increasing the burden on rural practices could increase barriers to care for the rural population. **Therefore, we urge CMS not to finalize the proposed 2023 data completeness threshold increase so that small and rural practices are not further burdened and disadvantaged by the program and can continue to put patients over paperwork.**

MA is also concerned about the impact of this increase of eCQM reporters. We have seen multiple instances from our clients in which they are either unable to extract a full year of data or in which a registry is unable to extract a full year of data (due to changes in EHRs during the performance year, issues with a registry vendor, ransomware, etc.). Oftentimes, this is revealed after the performance year during the submission period. Thus, these practices are unable to file for a hardship. In many, but not all, of these circumstances, we are able to meet the 70% data completeness threshold for these practices but would be unable to meet an 80% data completeness threshold. If the increase to 80% is finalized, these practices would be less likely to be able to meet the threshold and would, therefore, receive significantly lower Quality scores through no fault of their own.

iii. Scoring for the 2022 Performance Year

1. Small Practice Bonus

MA appreciates the continued acknowledgement of the unique challenges faced by small practices participating in MIPS through the maintenance of the MIPS Quality category small practice bonus.

2. High-Priority Measure Bonus

CMS is proposing to remove high-priority measure bonus points beginning with the 2022 performance year. CMS states these bonus points are no longer necessary to drive ECs to report these measures. From what we have seen in our practice, these bonus points are still necessary for many specialty and sub-specialty practices. The removal of this incentive will cause practices in specialties with few benchmarked high priority or outcome measures that are not topped out to turn to unrelated process measures to have a chance at a decent Quality score. Because of this, we strongly encourage CMS to continue to encourage high priority and outcome measure reporting by maintaining this bonus. **CMS must continue to incentivize ECs to report available germane outcome and high priority measures to drive high quality care.**

3. End-to-End Reporting Bonus

MA opposes CMS's proposal to remove the end-to-end electronic reporting bonus beginning with the 2022 performance year. We respectfully recommend that CMS maintain this incentive, in compliance with section 1848(q)(5)(B)(ii) the SSA which was modified by MACRA to require encouraging electronic reporting. We believe this will continue to drive electronic reporting, as well as provide much-needed stability in the MIPS program for participating ECs.

In future years, if CMS decides to remove this category bonus, we ask CMS to, at minimum, consider a bonus on the MIPS Final Score for active engagement in a clinician-led QCDR.

4. Point Floor

We support the proposed maintenance of the 3-point floor for measures reported by small practices. We agree that it is more difficult for small practices, especially small subspecialty practices, to meet case minimums. Not only do these practices see fewer patients than do larger practices, but subspecialty practices are also less likely to be able to find six germane quality measures on which to report. Because of this, they often resort to reporting measures that not directly related to their clinical practice, making it even more difficult to meet case minimums. Thus, we applaud CMS for proposing to maintain this important accommodation and support its finalization.

5. 5-Point Floor for New Measures

MA overwhelmingly supports CMS's proposal to establish a 5-point floor for new measures in their first two years in MIPS. As measures become topped out and removed, we are in increasingly dire need for new specialty-specific quality measures. There are several specialty-specific QCDRs that have risen to this challenge.

Unfortunately, since the inception of MIPS, reporting on unbenchmarked quality measures has been a risky decision given the limited contribution they have been allowed to make toward the quality score. Because of this, many thoughtfully developed and important measures remain unbenchmarked. This is particularly a problem with our clients in dermatology as the American Academy of Dermatology's QCDR, DataDerm, currently has no benchmarked measures.

CMS states that this proposal stems from the desire that policies not "discourage the reporting of new measures in the program". MA applauds this desire and agrees that, for new measures, this proposal is an excellent solution. However, countless hours and resources have been spent on developing the currently unbenchmarked QCDR measures, many of which have already been in MIPS for two or more years but have been largely ignored due to the risk assumed in reporting them. **To address this discrepancy and the growing gap in specialty-specific measures, we ask that CMS also apply this policy to measures that have never been benchmarked.**

6. Benchmark Determination: Measures Suppressed in the Baseline Year

MA supports CMS's proposal to use data from 3 years prior to the performance period to establish benchmarks for measures suppressed in the baseline year.

7. Benchmark Determination: 2022 Performance Year

We appreciate CMS's recognition of the difficulties calculating representative benchmarks from performance year 2020 given the COVID-19 flexibilities on data submission. In response to this issue, CMS proposes to adopt one of two options for the determination of quality measure benchmarks for the 2022 performance year. The primary proposal is to use performance period benchmarks; the alternate proposal is to use historical benchmarks from 2019.

We are strongly opposed to the primary proposals which would be strict change from historical benchmarks to performance period benchmarks. We support over 1,000 eligible clinicians with their MIPS submissions, and we use the benchmarks throughout the year to track our score. Without a known benchmark, we will be flying blind which will lead to additional documentation burden to setup supplementary measures as a safety net. **We urge CMS to continue to use the historical benchmark of baseline period 2019 as we are currently using for 2021 performance period.**

8. Topped Out Measure Scoring in 2022

MA supports CMS's proposed two criteria for determining which measures should have the 7-point cap applied to them in the 2022 performance year. We thank CMS for creatively and fairly addressing the problem by providing confidence in measure scoring to clinicians choosing quality measures for the 2022 performance year.

9. Measure Suppression and Truncation Proposal

MA supports CMS's proposal to expand the list of reasons that a quality measure may be suppressed or truncated to include errors in the measure specifications as finalized. As many of our clients are ophthalmologists, we had several impacted by the issues with measures 1 and 117 this year in which MACs were rejecting the submission of the QDCs due to an inactive status for certain CPT codes. We agree that, without suppression, this would lead to misleading results. **MA requests clarification on how CMS will determine which ECs were trying to submit these measures as the QDCs that are rejected are not available to CMS for Quality measurement.**

iv. Proposed Changes to Quality Measures

1. Changes to Measure 117: Diabetes Eye Exam

MA supports CMS's proposed change to clarify that the diagnosis must be active during the measurement period, rather than "overlapping the measurement period". This has been a long-standing source of confusion for people reporting this measure and this is a welcome clarification.

2. Changes to Measure 265: Biopsy Follow-Up

MA supports CMS's proposed clarifications to this measure that if multiple biopsies are performed, only the first biopsy is used for this measure and that only new patients should be reported for this measure.

3. Changes to Measure 374: Closing the Referral Loop: Receipt of Specialist Report

MA supports CMS's proposed change to clarify that the first referral during the measurement period is the one that will count toward this measure.

v. Proposed Quality Measure Removals

MA understands that CMS wants to ensure that the measures that clinicians report on are truly meaningful, however, by eliminating specialty-specific measures every year, we have seen the opposite effect. Without sufficient specialty-specific measures to report on, clinicians are forced to report on measures that are outside of their scope-of-practice and meaningless to their quality of care. **MA urges CMS to take this into account and to maintain sufficient specialty-specific MIPS quality measures.**

1. **Measure 14: Age-Related Macular Degeneration (AMD): Dilated Macular Examination**

MA is opposed to CMS's proposal to remove Measure 14. Although the measure is topped out, it is still an important measure for patient care. Moreover, there are currently only four benchmarked MIPS measures for the retina subspecialty, two of which are being proposed for removal. This would leave clinicians in the retina subspecialty to try to find measures completely unrelated to their clinical practice, rather than meaningful measures.

This will also have a disproportionate impact on small and rural practices as they are more likely to have a smaller patient population or be single-specialty. Both of these features make it less likely that the practice will be able to reach sufficient patient numbers for measures unrelated to their clinical practice.

2. **Measure 19: Diabetic Retinopathy: Communication with the Physician Managing On-going Diabetes Care**

MA opposes CMS's proposed removal of Measure 19. This measure has seen year-over-year improvement and is still important for improving and driving coordinated care. By removing this measure, CMS is removing the structure and incentive for clinicians and practices to monitor this important metric.

In addition, there are currently only four benchmarked MIPS measures for the retina subspecialty, two of which are being proposed for removal. This would leave clinicians in the retina subspecialty to try to find measures completely unrelated to their clinical practice, rather than meaningful measures.

3. **Measure 137: Melanoma: Continuity of Care – Recall System**

MA opposes CMS's proposed removal of Measure 137: Melanoma: Continuity of Care - Recall System. The reason for the proposal is that it does not advance quality care. However, this measure does advance quality care because it holds practices accountable to ensure patients with a history of melanoma have a recall process established to confirm exams are scheduled and occur. Considering the risks involved with a melanoma diagnosis and patients "slipping through the cracks", the recall process of this MIPS measure provides a fail-safe way for clinicians to ensure their patients have skin exams in their predetermined time frame. **Therefore, we strongly urge CMS to retain measure 137 to promote critical, life-saving exams for melanoma patients.**

There are currently only nine benchmarked MIPS quality measures that are relevant to dermatology, only four of which are not 7-point capped. Measure 137 is one of these four

measures. In addition, there are currently no QCDR dermatology measures that are benchmarked. Further reducing the ability of dermatologists to score well in Quality, based solely on the measures available, does a disservice to the program and the specialty.

4. **Measure 337: Psoriasis: TB Prevention for Patients with Psoriasis, Psoriatic Arthritis and RA on a Biological Immune Response Modifier**

MA opposes CMS's proposal to remove Measure 337. The stated reason for proposed removal is that measure 176 (TB Screening Prior to First Course Biologic Therapy) is proposed to be expanded to include the scope of CQM 337's measure intent. However, measure 176 is neither supported by the AAD's MIPS registry nor in the dermatology measure set, thus this proposal would create increased compliance burden for dermatologists who have relied on measure 337.

Moreover, **the proposed changes to measure 176 do not adequately encompass the biological response modifiers used in dermatology and listed in measure 337.**

There are currently only nine benchmarked MIPS quality measures that are relevant to dermatology, only four of which are not 7-point capped. Measure 337 is one of these four measures. In addition, there are currently no QCDR dermatology measures that are benchmarked. Further reducing the ability of dermatologists to score well in Quality, based solely on the measures available, does a disservice to the program and the specialty. **Therefore, we strongly urge CMS to retain measure 337 by at least two years to allow additional dermatology measures to be added to the program.**

vi. Proposed New Quality Measures

1. **Risk-Standardized Acute Unplanned Cardiovascular- Related Admission Rates for Patients with Heart Failure**

MA is concerned that PAs and NPs who don't provide any cardiac care will be inappropriately included in this measure. In the proposed measure specification, CMS states that this measure would be applied to Primary Care Providers, including NPs, PAs, and certified clinical nurse specialists (CCNSs) as identified by two-digit specialty code. While we understand the thought process behind this designation, we represent multiple practices that employ NPs or PAs but provide no primary care. For instance, we have a dermatology practice that employs PAs and NPs who bill under the practice TIN. As written and proposed, this measure would inappropriately score their performance and, thus, the practice would be scored on this measure.

The TEP identified the following as appropriate for attribution under this measure: cardiologists, internal medicine, family medicine, general medicine, and geriatric medicine. NPs, PAs, and CCNSs are also identified, but only under the assumption that they provide primary care. Clearly, for practices like this dermatology practice, the NPs and PAs do not provide primary care but, rather, dermatologic care.

Until CMS is able to remedy the issue of inappropriate attribution to NPs and PAs not practicing in the measured specialties, we strongly urge CMS not to finalize this measure for inclusion in MIPS.

2. **Annual risk-standardized rate of acute, unplanned hospital admissions among Medicare Fee-for-Service (FFS) patients aged 65 years and older with multiple chronic conditions (MCCs)**

As with the above measure, we are concerned that PAs, NPs, and other mid-level providers could be attributed this measure, even if they do not practice in the measured specialties (primary care, cardiology, pulmonology, nephrology, neurology, endocrinology, and hematology/oncology). For instance, a PA or NP working at a dermatology practice should never be attributed this measure. **Until CMS and the measure developer are able to remedy the issue of inappropriate attribution to NPs and PAs not practicing in the measured specialties, we strongly urge CMS not to finalize this measure for inclusion in MIPS.**

3. **COVID-19 Measure Specification for Potential Future Use**

MA agrees that measuring patient COVID-19 vaccination is incredibly important for mitigating the impact of the pandemic and the emergence of new variants. Therefore, **we ask CMS to issue an Interim Final Rule making this measure mandatory in the 2022 performance year**. However, given that convincing patients that the conspiracies circulating about this vaccine are not accurate is not entirely dependent on physician skill at motivational interviewing, we strongly recommend the measure be amended to take this into account. **Specifically, we suggest either the addition of a denominator exception for patient refusal to receive the vaccine, or that the numerator measure whether clinicians have a conversation/education with the patient about the importance of COVID-19 vaccination.** Without this modification, clinicians in certain geographic areas, including rural physicians, will be disadvantaged under this measure.

G. Improvement Activities Category

i. Category Weight and Reporting

MA appreciates the consistency in category weight and reporting period for the Improvement Activities Category for performance year 2022.

ii. Scoring

In this proposed rule, CMS has preserved the provision of double points for each improvement activity reported by small practices. Maintaining this accommodation aligns with the goal of reducing burdens, particularly on small practices. **MA supports this decision and encourages CMS to continue this policy in future years.**

iii. Proposed Changes to the Engagement of New Medicaid Patients and Follow-up IA

MA agrees with the goal of increasing attention on social determinants of health which, of course, extend beyond the Medicaid population. Despite this, we are concerned that the proposed modification to expand the patient population of this IA to "other underserved patients" may complicate the reporting and documentation of this measure. In order to perform this measure, practices would have to ask patients how much they make, how big their family is, and other questions that may make patients uncomfortable if asked by a scheduler. In addition, this will make it more difficult to filter records for these patients in practice management and scheduling software. Therefore, **we encourage CMS to maintain more clear definitions on the applicable patient population for this IA.**

CMS is also proposing to remove the reference to timeliness as within 10 business days and to replace it with the collection of time-to-treat data. In combination with the change in patient populations, this would require more complex analysis by clinicians and practices to determine and evaluate patterns of care and engagement. **Rather than adding all of these factors into one, much more complex IA, MA recommends that CMS consider creating separate IAs for identified barriers to care.**

iv. Proposed New IAs

1. IA_AHE_XX: Create and Implement an Anti-Racism Plan

We applaud CMS's proposal to include this IA in the inventory in 2022.

2. IA_ERP_XX: Implementation of a PPE Plan

We agree with CMS that preparation for current and future pandemics is essential for healthcare workers. Because of this and because of the impact of inadequate policies and PPE has had during the COVID-19 pandemic, we urge CMS to finalize this as a high weighted IA.

H. Promoting Interoperability Category

i. Category Weight and Performance Period

MA supports CMS's maintenance of a 90-day reporting period for Promoting Interoperability (PI) for the 2022 performance year and all future years. Achieving full-year reporting for Promoting Interoperability is very difficult for many clinicians. There are several factors outside of clinician control that contribute to this difficulty. Some examples include switching EHRs, system glitches, updates and downtime, and office relocations.

ii. Hardships

MA enthusiastically supports CMS's proposal to establish automatic reweighting for the Promoting Interoperability category for small practices. Small practices are more likely to be unable to afford increasing EHR maintenance and upgrade costs, especially when combined with the IT and cybersecurity staff required to maintain electronic health record security. By giving such practices an automatic hardship exception from the Promoting Interoperability category, small practice clinicians can continue to participate in MIPS and provide quality care to those who need it most.

iii. Scoring: Multiple PI Scores

MA is opposed to the way in which CMS scores the PI category when it is reported through multiple mechanisms or from multiple sources for the same EC or group. CMS established only through subregulatory guidance, *not through rulemaking*, that if a clinician or group submits PI data more than once, they will receive a score of 0 in the PI category. This decision has a negative impact on clinicians who may report through multiple mechanisms or who may have PI reported for them by another body, such as an ACO, without their knowledge. **Moreover, it violates policy that was previously finalized through notice-and-comment rulemaking and the Administrative Procedures Act** (as CMS established this important policy without notice-and-comment rulemaking)**.** In the 2018 QPP Final Rule, CMS finalized that clinicians and groups would be allowed to submit data for the same performance category via multiple submission mechanisms and would be assigned the highest of the reported scores for each measure. No change to this policy has been proposed or finalized. **We strongly urge CMS to allow clinicians**

impacted by multiple PI submissions to receive the highest PI category score of their submissions. We also ask CMS to allow these practices to submit a targeted review after the deadline (as the deadline will be prior to the publication of the final rule) so that they may receive the PI category score from the highest scored collection type as required under CMS-finalized policy.

iv. Scoring: Public Health and Clinical Data Exchange Objective

We understand and agree with the importance of both Immunization Registry Reporting and Electronic Case Reporting, particularly in light of the COVID-19 pandemic and in preparation for future pandemics. We are, however, concerned that **eliminating credit for this objective for those who are unable to report for those two measures due to their specialty or region will eliminate the incentive for other forms of meaningful reporting that has proven useful during the pandemic. Clinical data registries have been instrumental in identifying symptoms and sequelae of COVID-19**, as demonstrated by CMS's continued inclusion of the COVID-19 registry reporting improvement activity. We ask CMS to consider this when developing the final policy for this objective. Many specialists cannot report to the Immunization or Case Reporting registries but are able to report to a Qualified Clinical Data Registry (QCDR). **We strongly recommend including QCDRs as an option in the required measure set for this objective as the points earned in measure have been a driving factor in our practices choosing to join a QCDR.**

In addition, under MACRA (Sec. 101 (c)(1)), CMS is supposed to incentivize QCDR and EHR reporting of quality measures. This section modified section 1848(q)(5)(B)(ii) of the SSA to state that "Under the MIPS, the Secretary shall encourage the use of qualified clinical data registries pursuant to subsection (m)(3)(E) in carrying out this subsection."
Despite this statutory requirement, CMS is proposing to remove credit for active engagement with a QCDR unless at least one of the two proposed required measures is attested to; in addition to CMS is proposing, in the Quality category, to remove the end-to-end electronic reporting bonus. These were the only two methods of encouraging the use of QCDRs in MIPS. As such, we are struggling to identify any encouragement or stand-alone credit for active QCDR participation in MIPS as proposed for performance year 2022.

Congress has made clear their desire to drive true value under Medicare and has recognized the lowest burden and most effective tool to achieve this goal – clinician-led, specialty society QCDRs. We ask that CMS follow their Congressional mandate to better leverage and encourage participation in clinician-led, specialty society QCDRs in the MIPS program in this and all future years.

v. Proposed Changes to Promoting Interoperability Objectives and Measures

1. Provide Patients Electronic Access to Their Health Information

MA understands the impetus for the proposed change to this measure, however, **we strongly urge CMS to not finalize the proposed change**. Requiring clinicians in non-hospital-affiliated practices to store and make available patient data indefinitely and using any application of their choice (if configured to meet the technical specifications of the EHR's API) is a significant increase in burden and does not align with current HIPAA regulations or requirements placed on EHRs. We anticipate that this will lead to a decrease in clinicians able to report the PI category due to EHR hardships related to this measure and, thus, a backtrack on the progress CMS has made toward promoting interoperability under MIPS. **We urge CMS to delay this proposal at least until 2024, when EHRs must be certified to the data export functionality.**

Even in this scenario however, practices would have to pay for additional data storage. This would be especially burdensome for small and rural practices that are already operating on slim margins.

Finally, CMS states that they believe that this aligns with Patient Access and Interoperability final rule. The related provisions in the referenced rule apply only to hospitals and CAHs, not to physician practices. **Therefore, we strongly recommend that CMS not finalize this change for the 2022 MIPS performance year and, at minimum, conduct a study with physician stakeholders to evaluate the impact of this proposal on small and rural practices.**

2. Query of Prescription Drug Monitoring Program (PDMP)

MA agrees that the continued impact of the opioid epidemic should be addressed on all fronts. We would support making this measure mandatory in the future with one stipulation – there must be an exclusion for ECs who do not prescribe opioid medications. If this exclusion is not added prior to making this measure mandatory, this measure would have the opposite of the intended effect. Rather than driving more responsible opiate prescription practices, it could drive physicians who do not prescribe opioid medications to prescribe one at least one time during the performance period in order to avoid failing the PI category and, by extension, likely failing MIPS. As such, **MA strongly urges CMS to add an exclusion for ECs who are low-volume or never prescribers of opioid medications prior to making this measure mandatory.**

vi. Proposed New Measure: SAFER Guides

In the context of the continuing increase in cyberattacks against medical providers, **MA supports the addition of the SAFER Guides measure to the PI category**.

I. Cost Category

i. Category Weight

MA supports the proposed performance category weight as the proposed changes are as required by law. Despite our support, we remain concerned that the Cost category has not yielded predictable results based on practice patterns and best practices.

ii. Cost Measure Suppression

MA supports the proposal to suppress cost measures impacted by significant changes during the performance period. We agree that, should changes likely yield misleading or inaccurate results, it would be inappropriate to score clinicians on impacted measures.

iii. Melanoma Resection Cost Measure

We are concerned with the low 10-episode case minimum for this measure. Though we understand that CMS has determined that this provides sufficient reliability and that this is consistent with previously finalized regulations regarding the case minimums for procedural measures, we are concerned that this may result in 30% of a clinician's MIPS score being based on a procedure they perform only very rarely. We ask that CMS reevaluate this policy.

iv. Diabetes Cost Measure

Based on the measure specification and the field test results, MA is concerned that clinicians who do not manage a patient's diabetes will be attributed this measure. Specifically, clinicians who are only treating a system-specific complication such as diabetic retinopathy or diabetic dermatitis, should be excluded from this measure. This measure is more appropriate for the clinician managing the patient's diabetes. Clinicians who are only treating system-specific complications, rather than managing the patient's diabetes, should be excluded from this measure.

J. MIPS Value Pathways

i. Delay of MVP Implementation

MA approves of the proposal to delay the implementation of MVPs to performance year 2023. The impact of the COVID-19 PHE has been dramatic; we agree that this proposed delay is appropriate.

ii. Mandatory MVP Participation

In this proposed rule, CMS stated their intent to sunset traditional MIPS at the end of the 2027 performance year and make MVP participation mandatory beginning with the 2028 performance year. **MA strongly recommends that CMS reevaluate this timeline.** We do not believe that there will be sufficient specialty- and subspecialty-specific MVPs by performance year 2028 to allow for appropriate measurement of all MIPS clinicians under the MVP.

Making MVPs mandatory before such a time as all specialties and subspecialties have germane MVPs to participate in will disadvantage certain specialties and small and rural practices. Clinicians whose practice mix and focus is inappropriately represented among MVPs will have difficulty being measured on the care they provide as they will have a smaller proportion of their patients who qualify to be included in the MVP's measures. Furthermore, due to the smaller number of patients seen by small practices, singular adverse events will have a substantially greater impact on small practices than large practices.

In addition, topped out measure inclusion in MVPs pose another problem. By requiring clinicians to report on specific measures, CMS may directly disadvantage particular specialties and types of practices. As stated above, small practices have a smaller number of patients, making singular adverse events have a substantially greater impact on them. This is particularly pertinent as clinicians would no longer be able to choose measures with less clustered performance.

Although CMS has stated that "maintaining both traditional MIPS and MVPs is not a feasible long-term approach for the agency" we believe that this is an approach that must be attempted, at minimum, **until such a time as sufficient MVPs are available to allow appropriate measurement of all MIPS specialties and subspecialties.**

iii. Subgroup Reporting

MA supports the proposal to require sub-group reporting for those in the MVP track beginning in performance year 2025. We agree that it is important to ensure that each clinician can be measured and scored on metric germane to their practice. For these same reasons, we also support the proposal to allow voluntary subgroup reporting beginning with the 2023 performance year.

We believe that these sub-groups should be limited only to ECs in the same or related specialties. We also believe that an approved list of specialties for each finalized MVP would be an appropriate step. It is, however, important to note that this can be difficult for mid-level providers. For example, PAs and NPs are often labelled as primary care providers. Despite this, many work in specialty care-only practices. It is important that CMS be able to determine the specialty of care provision of mid-level providers before mandatory subgroups are implemented.

Finally, **MA supports allowing, but not requiring, subgroup level PI performance data reporting beginning in performance year 2023. When both a group and a constituent subgroup both submit PI data, we strongly recommend that CMS not penalize the group or subgroup by assigning them a PI score of 0 as has been the case under traditional MIPS.**

iv. MVP Participant Registration

MA supports the proposed registration proposed for MVP and subgroup elections.

v. Scoring

MA supports the following MVP scoring proposals:

- Proposal on facility-based scoring
- Proposal on complex patient bonus
- Proposal to suppress the population health measure if it does not have a benchmark or if the subgroup does not meet case minimum
- Proposal to reduce the total Quality denominator accordingly for small practices reporting via claims
- IA proposal to give all practices 40 points for high-weighted IAs and 20 points for medium-weighted IAs.

vi. Category Weight Redistribution

MA opposes the proposal to not allow for MVP Quality category reweighting. We believe that category reweighting should align with traditional MIPS. CMS has previously recognized that there are extreme circumstances that could eliminate a practice's ability to report on the categories with year-long performance periods, but not on the shorter performance periods. **Should CMS finalize the proposal to not allow for MVP Quality category reweighting, they must allow practices and subgroups that cannot report Quality to be excluded entirely from MIPS and MVPs for that performance year.**

MA largely supports CMS's proposal to apply any reweighting applied to a group to any constituent subgroups of the group, with one exception. **We strongly urge CMS not to score the entire practice should a subgroup of the practice submit data on a category that the practice, as a whole, received reweighting on** (either via application or automatic EUC policy)**.** We believe it will be a likely point of confusion for groups and subgroups and could inappropriately contribute to poor performance.

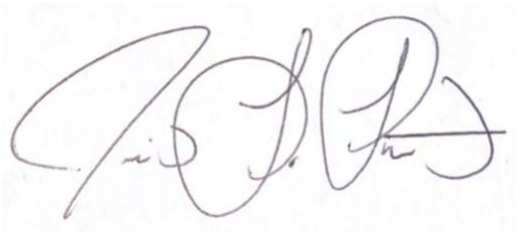
K. APM Scoring Standard and APM Performance Pathway (APP)

MA applauds CMS's development of the APP and believes that it is an excellent way to measure primary care. The quality measures included are not appropriate for most specialists though. **As such, we strongly encourage CMS to maintain the APP as optional in the future** to allow clinicians in MIPS APMs to report in alternative ways so they may be evaluated on measures germane to their specialty.

Conclusion

We appreciate the opportunity to work with CMS to improve the Quality Payment Program. If you have questions or need any additional information regarding any portion of these comments, please contact Dr. Jessica Peterson, VP of Health Policy at MarsdenAdvisors at jessica@marsdenadvisors.com.

Sincerely,



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