September 9, 2024

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–1807–P] RIN 0938–AV33; Medicare and Medicaid Programs; CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments

Dear Administrator Brooks-LaSure,

Anatomy IT (AIT) is submitting our comments on the Centers for Medicare & Medicaid Services (CMS) proposed rule regarding the 2025 Quality Payment Program. AIT Value-based Care division 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

MIPS Performance Threshold

AIT appreciates and strongly supports CMS' proposal to maintain the performance threshold at 75 points for the 2025 performance year/2027 payment year. To ensure that MIPS policies do not lead to these unintended outcomes in future years, we ask CMS to remain nimble on whether to use the mean or the median in case the data is skewed by unforeseen circumstances.

Cost Measure Scoring Proposal

AIT applauds CMS' proposed changes to the cost measure scoring methodology.

MIPS Cost Measures: Pre-Rulemaking Transparency and Specialty Exclusions

AIT is deeply concerned about the lack of transparency and clarity in pre-rulemaking cost measure development, particularly in the post-field-test period. After field testing, Acumen can make (and has made in the past) significant changes to measures, including changes that impact attribution. Despite this, these changes are not clearly enumerated nor are the post-field-test refinements tested prior to CMS proposing the measure for inclusion in MIPS. This issue was highlighted with the version of the Rheumatoid Arthritis (RA) episode-based cost measure in this proposed rule. Please see our Cost Category comments (pg. 15) for more details.

To ensure that the public has accurate and up-to-date information on what is included in proposals, increased transparency is necessary.

Use Specialty Attribution Exclusions to Avoid Inappropriate Attribution

AIT strongly urges CMS and Acumen to use specialty attribution exclusions for existing and future MIPS Cost measures to ensure that only the clinicians responsible for the care of a condition or procedure are attributed the cost.

Cataract Episode-Based Cost Measure

AIT is deeply concerned about the negative impact of the proposed changes to the exclusions and the inclusion of Part B drugs on separate payment status in the Cataract Cost Measure. Please see our Cost Category comments (pg. 19) for a more detailed analysis and comment.

Advanced Practice Nonphysician Practitioners Who Do *Not* Provide Primary Care

Although CMS has not requested comment on this topic, we feel it is a priority to address this issue in order to ensure meaningful measurement. In both the Cost and Quality performance categories, there are several measures that are attributed only to certain specialties. These measures classify advanced practice nonphysician practitioners – NPs, PAs, and CCNSs – as primary care providers. This is problematic for specialty-only

practices that employ advanced practice nonphysician practitioners as it inappropriately classifies these practices as ones that provide primary care.

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 advanced practice nonphysician practitioners as primary care inappropriately scores specialty practices on primary care measures, such as the Total Per Capita Cost (TPCC) measure. **We urge CMS to address this problem promptly and to include a solution as early as in an Interim Final Rule for the 2025 performance period, if not also retroactively for 2023 and 2024.** A solution we recommend would be to allow these clinicians and practices to submit targeted reviews to show that they are not providing primary care.

Multiple PI Scores

AIT commends and deeply appreciates CMS' proposal to assign the highest score for the PI Category when a practice has multiple submissions for a single performance year, rather than assigning a score of zero to the entire category. Every year, there are clinicians and practices that are impacted by having multiple PI scores submitted. This proposed change will ensure that these practices are not penalized for non-performance-based factors.

Request for CMS to Add Outcome Measure Exception or Exclusion: Patients Who Pass Away During Follow-Up Window

AIT has seen issues surrounding outcome measure reporting when a denominator-eligible patient dies during the follow-up period. **We request CMS add an exclusion or exception for all outcome measures for denominator-eligible patients who die during the outcome window.**

Complete Ophthalmologic Care MVP Proposal

AIT strongly objects to the proposed Complete Ophthalmologic Care MVP proposal. Although CMS has improved this MVP from the earlier drafts and from the Comprehensive Ocular Care MVP released in December 2023, much of the feedback and many of the recommendations provided by the ophthalmic societies has been ignored. **This proposed MVP continues to offer many subspecialists no path for success under MIPS.**

Dermatologic Care MVP Proposal

AIT strongly objects to the proposed Dermatologic Care MVP proposal. Similar to our concerns about the Complete Ophthalmologic Care MVP proposal, we note that the recommendations of the relevant specialty societies have been repeatedly ignored.

Based on our evaluation of this MVP, it is likely we will see subspecialty practices with no path to a Quality score of 40/40, regardless of measure performance.

RFI on Sunsetting MIPS in 2029

AIT strongly recommends that CMS maintain traditional MIPS as an option in all future years.

As discussed in our comments on the proposed ophthalmology and dermatology MVPs, current MVP proposals do not provide meaningful comparisons or, indeed, opportunities for all included subspecialties to succeed.

Improve MVP Adoption by Streamlining Quality Category Scoring Methodology

While there is no one-size-fits-all approach to MVPs that will work for every medical specialty, we believe that modifying MVP scoring policy would, at minimum, acknowledge the variation in care provided by subspecialists and to different patient populations. To that end, we include recommendations on subspecialty MVP measure sets, topped out measure scoring within MVPs, and scoring measures without a benchmark within MVPs.

Detailed QPP Comments of Anatomy IT: Contents

SPECIFIC ISSUES ON THE QUALITY PAYMENT PROGRAM

I. Performance Threshold

AIT appreciates and strongly supports CMS' proposal to maintain the performance threshold at 75 points for the 2025 performance year/2027 payment year. We appreciate CMS' explicit consideration of the impact and unintended burdens that an increase in the performance threshold would have on small and rural practices.

Increased MIPS burden and a lack of adequate compensation has been shown to drive consolidation and disincentivize physician participation in Medicare, leading to barriers in access to care, particularly for vulnerable populations who rely on Medicare for essential healthcare services.[1, 2] Healthcare consolidation has consistently been shown to drive up the cost of care without improvement in quality.[3,4,5] In fact, a recent review shows that the acquisition by or affiliation with larger health systems is associated with a decrease in available services in rural hospitals and practices.[6]

To ensure that MIPS policies do not lead to these unintended outcomes in future years, we ask CMS to remain nimble on whether to use the mean or the median in case the data is skewed by unforeseen circumstances.

II. Reweighting Policies, PI Scores, and Targeted Reviews

A. Reweighting When a Third Party Intermediary Does Not Submit Data

AIT strongly supports CMS' proposal to adopt this reweighting policy beginning with performance year 2024. Every year, we see clients impacted by factors outside of their control due to a third party intermediary. Not all of these issues include a complete failure to submit data. Often, a third party intermediary will submit incomplete data. Therefore, **we ask CMS to finalize this proposed policy with the modification that this would also apply to circumstances in which the third party intermediary submitted inaccurate or incomplete data** (rather than only applying when no data was submitted).

B. Multiple Promoting Interoperability Category Scores

---

[1] Khullar et al. "Association Between Patient Social Risk and Physician Performance Scores in the First Year of the Merit-based Incentive Payment System"(JAMA, 2020), available at https://jamanetwork.com/journals/jama/fullarticle/2770410

[2] MedPAC Report to the Congress: Medicare Payment Policy | March 2023

[3] Schwartz et al. "What We Know About Provider Consolidation" (San Francisco, CA: Kaiser Family Foundation, 2020), available at https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/,2020).

[4] MedPAC, "March 2020 Report to the Congress: Medicare Payment Policy," March 13, 2020.

[5] Beaulieu ND, Chernew ME, McWilliams JM, et al. Organization and Performance of US Health

[6] Oyeka, O; Ullrich, F; Shane, D; Mueller, K. Changes in Service Offerings Post-System Affiliation in Rural Hospitals. RUPRI Center for Rural Health Policy Analysis, Brief 2023-2.

AIT commends and deeply appreciates CMS' proposal to assign the highest score for the PI Category when a practice has multiple submissions for a single performance year, rather than assigning a score of zero to the entire category.

Many practices that submit multiple entries do so unintentionally. For instance, an ACO representative might submit data on behalf of a practice, while the practice itself remains unaware of the submission. This proposal will help prevent unfair penalties. It will also ensure that scoring policies for PI are in alignment with those applied in other MIPS categories.

AIT supports the implementation of this policy starting with the 2024 performance year. **Additionally, we encourage CMS to permit practices affected by multiple 2023 PI submissions to request a targeted review. Since the targeted review deadline is before the final rule will be published, we ask that CMS accept these 2023 targeted review requests even if they are submitted after the deadline.** This extension would make it possible for practices to receive a non-zero PI score for 2023.

C. Advanced Practice Nonphysician Practitioners Not Providing Primary Care, Future Fixes and Targeted Reviews

In both the Cost and Quality performance categories, there are several measures that are attributed only to certain specialties. These measures classify advanced practice nonphysician practitioners – NPs, PAs, and CCNSs – as primary care providers. This is problematic for specialty practices that employ these clinician types.

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 advanced practice nonphysician practitioners as primary care-only inappropriately scores these practices on primary care measures. **We urge CMS to address this problem promptly and we would support a solution being included in an Interim Final Rule.**

Potential Solutions

One solution with infrastructure already in place would be to use the targeted review process to allow these clinicians and practices to submit proof to show that they are not providing primary care. A longer-term solution could be to evaluate ICD-10 codes on administrative claims to evaluate the percent of single-specialty conditions evaluated and treated by the clinician or practice.

III. MIPS Quality Category

A. Data Completeness Threshold

AIT applauds CMS' decision to maintain the current data completeness threshold until at least performance year 2028. While AIT understands that CMS wants more complete data under MIPS, we appreciate CMS' acknowledgement of the barriers to achieving a higher data completeness level, even among practices reporting in good faith and at top effort.

We are concerned, however, with CMS' stated intent to continue to "incrementally increase the data completeness criteria" and to incorporate "high data completeness thresholds in future years". **Not only will an increased data completeness threshold pose a disproportionately high burden on small and rural practices, but it also will not improve data accuracy**.

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 75% data completeness threshold for these practices but would be unable to meet a higher data completeness threshold. If the data completeness threshold is further increased, the impacted practices would receive significantly lower Quality category scores through no fault of their own.

If, for instance, a practice planning to submit eCQMs switches EHRs midyear, often the new EHR will not include data from encounters that occurred prior to the transition in the measure calculation. Neither CMS nor the majority of registries will aggregate data from two EHRs. In this case, the practice would be left with one option: manually extract the data. **We have seen that this is a substantial burden that no amount of experience with MIPS can or will remedy. Practices in situations like this rely on the current data completeness threshold to allow them to report on the data they have available in their current EHR.** *If a practice becomes required to manually extract and aggregate large amounts of quality measure data themselves, it is reasonable to expect unintentional errors.* Because of this, a higher data completeness threshold will not always result in more representative quality performance data.

We agree that it is important that quality data represent a clinician's true performance, rather than a cherry-picked sample. Circumstances, like EHR switches during the performance year, can make high data completeness thresholds not only hard to meet, but also difficult to meet *accurately.* For the reasons outlined herein, we strongly urge CMS to maintain the current data completeness threshold. **If CMS decides to continue increasing the data completeness threshold in the future, we recommend the following options to ensure that practices are able to continue to report quality data in good faith:**

- CMS-facilitated quality data aggregation: Allow practices to report quality data from multiple EHRs with an indication that they should be aggregated to determine the measure's final score.

- Shortened performance periods for special circumstances: If a practice switches EHRs during the performance period or encounters an unforeseen data completeness-related issue, allow the practice to report on the longest period of consecutive data available. For example:
    - If a practice switches EHRs in March and is unable to submit yearlong aggregate data, the practice would have 9 consecutive months of data available in the new EHR, on which they could report 100% data completeness.
    - If a practice switches EHRs in October, the first EHR would have 9 consecutive months of data available.
    - For practices unable to switch during the first or last quarter of the year (would have less than 9 consecutive months of data), allow the practice to apply for a Quality Category EUC.

- Extreme and Uncontrollable Circumstance Quality Category Exceptions: for practices that switch EHRs during the performance period or encounters an unforeseen data completeness-related issue.

B. Add Exclusion or Exception for Outcome Measures: Patients Who Pass Away During the Follow-Up Window

AIT has seen issues surrounding outcome measure reporting when a denominator-eligible patient dies during the follow-up period and we request that CMS issue a policy to exclude or except these patients from those measures. For example, measure 191 (Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery) only has two reporting options: 1. Performance met, or 2. Performance Not Met (Best-corrected visual acuity of 20/40 or better no achieved within 90 days, reason not otherwise specified). There is no exclusion or exception for patients that have a reason for not achieving the desired outcome. In instances in which patients expire before their follow-up appointment and within the 90-day window, there should be an exclusion or exception. **We request CMS add an exclusion or exception for all outcome measures for denominator-eligible patients who die during the outcome window.**

C. Support for Maintaining 3-Point Measure Scoring for Small Practices on Measures that Cannot be Accurately Scored Against a Benchmark

AIT supports CMS' decision to maintain the 3-point quality measure scoring policy for small physician practices for cases in which a measure cannot be scored against a benchmark (e.g., measure does not have a historical benchmark, data completeness is not met, or case minimum is not met).

D. Support for Maintaining 6-Point Bonus for Small Practices

AIT supports CMS' decision to maintain the 6-point quality bonus for small physician practices in all future years.

E. Topped Out Measure Scoring

AIT commends CMS for revising its approach to scoring certain topped-out measures, particularly to better accommodate specialty practices with a limited number of relevant quality measures. We agree that this decision will result in a more fair assessment of clinicians based on the measures available to them.

We want to highlight that we believe this proposal is only a first step. It is important to recognize that specialty measure sets do not account for the measures available to the included subspecialists. Thus, even if a measure set has a sufficient number of measures for a general specialty, it may still fall short for its subspecialties. For example, the refractive surgery subspecialty of ophthalmology only has five eCQMs available in the ophthalmology measure set. One of these five available measures is 7-point capped and another does not have a benchmark. **Given these issues, we encourage CMS to further evaluate measure options for *subspecialties* to ensure that they include a sufficient number of relevant, non-topped-out measures.**

F. Quality Measure Proposals

i. Measure 117: Diabetes: Eye Exam

AIT supports the proposed update to the denominator exclusion for both the MIPS CQM and eCQM collection types. Removing the encounter requirement for frailty exclusion will enable practices to more easily and accurately identify the appropriate population for this measure.

ii. Measure 130: Documentation of Current Medications in the Medical Record

AIT supports the proposed modification to the timing of the numerator action – allowing practices to perform quality actions on the encounter day rather than solely during the encounter itself. **If finalized, we request that CMS ensure Qualified MIPS registries can map to a date stamp, thereby verifying that the quality action took place on the encounter day.**

iii. Measure 137: Melanoma: Continuity of Care—Recall System

AIT opposes the removal of measure 137. Eliminating this measure would burden clinicians because the type of data currently being used by practices to satisfy this measure is difficult to translate to the newly proposed Melanoma: Tracking and Evaluation of Recurrence measure. The American Joint Committee on Cancer (AJCC) staging references are usually documented in PDF files, rather than in structured text that can be easily mapped to EHR fields. As a result, identifying the appropriate denominator population for the new proposed measure, Melanoma: Tracking and Evaluation of Recurrence, would be very challenging for practices.

Moreover, the proposed five-year lookback period for the Melanoma: Tracking and

Evaluation of Recurrence measure could further complicate accurate denominator calculations due to transitions between EHR systems. When practices switch to new EHR systems, historical data from the previous EHR is often retained as PDF attachments rather than as structured data fields.

Furthermore, as we have mentioned in previous comments, dermatology has limited benchmarked Quality measures. 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. **AIT urges CMS to also take this into account and to maintain sufficient specialty-specific MIPS Quality measures.**

iv. Measure 176: Tuberculosis Screening Prior to First Course of Biologic and/or Immune Response Modifier Therapy

AIT generally supports updating this measure to reflect the medications used. **We request that, if finalized, CMS clearly communicate a comprehensive list of the additional biosimilar medications that will be added to this measure by December 2024. This information was not included in this proposed rule, and we will need time to help practices to implement these changes.**

v. Measure 236: Controlling High Blood Pressure

AIT supports CMS' proposed update to frailty exclusion criteria. Similar to the proposed update for measure 117, removing the encounter requirement for frailty exclusion will help practices to more effectively and accurately capture the appropriate patient population for this measure.

vi. Measure 277: Sleep Apnea: Severity Assessment at Initial Diagnosis

AIT supports CMS' decision to add the denominator exclusion for patients previously diagnosed with OSA and severity assessed by another provider. We agree that this will remove the necessity for unnecessary repeat assessments for clinicians reporting this measure.

vii. Measure 317: Screening for High Blood Pressure and Follow-Up Documented

AIT supports CMS' proposal to eliminate the minimum timeframe for follow-up screenings for patients with elevated BP readings for all collection types. We agree that this change would enable clinicians to exercise their judgment in recommending follow-up plans based on each patient's health status, thereby personalizing care to better meet individual needs and ultimately enhancing the quality of care delivered.

viii. Measure 374: Closing the Referral Loop: Receipt of Specialist Report

AIT supports CMS' proposal to require documentation of patient no-shows or missed appointments in the reports sent to referring clinicians.

ix. Measures 500 and 501: Acute Posterior Vitreous Detachment (PVD)

For measures 500 and 501, **AIT requests clear guidance on what specific coding will be added to indicate acute PVD.** Currently, the measure specification for measure 500 does *not* require a HCPCS code for acute PVD, while the measure specification for measure 501 does. Since CMS is proposing to modify both of these measures to "add coding for acute PVD", we request that the coding requirements be consistent for these two measures.

We would also like to note that the 2024 measure specifications for 500 and 501 both have the following definition of Acute PVD specified in the Denominator section "Acute PVD – For the purposes of this measure, acute PVD and vitreous hemorrhage is defined as recent onset of 30 days or less. For PVD, acute can be documented as new onset vitreous separation or vitreous detachment." This indicates that these measures could be mapped to keywords for reporting, rather than relying on coding. **We are requesting that CMS allow providers to use *either* the HCPCS code *or* the field mapping to identify the patient population.**

Since a significant percentage of clinicians do not use the acute PVD HCPCS code, there will need to be significant education required to implement new practices should the code be required for these measures in 2025. **Therefore, in addition to making the denominator requirements the same for 500 and 501, we request that CMS clarify and clearly communicate what the coding changes for these measures will be prior to December 2024. This would allow both us and medical societies time to educate our clients and members to ensure they are able to code appropriately for these measures for a full year starting on January 1, 2025.**

x. Measure 503: Gains in Patient Activation Measure (PAM®) Scores at 12 Months

AIT supports the proposed updates to this measure. We agree with the proposal to lower the minimum performance threshold for collected follow-up PAM® surveys from 50 percent to 25 percent. We also support the proposed modification to the denominator criteria to require two visits. This will ensure that patients who are lost to follow-up do not count against a reporting clinician.

xi. New Measure for Adult COVID-19 Vaccination Status

AIT is concerned about the implementation feasibility of this proposed measure. Many EHRs are do not have discrete fields or options for each of the vaccine manufacturers. As the required vaccination course varies based on whether a patient received a single- or two-dose regimen for their initial vaccination course, it will be difficult to determine if a patient is up-to-date. We ask CMS to use one of the following strategies to allow this measure to be accurately operationalized:

- Ensure EHR systems are capable of recording the specific COVID-19 vaccination product administered prior to finalizing this measure
- Allow patient attestations for recipients of the original COVID-19 vaccine series as sufficient data, or

- Focus the measure's requirements only on vaccine doses given subsequent to the original series.

IV. MIPS Improvement Activities Category

A. Category Weight and Reporting Period

AIT appreciates the consistency in category weight and reporting period for the Improvement Activities (IA) Category for performance year 2025.

B. Scoring: Small Practices

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. **AIT supports maintaining special scoring for small practices and encourages CMS to continue this policy in future years.**

C. Category Scoring Changes

AIT commends CMS for its decision to simplify the reporting and scoring process for the Improvement Activities Category. We support the proposal to eliminate the weighted methodology and, instead, assign equal point values to each IA. By simply requiring practices to attest to a fixed number of IAs, CMS will reduce the administrative burden associated with this category.

AIT strongly encourages CMS to maintain the requirement of attesting to a defined number of IAs in all future years.

D. Proposed Removal of IA_EPA_1: Provide 24/7 Access to MIPS Eligible Clinicians or Groups Who Have Real-Time Access to Patient's Medical Record

AIT opposes the proposed removal of IA_EPA_1. We urge CMS to retain this crucial improvement activity because it enhances patient access to clinicians and is highly valued by patients. For example, our clients have indicated that this improvement activity helps them ensure that their schedules are able to accommodate their patients' urgent medical needs. Retaining IA_EPA_1 in MIPS will motivate clinicians to be available to their patients when needed, leading to improved patient experiences and better care.

V. MIPS Promoting Interoperability (PI) Category

A. Multiple Data Submissions

AIT commends and deeply appreciates CMS' proposal to assign the highest score for the PI Category when a practice has multiple submissions for a single

performance year, rather than assigning a score of zero to the entire category.

Many practices that submit multiple entries do so unintentionally. For instance, an ACO representative might submit data on behalf of a practice, while the practice itself remains unaware of the submission. This proposal will help prevent unfair penalties. It will also ensure that scoring policies for PI are in alignment with those applied in other MIPS categories.

AIT supports the implementation of this policy starting with the 2024 performance year. **Additionally, we encourage CMS to permit practices affected by multiple 2023 PI submissions to request a targeted review. Since the targeted review deadline is before the final rule will be published, we ask that CMS accept these 2023 targeted review requests even if they are submitted after the deadline.** This extension would make it possible for practices to receive a non-zero PI score for 2023.

B. New TINs Formed with Fewer than 180 Days Remaining in Performance Year

AIT requests that CMS provide guidance on what practices can submit when they are formed as a new TIN after July 5 of the performance year (fewer than 180 days from the end of the performance year). We have clients in this scenario and, after conversations with CMS, we remain unsure how to proceed. As any data submitted under the new TIN must only be from that TIN, there is no way for these practices to meet the 180-day performance period. *For practices that want to report PI and are willing to do so for the time they have available after the TIN is established, we request CMS allow these practices to report on all days after TIN formation (even if that is fewer than 180 days).* For practices dealing with the unexpected administrative and/or IT issues that frequently occur for brand new practices, we request CMS allow them to be covered under a PI exception.

C. Maintenance of Automatic Small Practice PI Hardship

AIT enthusiastically supports CMS' decision to maintain automatic reweighting for the PI 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 PI category, small practice clinicians can continue to participate in MIPS and provide quality care to those who need it most.

D. RFI: Public Health and Clinical Data Exchange Objective

AIT appreciates the opportunity to provide feedback on the future of the PI Public Health and Clinical Data Exchange objective. We are pleased to read that CMS is working closely with ONC and the CDC to improve the health IT infrastructure for case reporting and that CMS recognizes the challenges posed to clinicians and practices by the health IT used by public health agencies (PHAs). **While we agree that the PHA data exchange infrastructure needs to be modernized, we do not see the MIPS PI category as a viable or effective lever to increase clinician-PHA data exchange. The current issues with clinician-PHA data exchange derive**

largely from communication between EHRs and PHAs, not from clinicians. There are significant barriers to improving seamless data exchange with PHAs including:

- Incomplete or out-of-date state lists of reportable conditions
- Unclear or misleading information on state websites
- PHAs with insufficient resources to onboard new clinicians or EHRs in a timely manner
- Significant state-by-state variation in:
    - Reportable conditions
    - Whether a condition must be reported only if a patient is diagnosed or tests positive, or if a condition must be reported even if it is only suspected
    - The types of providers allowed to participate
    - The data the PHA requests and the vocabulary standards used

The significant state-by-state variations and widespread barriers make it difficult for clinicians to comply with current requirements in the Public Health and Clinical Data Exchange Objective. To remedy these issues, **HHS's efforts should remain focused on improving the state PHA infrastructure.** States likely need assistance and guidance in modernizing and streamlining their PHA infrastructure and information availability as both the financial and personnel resources available in each state's PHA are also highly variable. Often, states do not even have up-to-date information on their website. **One method to reduce the burden on clinicians is to create an up-to-date, centralized repository of each state's readiness and their participation requirements (e.g., provider type, EHR, case volumes, conditions treated).**

VI. MIPS Cost Category

A. Pre-Rulemaking Cost Measure Development and Transparency

AIT is deeply concerned about the lack of transparency and clarity in pre-rulemaking cost measure development, particularly in the post-field-test period. After field testing, Acumen can make (and has made in the past) significant changes to measures, including changes that impact attribution. Despite this, these changes are not clearly enumerated nor are the post-field-test refinements tested prior to CMS proposing the measure for inclusion in MIPS.

This issue was highlighted with the version of the Rheumatoid Arthritis (RA) episode-based cost measure in this proposed rule. After field testing the measure, Acumen added ophthalmic suspensions (eye drops) to the Part D condition-related prescription list. *This refinement has the potential to cause ophthalmologists who treat the ophthalmic complications of rheumatoid arthritis to be attributed the entire cost of care of those RA patients.*

Despite the magnitude of this refinement, there were only two ways to discover the change: 1. Reading through the entire list of Part D measures (for a measure

that ophthalmology had no reason to consider relevant and did not see in field testing), or 2. Read through the post-field test materials, up to page 30 of the measure justification (not included in the proposed rule materials).

We only identified this change because we were reviewing this measure for our orthopedics clients.

Strategies to Increase Transparency

To ensure that the public has accurate and up-to-date information on what is included in proposals, increased transparency is necessary. Without transparency, measures will be finalized without, effectively, allowing the public an opportunity to comment. Moreover, as we saw with the Diabetes Cost Measure last year, when attribution is not clear it creates crises that must be responded to, rather than prevented. Therefore, we strongly urge CMS to implement the following steps to increase transparency:

- Conduct additional field-testing of cost measures that undergo post-field-test refinements; particularly those that could reasonably be expected to subject additional specialties to the measure or change attribution in any way.
- Publish a list of the number of clinicians in each specialty attributed a measure (and percentage of MIPS ECs of that specialty attributed), for both initial field testing and post-field-testing refinements.
- For the first two years a new cost measure is used in MIPS, implement the measure on an information-only basis (not counted in the MIPS Cost score calculation). The first year would provide insight into how measures are attributed and scored; the second year would provide insight and an opportunity to test any refinements made based on any issues encountered in year one.

Use Specialty Attribution Exclusions to Avoid Inappropriate Attribution

AIT strongly urges CMS and Acumen to use specialty attribution exclusions for existing and future MIPS Cost measures to ensure that only the clinicians responsible for the care of a condition or procedure are attributed the cost. It has never been the intent of Cost measures to penalize clinicians who only treat complications, but not the measured condition. Therefore, it is of the upmost importance and urgency that specialty exclusions be utilized to ensure specialists who do not manage a condition, but only treat complications, are not inappropriately attributed to measures. This is particularly important for episode-based chronic condition measures as this type of inappropriate attribution is a known and continuing issue.

B. Cost Measure Attribution Issues

Advanced Practice Nonphysician Practitioners Who Do Not Provide Primary Care and the Total Per Capita Cost Measure

In the Cost performance category, there are several measures that are attributed only to certain specialties. These measures classify advanced practice nonphysician

practitioners – NPs, PAs, and CCNSs – as primary care providers. This is problematic for specialty practices that employ these clinician types, and particularly problematic under the Total Per Capita Cost (TPCC) measure.

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. This practice, and others like it, are attributed the TPCC measure, even though clinicians and groups only providing specialty-specific, non-primary care (like dermatology, ophthalmology, and orthopedics) are meant to be excluded from TPCC.

In the 2020 QPP Final Rule, CMS recognized that certain specialists, like ophthalmologists and dermatologists, should not be attributed the TPCC measure and excluded them. However, under current policies, this designation of advanced practice nonphysician practitioners as primary care-only inappropriately scores specialty practices on this measure. **AIT asks CMS to urgently address this problem for the TPCC measure and 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.**

Solve Inappropriate Cost Measure Attribution Through Use of Specialty Exclusions

In the 2020 QPP Final Rule, CMS implemented specialty exclusions to address the problem of attributing the TPCC measure to clinicians who did not manage a patient's total care. This was not the first attempt at fixing TPCC attribution, but it is the step that significantly improved attribution of the TPCC measure. For example, we no longer saw ophthalmologists attributed the costs of hernia revisions.

As this case shows, *using specialty exclusions is the most reliable and efficient method of avoiding inappropriate attribution of cost measures*. **We ask CMS to consider this precedent and to employ specialty exclusions in episode-based cost measures as well.**

By excluding HCFA Specialties that do not manage the measured condition from the measure, CMS and Acumen can avoid situations – like what we saw with the Diabetes Cost Measure in 2022 – in which clinicians who only treat complications of a condition, but do not manage the condition itself, are attributed the entire cost of care for the patient's care. For example, in 2022, we saw ophthalmologists and dermatologists be held accountable for the costs of surgeries to create A-V fistulas for dialysis access, limb amputations, and cardiovascular disease. We appreciate CMS' prompt response and investment of resources to fix these issues with the Diabetes Cost Measure.

The problems created by trying to encompass too large of a population for measurement can be seen in both the TPCC and Diabetes Cost Measure. These examples not only affected clinician reimbursements, but also created more work and incurred additional cost to the government to correct. **Specialty exclusions can help ensure that we don't see these issues with other cost measures in the**

future.

AIT strongly urges CMS and Acumen to use specialty attribution exclusions for existing and future MIPS Cost measures to ensure that only the clinicians responsible for the care of a condition or procedure are attributed the cost.

C. Cost Measure Feedback Reports and Specifications

Cost Measure Feedback Reports

AIT requests more information be provided in the Cost measure feedback reports. Though we appreciate the improvements in the 2023 cost measure feedback reports, they are still difficult to use in a meaningful way. In reviewing the feedback provided to our clients, we have had difficulty garnering actionable insights. As a division, almost all we work on every day is MIPS. We would like to emphasize that, if we struggle to find meaningful information in these reports, clinicians do as well.

In order to recommend meaningful changes, we need additional context, including:

- Date of service: Currently we only have the date of the trigger
- Provider who billed the service (name and practice)
- Subgroup of episode
    - For example, the Cataract Cost measure: ASC vs HOPD and bilateral vs unilateral
- National average costs displayed in an easily human-readable manner
    - Overall average cost
    - Part B drugs
    - ED visits, etc.

AIT strongly recommends CMS improve the usability of Cost measure feedback reports and conduct extensive testing and training to ensure they are understandable, user friendly, and actionable.

Cost Measure Specifications

AIT continues to see ambiguities and portions of Cost measures that are implemented in a way that conflicts with the measure specification. We ask CMS to review the specifications and ensure they provide correct information.

As an example, in the Cataract Cost Measure specification, CMS states the following: "The Routine Cataract Removal with IOL Implantation episode-based cost measure evaluates a clinician's risk-adjusted cost to Medicare for patients who undergo a procedure for routine cataract removal with IOL implantation during the performance period." However, we have recently discovered that the measure does not evaluate procedures performed during the performance period, but rather procedures with a cost episode window that ends during the performance period.

In the same measure specification, the term bilateral is used, but not defined. As

clinicians, we assume that bilateral would include any episode in which cataract surgery is performed for both eyes during the episode window. Upon reviewing the performance feedback reports, we are seeing that this is not the case. Instead, A second eye surgery done within 30 days of the first is considered bilateral whereas from 31 days onwards it is considered unilateral. *This misinformation will increase the costs for clinicians and therefore should be clarified.*

D. Cost Measure Scoring

AIT wholeheartedly endorses CMS' proposal to revise the cost measure scoring methodology, beginning with performance year 2024, to more closely align with the performance threshold and to use standard deviations to calculate performance ranges. We thank CMS for acknowledging and addressing the significant and negative impact of small variations in episode costs.

E. Rheumatoid Arthritis Episode-Based Cost Measure

AIT opposes this measure as proposed due to the untested post-field-test refinements that have the potential to substantively impact attribution. After field testing the measure, Acumen added ophthalmic suspensions (eye drops) to the Part D condition-related prescription list. *This refinement has the potential to cause ophthalmologists who treat the ophthalmic complications of rheumatoid arthritis to be attributed the entire cost of care of those RA patients.*

As we outlined in parts A and B of this section, **it is pivotal that CMS and Acumen take steps to avoid inappropriate cost measure attribution *and* increase post-field-testing transparency. AIT would also like to request that ophthalmologists, optometrists, and dermatologists be specifically excluded from this cost measure.**

F. Cataract Surgery Episode-Based Cost Measure

AIT opposes the proposed changes to the exclusions and the inclusion of Part B drugs on separate payment status in the Cataract Cost Measure.

Name Change

AIT is concerned that the proposed name change may forecast future expansion of trigger codes.

AIT does not believe that additional trigger codes should be added to the Cataract Cost measure. When this measure was developed, our Senior Director of Health Policy was staffing one of the committee co-chairs. **Limiting the trigger code to 66984 was done after careful consideration to avoid unintended consequences, while capturing the overwhelming majority (92.1%**[7] **) of cataract surgeries performed in the United States**.

[7] Part B National Summary Data File https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Part-B-National-Summary-Data-File/Overview

One major concern with expanding the list of trigger codes is that including more complicated cataracts in the measure will have negative consequences for patient access to care. These more complicated cases may be appropriate for Quality measures, but that is only because quality measures do not penalize clinicians for the additional treatment costs required to reach a desirable outcome.

With most ophthalmologists in small or independent practices that operate on small financial margins, incurring a penalty for a low MIPS Cost score would be cost-prohibitive. We heard many concerns about this taking place before the cataract cost measure's first year in MIPS and we were able to reassure ophthalmologists that they would not be inappropriately penalized under this measure**. In these circumstances, if the trigger codes are expanded to include complex cataracts, there is a real possibility that patients requiring these procedures will be pushed to tertiary care treatment, resulting in delayed patient care and increased costs to Medicare.**

Our second major concern is that complex cataracts are also done by clinicians and practices for which cataract is an extremely low percentage of their care, for instance, cataract surgeries performed by retina surgeons for patients with retinal complications or comorbidities. **In this case, retina surgeons would get inappropriately picked up on this measure, causing 30% of their MIPS score to be based on the complicated cataract patients which make up only a small portion of the surgeons' practice.**

Inclusion of Part B Drugs on Separate Payment Status

Part B drugs on separate payment status, such as IHEEZO and Dextenza, should not be included in any cost measure. These drugs improve the quality of care and are greatly preferred by both physicians and patients.[8] [9] [10] [11]

IHEEZO

AIT opposes the inclusion of IHEEZO in the Cataract Cost Measure. IHEEZO is currently on passthrough status. The purpose of pass-through status is to encourage

---

[8] Donnenfeld E, Holland E. Dexamethasone Intracameral Drug-Delivery Suspension for Inflammation Associated

[9] Tyson SL, Bafna S, Gira JP, et al. Multicenter randomized phase 3 study of a sustained-release intracanalicular

[10] Larsen J, Whitt T, Parker B, Swan R. A Randomized, Controlled, Prospective Study of the Effectiveness and Safety of

[11] Figus M, Giansanti F, Villani E, Alió JL, Jančo L, Mercuri S, Camnasio S, Cagini C. Chloroprocaine 3% Gel as a Novel Ocular Topical Anesthetic: Results from a Multicenter, Randomized Clinical Trial in Patients Undergoing Cataract Surgery. J Ocul Pharmacol Ther. 2024 Mar;40(2):117-125. doi: 10.1089/jop.2023.0096. PMID: 38489057; PMCID: PMC10951689.

and measure the use of innovative treatments within Medicare, to ensure a high level of quality care for Medicare beneficiaries. Once passthrough status expires, the cost of these drugs will be bundled into the facility fee and, thus, not included in the calculation of Cost measures. While we appreciate CMS' desire to encourage cost-conscious care, **we believe disincentivizing the use of IHEEZO would limit the access of Medicare beneficiaries to valuable innovation and negate the incentives provided in passthrough status**.

Given the negative impact on the validity of pass-through utilization data, on clinicians' ability to assess new Part B drugs without fear of penalty, and on innovation, we urge CMS to forgo inclusion of drugs on pass-through status on any MIPS cost measure now or in the future.

Dextenza

AIT opposes the inclusion of Dextenza in the Cataract Cost Measure. Dextenza is currently on separate payment status. Dextenza is widely beneficial in routine cases and likely reduces unmeasured cost.

The use of Dextenza helps providers avoid negative outcomes related to patient capacity to adhere to postoperative care, and significantly reduces the administrative burden of that care. Dextenza has been a key factor in improving care for cataract patients by replacing the traditional postoperative care regimens that are difficult for patients to understand, remember, and self-administer. In fact, use of Dextenza has become standard of care in European countries[12] given the significant positive impact they have on patient outcomes.

Current traditional postoperative cataract care regimens require substantial counseling to explain to patients and caregivers – in aggregate, the amount of time required is equivalent to the workload of a full-time staff member.[13] **Traditional post-operative care for patients with limited dexterity is also a significant issue, considering the advanced age of patients undergoing cataract removal.**[14]

Removal of Exclusion Diagnoses

AIT does not believe that removing the exclusions is appropriate at this time. CMS is proposing to eliminate 62% of the exclusion codes for the Cataract Cost Measure.

Limiting the measure to episodes that do not include patients with significant ocular comorbidities was intentional to avoid unintended consequences, such as pushing patients to tertiary care. For further discussion on these concerns, please see our

---

[12] Javitt JC. Intracameral Antibiotics Reduce the Risk of Endophthalmitis after Cataract Surgery: Does the

[13] https://www.ophthalmologytimes.com/view/dexamethasone-inserts-after-cataract-surgery-saves-time-in-patient-counseling-surgical-planning

[14] https://www.healio.com/news/ophthalmology/20211217/using-intracanalicular-dexamethasone-insert-after-cataract-surgery-saves-office-time

discussion on trigger codes in the “Name Change” section above.

Moreover, when combined with the low case minimum required for this measure, removing the exclusions will likely result in a disproportionate negative impact on low-volume small practices. Removing these exclusions would not only likely push these practices over the 10-case minimum, but also do so solely because of more complex cases. In these practices, these complex cases would make up a larger percentage of the cases that comprise their Cost score, putting them at higher risk for a low score due to an unavoidable complication in a patient with significant ocular comorbidities.

Before CMS finalizes a removal of exclusion codes, we urge a thorough evaluation of attribution changes, particularly among small, low-volume practices.

G. Melanoma Resection Episode-Based Cost Measure: Current Issues

Flaps and Grafts

AIT is concerned that the risk adjustment methodology for this measure is not adequately accounting for medically necessary flaps and grafts. Per the measure specification, “Measure-specific risk adjusters include but are not limited to melanoma site (e.g., eyelid, lip, nose, ear), resection size and tissue transfer or rearrangement size, presence of flap/graft reconstruction procedure, and patients undergoing chemotherapy/immunotherapy".

After reviewing performance feedback reports for Anatomy IT practices scored on this measure, we have derived that practices that perform medically necessary flaps and/or grafts scored significantly lower on this measure compared to practices that do not perform grafts/flaps.

These more complex reconstructions requiring flaps and grafts are medically necessary for the appropriate treatment of both large melanomas and smaller melanomas in certain areas (e.g., face, eyelid, genitalia, etc...). During the measure development process, there was broad consensus on the need to ensure the costs of these medically necessary procedures are appropriately risk adjusted. While these procedures are listed in the risk adjustment for this measure, it is clear that the risk adjustment methodology is inadequately accounting for the cost variation of these procedures. **Therefore, we request that CMS do a comprehensive reevaluation of this measure for the establishment of appropriate subgroups for flap and graft procedures.**

While a reevaluation is occurring, we urge CMS to temporarily exclude melanoma resections that include flaps and/or grafts until the costs can be adequately adjusted. If these steps are not taken, clinicians performing medically necessary, complex resections will continue to be inappropriately penalized under this measure.

Staged Melanoma Excisions

AIT is also concerned about inappropriate treatment of staged melanoma excisions (slow Mohs) under this cost measure. Currently, a staged melanoma resection performed by the same clinician (Modifier 58) is considered a related cost to the initial melanoma resection and is included in the patient's episode of care if billed within the episode window. This means that their cost of care will be considerably higher than a non-staged excision or other lower cost treatment. *Staged melanoma excisions are necessary to ensure complex removal pathologically is critical for high cure rates in head and neck melanomas that are often clinically ill-defined.*

We ask CMS to consider sub-grouping episodes that include staged resections. Doing so should result in a more accurate cost evaluation of these patients.

Inbound Melanoma Referrals

From our analysis of Melanoma Resection Cost Measure feedback, we believe that dermatologists who receive referrals for patients with an existing melanoma diagnosis have a higher cost than those that biopsy and resect internally. *The observed cost difference appears to be* ***due solely to differences in coding between the two scenarios, not due to actual cost of care****.*

When the biopsy and resection practice are the same: the pre-trigger period code captured is traditionally Neoplasm of Uncertain/Unspecified Behavior (NUB) because, at the time of the biopsy, pathology results are not available. Practices rarely hold claims for pathology results, thus the pre-trigger time period does not include the melanoma/melanoma in situ diagnosis, but rather the NUB diagnosis. *Therefore, any New Patient code would include a NUB diagnosis, not a melanoma diagnosis.* This also leads to very few patients attributed to them in the pre-trigger period.

If the resection practice receives an outside referral for melanoma: These patients already have a confirmed melanoma/melanoma in situ diagnosis. The specialist who receives the referral then uses a melanoma-specific diagnosis code for the pre-op visit and any related testing. This causes these practices to have higher costs associated with them because more costs are associated with the episode than are for practices that perform the diagnostic biopsy and the resection.

This was not the intent of the measure. **We request this difference in biopsy practice to be taken into account when there is a Neoplasm of Uncertain Behavior diagnosis vs. melanoma diagnosis during the pre-trigger window.** Specifically, AIT recommends sub-grouping episodes that have a melanoma pre-op diagnosis vs those that do not.

VII. MIPS Value Pathways (MVPs)

A. Complete Ophthalmologic Care MVP Proposal

AIT strongly objects to the proposed Complete Ophthalmologic Care MVP proposal. We have closely followed and provided feedback on the development of an ophthalmology MVP. Although CMS has improved this MVP from the earlier drafts and from the Comprehensive Ocular Care MVP released in December 2023, much of the feedback and many of the recommendations provided by the ophthalmic societies has been ignored.

This proposed MVP continues to offer many subspecialists no path for success under MIPS. Under this MVP's proposed selection of quality measures, large practices in only four subspecialties (cataract, glaucoma, neuro-ophthalmology, and retina) would be able to achieve 40/40 points for Quality if reporting via eCQMs + QCDR measures. If reporting on MIPS. CQMs + QCDR measures, only two subspecialties (cataract and retina) would be able to achieve 40/40 points for the Quality category.

Moreover, many of our ophthalmology clients would be forced to report only on general, non-specialty-specific quality measures (e.g., Tobacco Use Screening) under this MVP. From our work with hundreds of clients reporting MIPS, and our review of this MVP in all of its iterations over the past few years, it is clear that ophthalmologists are the people best situated to select the measures that are most meaningful to their practices and patients.

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. 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. Because of this, we have previously recommended that CMS develop condition-specific MVPs, rather than focusing on specialty MVPs.

Clinicians whose practice mix and focus are 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. **If CMS truly wishes to provide more meaningful clinician-to-clinician comparisons, it is critical that MVPs include sufficient measures for every included subspecialty.**

B. Dermatological Care MVP Proposal

AIT strongly objects to the proposed Dermatologic Care MVP proposal. Similar to our concerns about the Complete Ophthalmologic Care MVP proposal discussed

above, we note that the recommendations of the relevant specialty societies – the voices of American dermatologists – have been repeatedly ignored.

Much like ophthalmology, dermatology has 10 subspecialties – such as pediatric dermatology, micrographic surgery, dermatopathology, and immunodermatology – several of which have little-to-no overlap. **Based on our evaluation of this MVP, it is likely that we will see subspecialty practices with no path to a Quality score of 40/40, regardless of their measure performance.**

Moreover, just like in ophthalmology, many of our clients would be forced to report only on general, non-specialty-specific quality measures (e.g., Tobacco Use Screening) under this MVP. **CMS' goal for MVPs is to provide meaningful comparisons of clinicians reporting the same MVP. It is clear that this is not possible under this proposed version.**

As we have previously recommended, **we believe the only way for CMS to create MVPs that draw meaningful comparisons that are valuable and insightful for patients is through condition- and procedure-specific MVPs, rather than focusing on specialty MVPs.**

Clinicians whose practice mix and focus are 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. **If CMS truly wishes to provide more meaningful clinician-to-clinician comparisons, it is critical that MVPs include sufficient measures for every included subspecialty.**

C. RFI: Transforming the QPP

Sunset of Traditional MIPS: MVPs Must Remain Voluntary

In this RFI, CMS stated their intent to sunset traditional MIPS and make MVP participation mandatory beginning with the 2029 performance year. **AIT 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 continue to request**

that CMS work toward developing condition-specific MVPs, rather than focusing on specialty-specific MVPs. **Alternatively, CMS can adopt the quality category scoring modifications that we suggest below.**

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.

Improve MVP Adoption by Streamlining Quality Category Scoring Methodology

While there is no one-size-fits-all approach to MVPs that will work for every medical specialty, we believe that modifying MVP scoring policy would, at minimum, acknowledge the variation in care provided by subspecialists and to different patient populations.

Subspecialty MVP Measure Sets

Instead of the current approach of having a list of quality measures in this MVP ordered by Measure ID, we suggest that CMS organize the quality measures into categories, each of which is relevant to a particular subspecialty. Cross-cutting quality measures, such as Tobacco Use Screening, would be in a separate category. If there are fewer than four quality measures in an MVP subspecialty category, then clinicians of that subspecialty would only be required to report those measures, rather than being forced to use generic measures in the MVP that are not relevant to their care or to not participate in the MVP at all.

Topped Out Measure Scoring within MVPs

To ensure equitable scoring rules and incentive participation in MVP, we ask CMS to use flat benchmarks to score 7-point capped measures in MVPs. This would also align, conceptually, with the policy in this proposed rule to apply flat benchmark scoring to measures that belong to specialty sets with limited measure choice and a high proportion of topped out measures.

New or Existing Measures or Measures without a Benchmark

Given the limited choice of available measures within MVPs, measures without a benchmark reported under the MVP should be scored using a 7-point floor (similar to the current policy for scoring measures in their first year in MIPS).

VIII. Advanced Alternative Payment Models (A-APMs)

A. Lack of Specialty-Specific A-APMs

AIT 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).

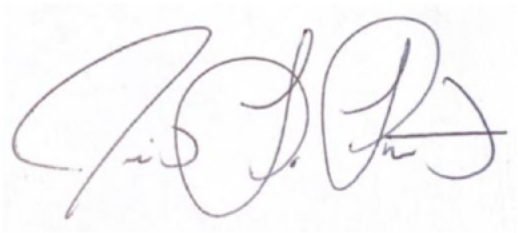
Most advanced APMs are primary care-focused and the Center for Medicare and Medicaid Innovation (CMMI) has largely ignored PTAC's recommendations. These recommendations represent extensive work done by specialties and extensive vetting performed by PTAC and CMMI's decisions not to advance any of the proposals has led to widespread frustration and loss of confidence in the advanced APM development process.[15,16]

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.**

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, Senior Director of Health Policy at Anatomy IT at jessica.peterson@anatomyit.com.

Sincerely,



Jessica L. Peterson, MD, MPH
Senior Director of Health Policy at Anatomy IT

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