December 29, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–5522–FC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS–5522–FC; Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year

Dear Administrator Verma,

On behalf of the 13,500 U.S.-based members of the American Academy of Dermatology Association (AADA), we are writing to provide comments on the Centers for Medicare and Medicaid Services (CMS) rule, Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year, published in the Federal Register on November 16, 2017. The AADA is committed to excellence in the medical and surgical treatment of skin disease; advocating high standards in clinical practice, education, and research in dermatology; and supporting and enhancing patient care to reduce the burden of disease. We appreciate the opportunity to provide comments on the proposed rule and urge CMS to take these recommendations and concerns into consideration when developing the final rule and formulating future policy.

Introduction

CMS is obligated to implement requirements of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) by proposing Quality Payment Program (QPP) policies to incorporate quality measurement into payments and to encourage participation in alternative payment models. There are two possible ways to participate in the QPP. First, clinicians may participate in the Merit-Based Incentive Payment System (MIPS). MIPS has four components: Advancing Care Information (ACI), Improvement Activities (IA), Quality, and Cost. The second participation option is through becoming a Qualified Participant (QP) in an Advanced Alternate Payment Model (APM).
I. PROVISIONS OF THE RULE

A. Extreme and Uncontrollable Circumstances

CMS includes an “automatic extreme and uncontrollable circumstance” policy in the interim final rule. This will give CMS discretion not to require MIPS eligible clinicians to submit an application for reweighting the performance categories in cases where an extreme and uncontrollable circumstance, such as an act of nature (for example, hurricanes and wildfires), affects an entire region or locale. Clinicians in the disaster areas of Irma, Harvey, and Maria can be exempt from MIPS requirements in the 2017 without submitting a hardship exception application. The regions impacted by these events are defined as a major disaster county, municipal (municipio in Spanish), or county equivalent by the Federal Emergency Management Agency (FEMA).1 The AADA fully supports this policy, and this rapid and appropriate application of the exemption for extreme and uncontrollable circumstances. We recommend that if any site of a practice with multiple sites is impacted, the entire practice should receive the exemption.

If not in the designated disaster areas, if a MIPS eligible clinician’s CEHRT is unavailable as a result of extreme and uncontrollable circumstances (e.g., a hurricane, natural disaster, or public health emergency), the clinician may submit a hardship exception application to be considered for reweighting of the Advancing Care Information performance category. This application was due by December 31, 2017. The final rule with comment period extends this reweighting policy for the three other performance categories (Quality, Cost, and Improvement Activities) starting with the 2018 MIPS performance period. This hardship exception application deadline is December 31, 2018. This expansion of the exemption for extreme and uncontrollable circumstances is appreciated, and should be continued in future years for all performance categories.

B. Small Practices

Small practices are defined as those with 15 or fewer clinicians. CMS allowed practices to attest to being small practices in 2017, but encountered significant operational issues because there was a need to account for small practices prior to the beginning of a performance period. Rather than placing the operation burden of attesting prior to the beginning of 2018, CMS finalized a proposal to use claims data from September 1, 2016, through August 31, 2017, to determine the number of clinicians in a practice.2 The AADA disagrees with CMS’s decision to not accept our

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1 82 Fed Reg 53898
2 82 Fed Reg 53581.
recommendation to use three months of claims data to determine practice size, beginning 7 months (June 1) and ending 4 months (August 31) prior to the beginning of the reporting period, and it’s rejection of the option to allow practices to attest to their small size. We hope that, in future years, CMS will allow an attestation period that begin as early as July 1 of the year prior to the reporting period.

Small practices will be given a 5-point addition to the final MIPS score, as long as data is submitted on at least one performance category in an applicable performance period. CMS will give clinicians in small practices three points instead of one for incomplete quality data reporting. The low volume threshold will exempt many clinicians from QPP requirements. The AADA appreciates these accommodations for small practices.

CMS finalized a small practices exemption from the Advancing Care Information Electronic Health Record (EHR) requirements if they attest that there are overwhelming barriers to procuring a certified EHR, such as the exorbitant cost. We support this exemption, and recommend that it be continued in future years.

CMS estimates that at least 80% of clinicians in small practices will receive a neutral or small positive MIPS payment adjustment. We greatly appreciate the CMS proposals that aim to alleviate much of the QPP burden on small practices.

C. Exclusions - Low Volume Threshold

The Secretary has authority to determine a low volume threshold, below which clinicians are exempt from QPP requirements, are not subjected to potential penalties, and are not eligible for any bonuses. We commend CMS for increasing the low volume threshold to $90,000 or 200 patients per clinician\(^3\). This threshold should not be decreased in future years.

D. Virtual Groups

CMS finalized implementation of virtual groups for the 2018 calendar year performance period. A virtual group is a combination of two or more Taxpayer Identification Numbers (TINs) that include groups with 10 or fewer eligible clinicians that elects to form a virtual group. CMS is not limiting the size of virtual groups. If the group chooses to join or form a Virtual Group, all eligible clinicians under the TIN would be part of the Virtual Group (VG). The deadline for forming a virtual group is December 1, 2017. Formal written agreements for all participants are required, binding the participants to the

\(^3\) 82 Fed Reg 53587.
virtual group for the performance year. CMS provided technical assistance, including an agreement template, via subregulatory guidance. CMS allows virtual groups with 16 or fewer NPIs to have small practice status, allowing them to have lower requirements for reporting, ACI, and improvement activities.

Most policies that apply to groups also apply to Virtual Groups. This option is intended to assist small practices, allowing them to gain the advantages of group reporting, such as getting credit for Improvement Activities of other Virtual Group members.

Because of the lack of understanding of the VG concept, and the requirement for applying in 2017, it is unlikely that many clinicians will participate in this option in 2018.

CMS made good progress toward establishing requirements for virtual groups. We agree with most of the recommendations. However, we disagree with the proposal that a virtual group would be identified as having a small practice status only if the virtual group does not have 16 or more clinicians. Because virtual groups will be made up of TINs that would qualify for the accommodations for small practices, we continue to recommend that all virtual groups be granted small practice status.

With CMS providing a number of practice support resources to help guide interested and eligible participants consider this option, we request that CMS make available any and all lessons learned about virtual group election, formation and participation by the next 2019 proposed rule so that all stakeholders can use this information when considering virtual groups in 2019 and in the future. CMS will need to make future adjustment and further enhancements to make virtual group a more compelling and attractive option for eligible participants in solo and small group practice settings, including but not limited to offering additional incentives.

E. Group Reporting

We recognize the challenge CMS faces with streamlining group size determination, and appreciate the continued efforts to make this approach more reasonable. We acknowledge the current operational constraints CMS faces in assessing and determining group reporting, and we support the need for groups to be notified as soon as possible of their status to help relieve unnecessary confusion, limit administrative burden, and avoid participants’ frustration. Finally, we commend CMS for considering innovative ways address a potential need for clinicians in larger groups to participate as a subset or “subgroup” as a future MIPS option, and hope that this option can be implemented in

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4 82 Fed Reg 53598.
future years. Such a forward-thinking approach may be conducive for specialty “subgroups” within multi-specialty clinics.

F. Performance Period

The AADA agrees with the CMS decision to keep the performance period for the improvement activities and advancing care information performance categories at a minimum of a continuous 90-day period within CY 2018, up to and including the full CY 2018 (January 1, 2018, through December 31, 2018)\(^5\). The full year reporting period for cost performance is reasonable, though the methodology for assigning costs is flawed. A more appropriate performance period for the quality category would be a minimum of a continuous 90-day period within CY 2018, rather than the full calendar year reporting requirement. A minimum 90-day quality reporting period should be used for the future iterations of this program, with longer periods allowed to meet minimum volume thresholds.

It is important that CMS reduce the amount of time between the performance period and feedback reports from CMS in order to allow practices time to make necessary adjustments before the next reporting period begins. Feedback to clinicians should be delivered by CMS to clinicians beginning no later than April 1, 2019.

II. MIPS CATEGORY MEASURES AND ACTIVITIES

A. Submission Mechanisms

We are appreciative that CMS intends to allow use of multiple reporting mechanisms per MIPS category, including claims, EHR, Qualified Clinical Data Registry (QCDR), qualified registry, and attestation via CMS web interface for quality, ACI, and improvement activities. Administrative claims will be used for the cost category\(^6\).

B. Quality Performance Measures

The Dermatology specialty measure set was increased from 11 to 12 measures, with the addition of measure 440, for Biopsy Reporting Time – Pathologist to Clinician for Basal Cell Carcinoma/Squamous Cell Carcinoma. Seven of the 12 Dermatology measures are designated as high priority measures. High priority measures are assigned one bonus point for each measure

\(^5\) 82 Fed Reg 53619.  
\(^6\) 82 Fed Reg 53619.
reported beyond the first high priority measure\textsuperscript{7}. The AADA appreciates that CMS is increasing the opportunities for dermatologists to score higher on quality measures.

CMS assigned quality 50\% of the total weight for 2018 activities. CMS will maintain the requirement to report on at least 50\% of eligible patients that meet the measures denominator criteria. The threshold for 2019 is to increase to 60\%.\textsuperscript{8} The AADA supports maintaining the requirement of 50\% of all payer claims for 2018 and future years. A requirement of 50\% provides the volume necessary to provide stable estimates across measures, without crushing the clinicians with administrative burden.

C. Cost Performance Category

After proposing a 0 percent weight in the QPP proposed rule, CMS finalized a 10 percent weight for the cost performance category in the final score. This is intended to ease the transition to a 30 percent weight for the cost performance category in the 2021 MIPS payment year\textsuperscript{9}. For the 2018 MIPS performance period, CMS is adopting the total per capita costs for all attributed beneficiaries measure and the Medicare Spending per Beneficiary (MSPB) measure that were adopted for the 2017 MIPS performance period.

Many physicians have reported problems with the current attribution methods. For instance, a dermatologist provided the most Evaluation and Management services to a patient during the reporting period. That patient suffered from recurring mental health problems that resulted in admission to an inpatient facility. The costs for hospitalization and other care associated with the mental illness were attributed to the dermatologist. We are surprised and disappointed that CMS is moving forward with assigning weight to the cost performance category when the attribution method is clearly flawed and the appeals process does not seem to be functional. We again urge CMS to correct the attribution method to ensure that costs of care not associated with the condition being treated are not attributed to the specialist caring for the patient.

D. Improvement Activity (IA) Category

The IA category has a 15\% weight, based on a selection of different medium and high-weighted activities. There was no change in the number of activities that MIPS eligible clinicians have to report to reach a total of 40 points. CMS is offering more activities to choose from, for a total of 112 options,

\textsuperscript{7} 82 Fed Reg 53995.
\textsuperscript{8} 82 Fed Reg 53632.
\textsuperscript{9} 82 Fed Reg 53574.
and is making changes to existing activities for the Inventory. MIPS eligible clinicians in small practices and practices in rural areas will keep reporting on no more than 2 medium or 1 high-weighted activity to achieve the highest score. **The AADA supports the lower threshold for clinicians in smaller practices. We encourage CMS to continue with the lower small practice threshold in future years, to encourage participation and minimize regulatory burden.**

E. **Advancing Care Information (ACI) Performance Category**

MACRA requires 25 percent of the MIPS final score be based on performance in the advancing care information performance category. The score for the Advancing Care Information performance category will be comprised of a base score, performance score, and potential bonus points for reporting on certain measures and activities. CMS is not proposing any changes to the base score methodology as established in the CY 2017 Quality Payment Program final rule.

CMS modified the performance score changes to give 10 points for participating in a specialized registry such as the AAD QCDR, DataDerm. **We appreciated the CMS accepted the AADA recommend that clinicians get 10 points for participation in a clinical data registry.**

MIPS eligible clinicians may use EHR technology certified to either the 2014 or 2015 Edition certification criteria, or a combination of the two, for the CY 2018 performance period. A MIPS eligible clinician may demonstrate through an application process that reporting on the measures specified for the Advancing Care Information performance category is not possible because the CEHRT used by the MIPS eligible clinician has been decertified under ONC’s Health IT Certification Program. A clinician who prescribes fewer than 100 times during the reporting period is excluded from the E-prescribing requirement. There is also an exclusion from the requirement for use of a Health Information Exchange if there are fewer than 100 transitions of care during the reporting period. Providers in practices of less than 15 providers can apply for a hardship to re-weight their ACI score to 0 if they don’t have EHR. **We support these exceptions.**

F. **Qualified Clinical Data Registries (QCDRs)**

CMS finalized a simplified application process for current QCDRs, so that QCDR’s in good standing can resubmit the previous year’s application with little or no changes. QCDR’s must self-nominate annually. Though the AADA recommended multiple year approvals, we support the simplified process for annual self-nomination.

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10 82 Fed Reg 53807.
CMS recommends that QCDRs assist MIPS Eligible Clinicians (ECs) in updating their email addresses in the CMS systems, including PECOS and the Identity Access System. It is important that the AADA QCDR, DataDerm, focus on important functions of a registry, such as data standardization and validation, benchmarking, reports, accurate submission, analytics, and policy, so the AADA is pleased that CMS accepted our recommendation not to require QCDRs to assist with updating email addresses. We have also found that a clinician’s email address is often not an effective means of communication regarding MIPS reporting. Office and administrative staff are frequently the main contacts. We recommend that Eligible Clinicians (ECs) remain solely responsible for maintaining their current contact information.

CMS has been working on process improvements for the review of QCDR measures. However, the review of 2018 QCDR measures continues to be inefficient, opaque and disconnected from clinical evidence. CMS reviewers request clinical evidence and/or rationale already provided in the measure application. There are requests for modification or harmonization with other measures without clinical or data driven rationale. Timelines for harmonization or analysis requests are inadequate to provide data analyses, supporting performance data, or review clinical evidence requests. As part of the Physician Clinical Registry Coalition, the AADA has written to and met with CMS staff about issues encountered in previous cycles (July 11, 2017 letter to Pierre Yong, Director of Quality Measurement and Value Based Incentives Group).

In the Final Rule CMS seeks comment “on whether the standards used for selecting and approving QCDR measures should align more closely with the standards used for the Call for Quality Measures process for consideration in future rule making.” While we agree in general with the goals of the Call for Measures, we strongly oppose applying the MIPS Call for Measures process to QCDR measures. The MIPS process is slow (6 months between measure submission and publication of the final list), cumbersome, and ill-suited to specialty care. The Measurement Application Partnership (MAP) process hinges on NQF endorsement, a separate lengthy process with few standing committees that include Dermatology topics. Historically, the Measures Advisory Panel lacks the expertise to review the clinical importance and evidence for specialty measures. The measure approval process must be based on specialty-relevant clinical expertise and rationale.

Instead of applying the MAP process to QCDR measures, we urge CMS improve the current QCDR measure review by implementing a transparent review process with clear criteria about the acceptability of measures and clear timelines for the CMS review. Harmonization is a worthy goal that should be addressed outside the measure approval process.

11 82 Fed Reg 53814.
CMS finalized the proposal that QCDR vendors must seek permission to use measures owned by another QCDR. Permission must be granted at/before the time of self-nomination, and that QCDR must include proof of permission for CMS review and approval to use the measure for 2018. **The AADA supports this process of seeking and granting permission.** Developing and testing measures is a costly process. Measures are often copyrighted intellectual property. In addition, the measure steward has the resources and clinical guidance to ensure appropriate use for consistency that will assist with reporting.

CMS is not changing the error rate of QRs from 3% to 5%.12 **We disagree with this decision. The inaccuracy rate for QRs should be consistent with QCDRs, so that both error rate thresholds are 5% for auditing.**

G. **Physician Compare**

CMS intends to publish final 2018 score for each MIPS eligible clinician for each performance category. For improvement activities13, CMS will indicate successful completion of the IA category. For ACI14, will include “high” ACI performance as feasible but will not include “low”.

AAD agrees with public reporting where feasible of measures used 2 years or more. However, CMS needs to publish, for public review, the methodology for determining “high or low” performance before including that information on physician compare. Rather than posting first year ACI and IA measures, the policy should be consistent with other categories and not posted until the second year of use. **We recommend that IA and ACI indicators connote that the clinician has submitted data – rather than whether the performance was high.**

III. ADVANCED ALTERNATIVE PAYMENT MODELS (APMs)

A. **Performance Period and QP Determination**

CMS has finalized the proposal for the Qualifying APM Participant (QP) performance period to run from January 1 through August 31 for 2018. For Advanced APMs that start or end during the QP performance period, QP Threshold Scores would be calculated using only the dates that APM Entities were able to participate in the Advanced APM, as long as they were able to participate for at least 60 continuous days during the QP performance period. CMS had considered increasing the 60 continuous days active testing requirement for participation in an Advanced APM to 90 continuous days. CMS allows eligible clinicians to be QPs based on participation in multiple Advanced APMs.

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12 82 Fed Reg 53818.
13 82 Fed Reg 53826.
14 82 Fed Reg 53827.
The AADA supports maintaining the current 60-day performance period to encourage as much participation as possible.

B. Physician-Focused Payment Models Technical Advisory Committee (PTAC)

CMS maintained the current definition of a Physician Focused Payment Models to include only payment arrangements with Medicare as a payer, excluding Medicaid and CHIP programs. In the proposed rule, CMS sought comments on guidance needed by stakeholders who are interested in developing physician focused payment models to help them meet CMS requirements. The Secretary will post a detailed response to the recommendations received from commenters on the CMS Website. The AADA has asked CMS to provide a platform and a roadmap for testing the models that stakeholders develop for PTAC’s considerations. Additional guidance on how to access Medicare data is needed to ease the model development process.

Conclusion

The AADA appreciates the opportunity to provide comments on the Medicare Program; CY 2018 Updates to the Quality Payment Program final rule. We look forward to additional opportunities to discuss these issues and to provide feedback that may help guide policy development. We expect that CMS will continue work to simplify and shorten the Quality Payment Program while easing the reporting burdens imposed on medical practices. We see such efforts to be in line with the Federal government's deregulation efforts. Please contact James Scroggs, Associate Director of Regulatory and Payment Policy, at (202) 842-3555 or jscroggs@aad.org if you require clarification on any of the comments in this letter or would like more information.

Sincerely,

Henry W. Lim, MD, FAAD
President
American Academy of Dermatology Association

CC: Suzanne Olbricht, MD, AADA President-Elect
    Elaine Weiss, JD, AADA Executive Director