September 6, 2022

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-1770-P; Medicare and Medicaid Programs; CY 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies.

Dear Administrator Brooks-LaSure,

MarsdenAdvisors (MA) is submitting our comments on the Centers for Medicare & Medicaid Services (CMS) proposed rule regarding the 2023 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

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 and for ophthalmologists reporting via claims. There are currently only eight benchmarked MIPS quality measures that are relevant to dermatology and only two ophthalmology-specific claims measures. In this proposed rule, CMS is proposing to remove several important measures, including a benchmarked dermatology measure and an ophthalmology-specific claims measure.

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.**

In addition, MA does not support the proposal to increase the data completeness threshold to 75% in 2024 as this puts undue burden on small practices.

Quality Social Drivers of Health (SDOH)

We strongly disagree with the proposed addition of "Screening for Social Drivers of Health" as a quality measure, due to its inability to address SDOH for the patient and its potential for unintended harm.

2015 Cures Edition Certified EHR Technology

MarsdenAdvisors strongly urges CMS to monitor the progress of EHRs receiving the Cures Update certification and to ensure that clinicians using an EHR vendor that does not meet the deadline for the Cures Update have access to the PI decertification hardship exception for the 2023 reporting year.

We also *request clarification* on the impact of the move to the Cures edition on 2023 eCQM reporting.

Promoting Interoperability (PI) Query of Prescription Drug Monitoring Program (PDMP) Measure

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.

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.**

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 maintain traditional MIPS in all future years. We do not believe that MVPs will 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 will be requiring single-specialty subgroup reporting for clinicians in multi-specialty groups starting in 2026. 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 applaud CMS' continued commitment to remove the CMS Web Interface collection type.

iii. Performance Thresholds

MA supports the proposed performance thresholds. We believe that this will provide some stability during the continued public health emergency (PHE). 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 current performance category weights as they are 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.

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.[1] 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 of these comments (pg. 22).

C. Extreme and Uncontrollable Circumstances

MA appreciates that CMS is continuing to accept EUC applications for issues arising from COVID-19. 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 inaccurately reporting data after the end of the performance period and, for us and our clients 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. Small Practices

MA strongly supports CMS' decision to maintain policies that account for the increased strain faced by small practices participating in MIPS. Specifically, we strongly support the policies that established automatic reweighting for the Promoting Interoperability category and the revised category redistribution policies for small practices. These policies have helped to level the playing field for small practices operating on narrow margins.

Small practices are less likely to be able 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 with the**

[1] 83 FR 59452

negative impact of CMS' proposals to eliminate more non-eCQM 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. 12).

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.

E. Quality Category

i. Category Reporting

1. eCQM Reporting: 2015 Edition Cures Update

MarsdenAdvisors requests clarification on the impact on those reporting eCQMs of CMS' previously finalized policy requiring providers to transition to 2015 Cures Update Certified Electronic Health Record Technology (CEHRT) by the beginning of the 2023 MIPS PI performance period. Specifically, we ask the following:

- Will clinicians and groups that are EHR-integrated with a certified QCDR be able to continue reporting eCQMs through the QCDR even if their EHR is unable to get Cures Update certified?
- Will clinicians and groups be able to report eCQMs for MIPS via their EHR if the EHR is unable to get Cures Update certified by the beginning of 2023? What if the EHR is unable to get Cures Update certified by the end of 2023?
- If any of the above circumstances occur, will CMS provide Quality category EUC hardships to those clinicians and groups for EHR decertification?

We remain concerned with the current progress toward viable adherence with any 2015 Edition Cures Update CEHRT requirement. As of August 1, 2022, only a few major vendors have received full Cures Update certification.[2] MarsdenAdvisors strongly urges CMS to ensure that there is adequate time for clinicians to upgrade and implement Cures Update CEHRT. The Office of the National Coordinator (ONC) mandate requires EHRs to be updated by December 31, 2022. It is unreasonable to expect clinicians and practices to be able to implement the Cures Update or switch to a new EHR that is able to obtain Cures Update certification in a short time frame or to manually submitting quality measures if a practice was planning to submit eCQMs. Either option would present a significant burden to any reporter whose EHR fails to achieve Cures Update certification in time.

[2] https://www.healthit.gov/buzz-blog/healthit-certification/on-the-road-to-cures-update-certified-api-technology

2. Web Interface Reporting

We applaud CMS' continued commitment to remove the CMS Web Interface collection type.

ii. Data Completeness Threshold

CMS proposes to maintain the current data completeness threshold of 70% for the 2023 performance year and to increase the threshold to 75% for the 2024-2025 performance years. **MA supports the maintenance of the current data completeness threshold** but opposes the proposal to increase the data completeness threshold to 75% in 2024.

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 2024-2025 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 75% data completeness threshold. If the increase to 75% 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 2023 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 Measures

We agree with CMS that health equity should be a high priority. However, seeing as CMS has removed the high-priority measure bonus points beginning with the 2022 performance year, there is no incentive in place to encourage this prioritization.

3. Point Floor

We support the 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 are not directly related to their clinical practice, making it even more difficult to meet case minimums. Thus, we applaud CMS for maintaining this important accommodation.

4. Point Floors for New Measures

MA enthusiastically supports CMS' maintenance of a 7-point for new measures in their first year in MIPS, and the 5-point floor in their second year in MIPS. We encourage this policy to continue in future years. 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.

CMS stated that this policy stemmed 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 remains 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.**

5. Topped-Out Measure Cycle

MA appreciates CMS' clarification on the topped-out measure lifecycle in instances in which a measure is truncated or suppressed.

iv. Proposed Changes to Quality Measures

1. Changes to Measure 001: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)

MA supports the inclusion of secondary diabetes in the denominator in this measure, the inclusion of nutritionist and dietician coding, as well as the alignments made with the HEDIS measure.

MA requests that patient-reported values for this measure be allowed in the numerator of this measure. This addition would reflect CMS' prioritization of patient-reported outcomes. While patient-reported data was initially included in this measure, the 2021 Medicare Physician Fee Schedule final rule changed this. We believe that this change has made the measure more difficult to report and could be leading to unnecessary testing in order to reach numerator compliance.

2. Changes to Measure 176: Tuberculosis Screening Prior to First Course Biologic Therapy

MA supports the revisions and updates to the title, description, performance period, and denominator of QPP176**. We request clarification regarding the language of the list of therapies being "subject to change"**. Our concern is that EHRs may not be aware of, or able to review, recent FDA approvals relevant to this measure in real-time.

The lack of clarity as to what therapies qualify under this measure could lead to decreased reporting due to the risk of unintentionally not complying with the quality action. We ask CMS to provide further guidance regarding notification of the addition of applicable therapies to the measure, as well as clarification as to whether additions of new therapies could lead to measure suppression.

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

MA strongly supports the modification of this measure to reflect the time referrals require and to align it with other measures regarding follow-up care. This change would solve the main issue with this measure's use and allow for practices to assess their care coordination more accurately within each performance year.

We use this measure with many of our practices, and when we introduce measure 374 to practices, they often realize that care coordination (both sending and receiving specialist reports) is something they have neglected. Often, after discussing this measure, these practices

decide to use this measure as a motivation to improve their care coordination. This proposed change would greatly increase the appeal of this measure and could lead to improved care coordination for many patients.

4. Changes to Measure 440: Skin Cancer: Biopsy Reporting Time – Pathologist to Clinician

MA supports the addition of a denominator note excepting wide local excisions and re-excisions. We agree that these exceptions align the measure with its intended purpose more accurately.

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 117: Diabetes Eye Exam

MA opposes CMS' proposal to remove the claims collection type for Measure 117: Diabetes Eye Exam. While we recognize that it is topped out under the claims collection type, the clinicians reporting these measures are already limited in the number of appropriate measures that are relevant to the scope of practice for ophthalmologists, and this dearth of appropriate measures could lead to increased MIPS failures, not to due to poor practice, but inappropriate measurement.

We encourage CMS to retain the measure for the claims collection type, because removal of the measure from claims would adversely impact ophthalmologists, particularly those in small and rural practices that must rely on the claims reporting because they cannot afford to adopt CEHRT. Given these considerations and aligned with the goal of measuring quality for each specialty, we encourage CMS to make the removal of topped out measures contingent on the availability of replacement measures. Physicians should not be disincentivized from providing appropriate specialized care.

2. **Measure 265: Biopsy Follow-Up**

MA strongly opposes the removal of this measure as it is an important facet of care coordination. Improved care coordination is an important movement in medicine. According to the Agency for Healthcare Research and Quality (AHRQ), care coordination is vital to achieve safer, more effective, and more cost-efficient care.

NQF's EHR Care Coordination Committee wrote and emphasized the following statement in its Environmental Scan Report last year:

> Measurement using EHRs in this area is critical, as measurement will drive quality improvement efforts to enhance care communication and care coordination, two processes that are essential to achieving the Quadruple Aim of enhancing the patient experience, improving population health, improving the work life of healthcare providers, and reducing costs.

This measure provides a key incentive to practices engaging in clinician-to-clinician communication and practices find this to be a meaningful measure to their patients and their practice. While we understand that this measure has reached the "end of its topped-out lifecycle", we have seen how CMS' efforts to incentivize care coordination in other measures can meaningfully impact the priorities of practices. This measure is an important aspect that clearly communicates the value of communication and coordination on performance.

We have additional concerns about removing topped-out measures before analysis regarding disparities in care, as related to race, ethnicity and/or language can be completed. While the measure shows high performance among eligible clinicians, it does not serve the interests of Medicare beneficiaries to eliminate this measure before confirming their needs are being met optimally.

3. **Measure 110: Preventive Care and Screening: Influenza Immunization and Measure 111: Pneumococcal Vaccination Status for Older Adults**

MA opposes the removal of this measure, as its retention in MVPs would cause a fundamental lack of alignment between the programs. Additionally, replacing these measures could harm data analysis opportunities regarding immunization rates.

We are concerned with the complexity and the confusion this measure could bring to clinicians reporting the measure. For example, the performance data would not be actionable because it would combine the different immunization rates and without providing actionable

immunization-specific data. We are very concerned about the negative impact this would have on patients, essentially slowing the progress made on increasing specific immunizations needed for advancing public health.

vi. Proposed New Quality Measures

1. Psoriasis – Improvement in Patient-Reported Itch Severity

While we agree that patient-reported outcomes are important and we appreciate the addition of a new dermatology-specific MIPS measure, we are concerned that adequate training and education on using an itch-severity scale for psoriasis has not been expanded properly. We have heard from multiple practices that there is a lack of education on using these tools in this context.

2. Adult Immunization Status

MA opposes the addition of this measure to traditional MIPS. As stated in our comments above on Measure 110: Adult Influenza Immunization and Measure 111: Pneumococcal Vaccination Status for Older Adults, introduction of this new measure in MIPS prior to its introduction in MVPs further misaligns the two programs.

Furthermore, we are concerned that the Adult Immunization Status measure was not supported by the NQF Measure Applications Partnership, and that the measure has not been analytically tested at the clinician level. In addition, combining the separate immunization measures into one single measure reduces the impact of each individual measure. **We do not support the addition of this measure as a replacement for the separate immunization measures, and we encourage CMS to retain measures 110 and 111.**

3. Screening for Social Drivers of Health

MA commends CMS for prioritizing health equity and the inclusion of social drivers of health (SDOH) into the QPP, but **we strongly disagree that this measure in its current form will improve health equity or address SDOH.** We have three main concerns with the measure: harm to the provider-patient relationship, lack of equivalence with the AHC model leading to excessive burden to physicians, and inconsistency with data collection standards.

Harm to Provider-Patient Relationship

We believe that SDOH must be comprehensively addressed, and this requires the development and provision of centralized information regarding accessible referral services relevant to positive screens and patient needs. Without these resources, all doctors would be doing is

asking the question, hearing a vulnerable patient admit their vulnerability, and then moving on because they do not have the tools to help. This has high potential to do irreparable harm to the provider-patient relationship and decrease patient comfort in disclosing information and asking for help. These resources are best developed by city, county, state, and federal governments so that they can be standardized, centralized, and trusted.

To expect clinicians, who are already overstrained, and practices, which are likely understaffed, to provide data collection services, navigation services, referral services, and reorganize their entire operational output with no additional resources is unreasonable and out of the scope of the medical services physicians provide. We agree with the evaluations of the NQF Health Equity and Rural Health Advisory committees that simply screening when no actual community resources are available and accessible to patients would damage the provider-patient relationship. As research has shown in intimate partner violence[3] and alcohol use[4] scenarios, screenings can be detrimental to the integrity of the provider-patient relationship if resources provided after a positive screen are not seen as sufficient by the patient. **We urge CMS to prioritize patient safety and assess the appropriateness of screening in this environment.**

Lack of Equivalence with the AHC Model

The AHC model is referenced in the proposed rule as the prototypical example of the inclusion of SDOH in healthcare. In the first AHC model evaluation commissioned by CMS, the evaluation team determined that navigation and referral services necessitated a separate "workflow managed by new staff."[5] The evaluation also found that every participating facility had to customize and optimize their workflow and navigation services to meet the needs of the population they serve. There are potential unintended consequences discussed on page 18 of the evaluation that need to be more fully understood before this model can be scaled.

This is especially important given that the model sites were highly resourced health systems, hospitals, health departments, and networks. Applying this model to lower resourced settings, such as independent clinics, is likely to exacerbate any unintended consequences caused by this model's implementation in its current form.

Given the concerns laid out by CMS' contractors in the AHC evaluation, we are especially concerned with CMS' discussion of making this measure mandatory in the future under the MVP.

[3] https://www.sciencedirect.com/science/article/abs/pii/S0196064407017866
[4] https://www.bmj.com/content/325/7369/870.short
[5] https://innovation.cms.gov/data-and-reports/2020/ahc-first-eval-rpt

Inconsistency with Data Collection Standards

According to section 4302 of the Affordable Care Act, data collection on race, ethnicity, sex, primary language, and disability status must be standardized across Medicaid and Children's Health Insurance Program (CHIP) and must comply with HHS' guidance. HHS' guidance currently states that:

> Agencies would also be permitted to include additional response categories for data standards with as much additional detail and granularity as desired, provided that the additional detail could be aggregated back to the minimum standard and the sample design and sample size support estimates at that level of granularity.

MA requests clarification from HHS regarding which aspects of SDOH would be exempt from necessary aggregation due to intrinsic intersection with race, ethnicity, sex, primary language, and disability status. If the data collected by a tool developed for this new proposed measure is not applicable or in line with Medicaid and CHIP data standards, it does not align with the first priority of CMS' Health Equity Framework of the "collection… of standardized data… across CMS programs".

We note that the Mandatory Medicaid and CHIP Core Set Reporting Rule, published in August 2022, highlights stratification of core-sets by race, but also does not provide a standardized tool by which to compare data across analyses. We are concerned that this level of data fragmentation will delay the collection of truly standardized national-level data and could hinder attempts to analyze and address SDOH.

Additionally, there is inconsistency with the proposed measure under the Hospital Inpatient Quality Reporting Program in the IPPS rule. Within that rule, the measure "Screening for Social Drivers of Health" would allow organizations to screen on "one or all" of the five factors for the numerator of the measure. As proposed in this rule, the measure lacks the same detail, and inconsistencies in data collection will lead to less reliable and useful data.

We agree that it is vital to collect data regarding social drivers of health as comprehensively as possible, while "[m]inimizing the administrative burdens of data collection and reporting on States, providers, and health plans participating", as the Affordable Care Act states. The impacts of SDOH cannot be overstated, but MIPS measures are not the only available avenue through which we can address the needs of the American population, nor are they the most effective.

vii. Request for Comment: Health Equity

How would a measure best capture health equity needs under MIPS in the future?

There is widespread agreement that tools to better capture data surrounding SDOH are urgently needed, however we believe that MIPS measures are not the place for this to occur, at least not currently.

We encourage CMS and its partners to invest in the development of tools that can best capture this type of data in the future. As stated above, we have concerns around the impact these screenings could have on the physician-patient relationship, specifically in the cases where referrals to appropriate services are limited or unavailable.

For any MIPS measure involving SDOH screening to be effective, it must be paired with connecting the patient to currently available and accessible resources. Given the diversity and variation of available resources community-by-community, county-by-county, and state-by-state, doctors do not have time, bandwidth, or expertise to be able to identify these resources for every patient who needs them. Therefore, before mandating any SDOH screening, CMS must work with local and state governments to develop centralized and trusted repositories of this information.

What, if any, would be the limitations in data interpretation if a future health equity- related measure would not be risk-adjusted?

Doctors are neither social workers nor case managers, and their primary job is to address the medical issues a patient presents with. Doctors in areas with high SDOH disparities likely will not have the time to address these issues in every patient they see and will need to triage what is most important to be addressed in the patient visit. Determining or prioritizing the most urgent medical and health related needs of a patient is more appropriately done by their treating physician than by the government. Because of this, risk adjustment is essential.

In addition, to do reasonable cross-measure analysis and determine actionable outcomes, it is important that all measures in this category be risk-adjusted.

Would there be any concerns if a future health equity-related measure did not specify requirements for use of consistent tool(s) for data collection under such a measure? Should such a future measure support flexibility in choice of tools while requiring standardized coding of responses to support interoperability?

If CMS' goal with this measure is to create a comprehensive dataset that can yield reliable analysis of the prevalence and impact of SDOH on the American population, then a

standardized and validated tool is necessary. Without a standardized tool, the results of this data collection would not be appropriate for the determination of statistical significance. It is important, however, to include stakeholders and frontline doctors in the development and testing of any tool to ensure there are no unintended consequences and that it fits within existing workflows.

F. 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 2023.

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 Existing IAs

1. IA_PSPA_7 (Use of QCDR data for ongoing practice assessment and improvements) and Removal of Remaining QCDR IAs (IA_PM_7, IA_BE_7, IA_BE_8)

CMS consolidated several QCDR improvement activities into IA_PSPA_7 in the 2020 QPP Rule. Although consolidating those activities did not receive much pushback, this new proposed consolidation is more problematic. With CMS' new focus on SDOH, it is important that activities that collect SDOH information are high-weighted. IA_PM_7 (Use of QCDR to generate regular feedback reports that incorporate population health, with a focus on vulnerable populations) and components of IA_PSPA_7 both emphasize this important goal. IA_PM_7 is currently high-weighted while IA_PSPA_7 is only medium-weighted. Thus, combining these improvement activities under IA_PSPA_7 would eliminate the high weighting of a health equity IA. **To align with the importance of health equity and CMS' stated goal of assigning health equity-related IAs a high weight, MA strongly urges CMS to either not finalize this proposal or to change the weight of IA_PSPA_7 to high.**

iv. Proposed IA Removals

1. Removal of IA_PM_7 (Use of QCDR for feedback reports that incorporate public health)

With CMS' new focus on SDOH, it is important that activities that collect SDOH information are high-weighted. IA_PM_7 (Use of QCDR to generate regular feedback reports that incorporate population health, with a focus on vulnerable populations) emphasizes this important goal. IA_PM_7 is currently high-weighted while IA_PSPA_7 is only medium-weighted. Thus, combining these improvement activities under IA_PSPA_7 would eliminate the high weighting of a health equity IA. **To align with the importance of health equity and CMS' stated goal of assigning health equity-related IAs a high weight, MA strongly urges CMS to either not finalize the proposal to remove IA_PM_7 or to change the weight of IA_PSPA_7 to high.**

v. Proposed New IAs

1. IA_AHE_XX: Create and Implement a Plan to Improve Care for Lesbian, Gay, Bisexual, Transgender, and Queer Patients

We applaud CMS' proposal to include this IA in the inventory in 2023 and we agree that it should be high-weighted.

2. IA_EPA_XX: Create and Implement a Language Access Plan

We applaud CMS' proposal to include this IA in the inventory in 2023 and we agree that it should be high-weighted.

3. IA_ERP_XX: COVID-19 Vaccine Achievement for Practice Staff

We agree with CMS that preparation for current and future strains of COVID-19 is essential for healthcare workers. Because of this, and because of the impact incomplete vaccination among healthcare workers can have on their patients, particularly in disadvantaged areas, **we urge CMS to finalize this as a high weighted IA**. Finally, CMS states that the effort for this IA is comparable to other medium-weighted IAs, however, fighting and reversing vaccine misinformation or hesitancy requires substantial effort particularly in the practices most likely to benefit from this IA – practices with low vaccination rates among staff.

G. Promoting Interoperability Category

1. Category Weight and Performance Period

MA supports CMS' maintenance of a 90-day reporting period for Promoting Interoperability (PI) for the 2023 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.

2. 2015 Edition Cures Update Timeline

MarsdenAdvisors strongly recommends CMS monitor the progress of EHRs towards receiving the Cures Update certification. We are concerned that adherence with CMS' previously finalized policy requiring providers to transition to 2015 Cures Update Certified Electronic Health Record Technology (CEHRT) by the beginning of their 2023 MIPS PI performance period is not feasible. This policy was finalized to align with the Office of the National Coordinator's (ONC's) December 31, 2022 deadline for CEHRT vendors to make the 2015 Cures Update available to their customers.

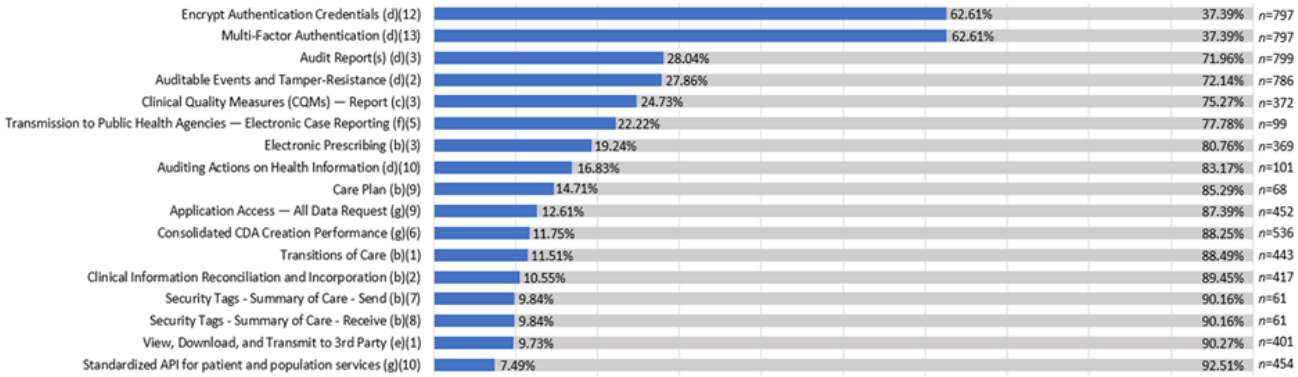
As recently as August 1, 2022, full Cures update certification has only been achieved by a few major vendors. A *HealthITBuzz* blog post, written by ONC officials Jeff Smith, Tony Myers, and Papia Paul and published on March 3, 2022 states:

> There are several other important Cures Update certification criteria where considerable progress will need to occur throughout the year to meet the December 31, 2022 deadline, including the new standardized FHIR application programming interface (API) for patient and population services.[6]

A more recent ONC blog post also contained the chart below showing the percent of products currently certified to each of the Cures Update criteria that are, at present, required by December 31, 2022.[7]

[6] https://www.healthit.gov/buzz-blog/healthit-certification/an-upcoming-milestone-in-our-interoperability-journey
[7] https://www.healthit.gov/buzz-blog/healthit-certification/on-the-road-to-cures-update-certified-api-tech

Progress of Certification to the 2015 Edition Cures Update Criteria Required to be Available by December 31, 2022 (as of August 2022)



Unprecedented progress needs to be made in the next four months for all clinicians to have access to the Cures Update from their current vendor. EHR adoption, switching, or upgrading is expensive and time-consuming. There is generally a year of preparation before a new EHR is used at a practice. This process necessitates work in preparing electronic patient records for the transition, staff education and training, and other data-merging actions that are vital to the safety and security of this important information. **A rushed transition could lead to the loss of records, missing diagnosis codes, loss of e-prescribing functionality, access designations that are applied improperly, and other substantial issues that could negatively impact patient care or prevent it entirely.**

Due to the COVID-19 pandemic leading to the current, widely documented healthcare staff shortages nationally, providers and practices are already running short on time and resources. It is crucial that providers have enough time and resources to install these new updates before the Cures Update is required to be used within MIPS.

Only 7.49% of vendors are certified to the API criterion, which reflects how unprepared EHR vendors and practices are for the transition to the Cure Edition within the previously finalized timeline. **We ask CMS to ensure that clinicians using an EHR vendor that does not meet the deadline for the Cures Update have access to the PI decertification hardship exception for the 2023 reporting year.** ONC states that vendors with a (g)(10) API certification represent 77% of ambulatory clinicians, yet our discussions with our clients make it apparent that this proportion reflects practices with the resources to afford large market-share vendors and are often affiliated with larger hospitals or health.

3. Hardships

MA enthusiastically supports CMS' decision to maintain 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.

4. Scoring: Multiple PI Scores

MA is strongly 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.**

5. Proposed Changes to Promoting Interoperability Objectives and Measures

1. Public Health and Clinical Data Exchange Objective

<u>Limiting Pre-Production and Validation to One Year</u>

MarsdenAdvisors opposes the proposal to limit the number of years that clinicians can be in the Pre-Production and Validation stage of active engagement. Moving from the Pre-Production and Validation stage to the Validated Data Production stage is not only clinician-

dependent, but also clinical data registry (CDR)- or public health agency (PHA)-dependent as the CDR or agency must qualify the data.

As such, it can take months or more of work for a clinician or practice to get their data qualified for a single registry, let alone for the multiple required registries. We have heard from clients that getting to the Validated Data Production stage of active engagement can take well over a year and is widely variable based on the clinician's state and locality.

Given these issues, clinicians need additional time to move from the Pre-Production and Validation stage to the Validated Data Production stage. Alternatively, CMS could offer an exclusion for clinicians unable to comply with this short timeline with the resources they have available or due to the PHA's or CDR's inability to meet the timeline CMS proposes.

Electronic Case Reporting (eCR) Measure: Clinicians and Practices in More than One Jurisdiction

MarsdenAdvisors requests clarification from CMS on what the proposal to limit active engagement option 1 to one year would mean for clinicians and practices that operate in more than one jurisdiction and more than one eCR. If they are in the Validated Data Production stage in one eCR and in Pre-Production in a second, what would they be required to report to CMS?

2. Query of Prescription Drug Monitoring Program (PDMP)

Changing to a Required Measure and Available Exclusions

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.**

Expansion of to Include Schedule III and IV Drugs

MA requests clarification on the proposed expansion. If finalized, will the Schedule III and IV drugs be limited to opiates in the same way that the Schedule II drugs evaluated by the

measure are currently? Will the Schedule II drugs covered by this measure be expanded to include non-opiate medications?

6. **Proposed New Health Information Exchange (HIE) Measure: Enabling Exchange Under the Trusted Exchange Framework and Common Agreement (TEFCA)**

CMS is proposing to establish a new optional TEFCA measure within the HIE objective which, if reported on, would satisfy the HIE category points.

MarsdenAdvisors believes this measure is premature. TEFCA is still in its infancy, with the Common Agreement and Qualified Technical Framework only released earlier this year. Much work must be done before this measure is fully executable, including QHINs joining TEFCA and state HIEs joining QHINs. **As such, we urge CMS to maintain this measure as optional in future years and during the growth of the TEFCA-HIE network.**

We also ask CMS for clarification on the requirements for providers participating in multiple state HIEs (e.g., clinics near state borders). If one state's HIE is a TEFCA signatory and the other state's HIE is not, would the clinician qualify for a "yes" attestation under this new proposed measure?

7. **Request for Information on TEFCA**

MA strongly recommends CMS not require TEFCA participation in any future year. TEFCA remains in its infancy (the Common Agreement and Qualified Technical Framework were only released earlier this year) and pushing adoption at this stage is premature. However, encouraging providers to look into any potential benefits of participation through widespread, easy-to-understand, multi-modality education would allow providers time to analyze workflows, costs, and benefits of participation. Currently, there is a lot of confusion about TEFCA in the provider community. Elucidating the program will likely drive participation without burdensome mandates or penalties.

8. **Request for Information on the Provider-to-Patient Exchange Objective**

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.**

MarsdenAdvisors understands CMS' desire to expand measurement of provider-to-patient exchange, but strongly disagree CMS' discussion of adding a measure of patient access to their health information. View, Download, and Transmit (VDT), the measure that used to evaluate this, was deeply problematic, particularly for ophthalmology.

Not only is it inappropriate to score clinicians on an action over which they have no control, in ophthalmology the patients suffer from low vision, making reading on screens difficult or even painful. In many cases, practices could only successfully report the VDT measure by hiring staff to help patients access their information while they were in the office because the patient had no interest in doing so otherwise.

Even in this scenario however, practices would have to pay for additional staff. Given continued staff shortages, this would present a large burden on practices, especially for small and rural practices that are already operating on slim margins.

Reinstating any form of a measure that requires patients to actively access their information creates burden on both practices and patients. We strongly urge CMS not to take this step backward.

H. Cost Category

We remain concerned that the Cost category has not yielded predictable results based on practice patterns and best practices and encourage CMS to consider the stakeholder feedback received in the review of Wave 1 episode-based cost measures earlier this year.

i. Cataract Surgery Episode-Based Cost Measure

More detailed analysis of our concerns with this current measure and the potential modifications included in request for comment is available in our response to the Call for Public Comment for Measure Reevaluation.[8] Here we will summarize, at a high level, our evaluation.

We reiterate our concern that this measure disincentivizes the use of drugs prioritized through policies like the transitional pass-through policy and the non-opioid pain management exclusion. If surgeons become wary of using these drugs due to concerns over this cost

[8] https://2169937.fs1.hubspotusercontent-na1.net/hubfs/2169937/Current%20Site/pdfs/2022%20MIPS%20Stuff/MA_2022CostMeasureReEvalRFI_Comments_Final.pdf

calculation, CMS loses the ability to accurately gauge utilization rates through the pass-through or special payment status period.

Currently, we strongly oppose the inclusion of Part D drugs in this measure as the prices of Part D drugs are outside of physician control. There are two important reasons for our current opposition to the addition of Part D drugs in this measure's cost calculation – a lack of experience in MIPS with inclusion of Part D drugs in cost measures and a lack of reliable and proven infrastructure for real-time benefits analysis available to providers.

Additionally, we identify trigger code 66984 as the only relevant trigger code for this measure. Other trigger codes relate to more complex, and thus more expensive, procedures. For this same reason, we support the maintenance of the current exclusions to this measure, as it ensures that only routine procedures are being evaluated.

I. MIPS Value Pathways

i. Mandatory MVP Participation

In the 2022 Medicare Physician Fee Schedule 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 maintain traditional MIPS as an option in all future years.**

From our work with hundreds of clients reporting MIPS, it is clear that physicians are best situated to select the measures that are most meaningful to their practices and patients. For instance, while ophthalmology is a specialty that is solely focused on the diseases of the eye, there are several different subspecialties, and not all ophthalmologists of a particular subspecialty focus on the same population of patients.

In ophthalmology, for example, the retina subspecialty focuses specifically on diseases at the back of the eye, neuro-ophthalmologists focus on visual problems related to the nervous system (not the eyes), and cataract and refractive surgeons focus on the front of the eye. Moreover, it is not uncommon for a physician to focus on a specific condition within their subspecialty. As such, **we request that CMS work toward developing condition-specific MVPs**, rather than focusing on specialty-specific MVPs.

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.

ii. Subgroup Scoring Proposals

1. Quality Outcomes-Based Administrative Claims Measure Scoring

MarsdenAdvisors strongly opposes CMS' proposal to assign the subgroup an affiliated group's score, if available, to each selected outcomes-based administrative claims measure in an MVP and the associate proposal to assign a zero score if a group score is not available. Subgroups select their administrative claims measure for its specificity to the population relevant to their specialty. It is, therefore, inappropriate to, by default, assign the group's score to the subgroup. Only in the event where a subgroup score cannot be calculated should subgroups be assigned the group score.

If a group or subgroup is unable to be evaluated reliably on a measure, it is incongruous to assign a score of 0/10, and the measure should instead be suppressed for that subgroup. This alternative aligns with the Cost measure subgroup scoring proposal.

2. Cost Measure Scores

We support CMS' proposal to assign an affiliated group's cost score to a subgroup if it is available for the cost performance category in an MVP. We similarly support their proposal to exclude measures for which a group score is not available from the subgroup's final score.

3. Population Health Measure Scores

For each selected population health measure in an MVP, CMS proposes to assign the affiliated group's score to subgroups. **MardenAdvisors opposes this proposal because subgroups elect their population health measure to reflect the specificity of their treatment population, and that specificity is lost if the group score is assigned by default.** Only if a subgroup score cannot be calculated should subgroups be assigned the group score.

We support CMS' proposal to exclude a population health measure from a subgroup's final score if a group score is not available.

J. APM Performance Pathway (APP)

MA applauds CMS' 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.

K. Advanced APMs

i. Specialty-Specific Advanced APMs

MarsdenAdvisors encourages CMS to begin prioritizing the development and implementation of specialty-specific advanced APMs, particularly those evaluated and recommended by the Physician-focused Payment Model Advisory Committee (P-TAC).

Most advanced APMs are primary care-focused and the Center for Medicare and Medicaid Innovation (CMMI) has largely ignored PTAC's recommendations. These recommendations represent extensive work done by specialties and extensive vetting performed by PTAC and CMMI's decisions not to advance any of the proposals has led to widespread frustration and loss of confidence in the advanced APM development process.[9,10]

While we continue to believe that CMS should preserve a viable fee-for-service option under the QPP and we support the continuation of traditional MIPS, because that is the best option for most ophthalmologists and dermatologists who provide care on an episodic basis, **there should be some advanced APM options available to any specialist who wants to participate.**

ii. RFI: QP Determination Calculations at the Individual EC Level

MarsdenAdvisors appreciates CMS' acknowledgement of the role of current policies in disincentivizing specialist participation within APMs. But, **we do not agree that changing the QP determination to be solely at the individual clinician level will reverse this pattern.** We are

[9] https://www.medpagetoday.com/publichealthpolicy/medicare/83502
[10] https://aspe.hhs.gov/sites/default/files/private/aspe-files/207901/aspe-charting-future-directions-ptac.pdf

concerned that this potential plan of action would not only not solve the current problem, but would also continue a pattern of under-valuing specialty care.

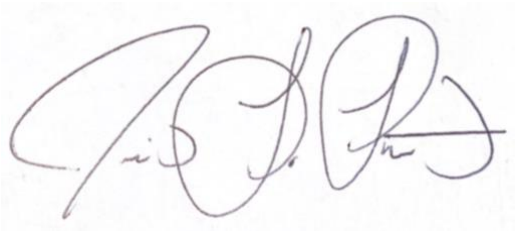
As CMS states in this proposed rule, specialists furnish proportionally fewer services leading to attribution when compared to primary physicians. This difference has created an environment where specialist participation can potentially lower an APM's threshold score. However, we do not agree that individual-level QP determinations are the best way to solve this problem, because, as CMS states, the methodology used in beneficiary assignment within the Shared Savings Program is "deliberately constructed such that assignment is largely based on primary care, rather than specialty care".

We agree with CMS' stated aim that specialists should not be removed from APM Entities because of the important part they play in the patient care continuum. As such, **we strongly suggest that a redesign of the beneficiary assignment methodology is necessary to create a complete patient-centered care experience that can include specialty care.** Specialists should be eligible for the same benefits as primary-care providers within APMs; eliminating those benefits due to an attribution methodology that does not appreciate their value is inappropriate and does a disservice to providers and, more importantly, to patients.

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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