August 16, 2017

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

Re: CMS-5522-P; Medicare Program; CY 2018 Updates to the Quality Payment Program

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) proposed rule, Medicare Program: CY 2018 Updates to the Quality Payment Program, published in the Federal Register on June 30, 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 dermatopathology; 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).

**Summary of AADA Recommendations**

Below is a list of our major recommendations. Each recommendation is elaborated upon in this letter. The AADA:

- Supports the accommodations that CMS is proposing for small practices.
- Recommends that the time period for determining practice size should be shorter and closer to the performance period.
- Supports the higher proposed low volume threshold.
- Recommends that members of virtual groups should have the same exemptions as clinicians in small practices.
- Recommends that all practices with fewer than 15 clinicians (the CMS definition of small groups) should be allowed to join virtual groups.
- Agrees with the proposed performance period and the expanded submission mechanism options.
- Appreciates the increased opportunities for quality scoring.
- Recognizes that cost attribution problems persist; cost scoring should not impact MIPS scoring until those issues are resolved.
- Does not support the proposed requirement that at least half of the members of a group report an IA for members of the group to get credit for that activity.
- Recommends that clinicians get 10 points for participation in a clinical data registry.
- Supports most proposals related to Qualified Clinical Data Registries (QCDRs), with some modifications recommended for the approval process and a longer approval interval.
- Recommends maintaining the current 60-day Advanced APM performance period to encourage as much participation as possible.
- Asks for additional guidance on the Physician-Focused Payment Models Technical Advisory Committee (PTAC) APM development process, including improved access to and assistance using Medicare data.

I. **PROVISIONS OF THE PROPOSED REGULATIONS**

A. **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 is proposing to use claims data from September 1, 2016, through August 31, 2017, to determine the number of clinicians in a practice. CMS has asked for comments on this proposal.¹

*The AADA recommends using 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.* This is sufficient time to determine the number of providers. Using three months of claims data close to the start of the reporting period will generate the most current practice size data. Claims data that begins 16 months prior to the reporting period is more likely to result in falsely identifying additional clinicians who are no longer part of a practice.

*We recommend that practices be allowed to attest their small size status beginning no later than September 30, 2017, and ending November 31, 2017.* This could be done through subregulatory guidance this year. This will allow those who may have been missed or misidentified as having additional providers during the claims data collection to self-identify their status. *In future years, the attestation could 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 is proposing to give clinicians in small practices three points instead of one for incomplete quality data reporting. The low volume threshold described below will exempt many clinicians from QPP requirements. *The AADA agrees with the proposed accommodations for small practices.*

CMS is proposing 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.

**B. Exclusions - Low Volume Threshold**

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¹ 82 Fed Reg 30020.
The MACRA legislation gives the Secretary authority to determine the low volume threshold. Clinicians below this threshold 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.\(^2\) This will mean that clinicians whose Medicare payments and/or number of Medicare patients exceed the threshold could see payment adjustments of $4,500 or more in 2020 for 2018 activities. Though still not sufficient to cover the cost of complying with MIPS requirements, it is an improvement over the current $30,000/100 patient threshold.

CMS is proposing to allow those who do not reach the low-volume threshold the opportunity to opt-into the QPP beginning in CY 2019, for 2021 payments.\(^3\) For technical reasons, that option is not available before then. Clinicians who do not reach the low volume threshold for payments or number of patients should be allowed, but not required, to participate in MIPS and/or APMs.

C. Virtual Groups

CMS intends to implement virtual groups for the 2018 calendar year performance period.\(^4\) A virtual group is a combination of two or more Taxpayer Identification Numbers (TINs) that include solo practitioners (individual MIPS eligible clinician who bills under a TIN with no other National Provider Identifiers (NPIs) billing under such TIN, or groups with 10 or fewer eligible clinicians under the TIN that elects to form a virtual group. CMS is not proposing to limit 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.

Participants must choose to join or form a virtual group by December 1, 2017. The opening date for this election process will be earlier, probably as early as mid-September. Formal written agreements for all participants are required, binding the participants to the virtual group for the performance year. CMS intends to provide an agreement template, and to set an opening date for the election process, via subregulatory guidance.

CMS proposes allowing virtual groups with 16 or fewer NPIs to have small practice status, allowing them to have lower requirements for reporting, ACI, and improvement activities. Technical assistance will be available for all virtual groups, as it will be for smaller practices.

\(^2\) 82 Fed Reg 30023.  
\(^3\) 82 Fed Reg 30026.  
\(^4\) 82 Fed Reg 30027.
Most policies that apply to groups would 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.

CMS has 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.\(^5\) Because virtual groups will be made up of TINs that would qualify for the accommodations for small practices, we recommend that all virtual groups be granted small practice status.

CMS asks for the approach of not establishing appropriate classifications (such as classification by geographic area or specialty) regarding virtual group composition. The AADA agrees that CMS should not establish classifications for virtual groups. CMS is also not proposing any limit on the size of virtual groups. We agree that CMS should not limit the number of TINs that may form a virtual group at this time.

CMS defines small groups as those with 15 or fewer clinicians.\(^6\) Establishing a different definition of small practice for potential virtual group participation is confusing and unnecessary. We recommend that all TIN identified practices that meet the definition of small practice be allowed to participate in virtual groups, rather than having the lower 10 provider threshold. This would simplify and standardize the qualifying criteria across the board without unnecessary confusion. Further, we encourage CMS to offer further incentives to make this untested model more appealing to solo and small group practices.

**D. Performance Period**

The AADA agrees with the CMS proposal 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). We also agree with the CMS proposal for a full calendar year performance period for the quality and cost performance categories (January 1, 2018, through December 31, 2018).\(^7\) 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. \textbf{Feedback to clinicians should be delivered by CMS to clinicians beginning no later than April 1, 2019.}

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\(^5\) 82 Fed Reg 30029.  
\(^6\) 82 Fed Reg 30019.  
\(^7\) 82 Fed Reg 30034.
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.\(^8\)

B. Quality Performance

The Dermatology specialty measure set was increased from 11 to 12, 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 reported beyond the first high priority measure. \textit{The AADA appreciates that CMS is increasing the opportunities for dermatologists to score higher on quality measures.}

CMS is proposing changes to two of the measures in the Dermatology measure set. Measure 226, for tobacco use care and screening has been modified to include performance rates for 3 rather than 1 screening and cessation activity. CMS is proposing to allow reporting using a registry, in addition to the EHR, for reporting measure 374, the percentage of patients for which the referring physician receives a report from the physician to whom the patient was referred. \textit{The AADA supports the proposed changes to the Dermatology measures 226 and 374.}

CMS plans to assign quality 60% of the total weight for 2018 activities. That will decrease to 30% in 2021. CMS proposes to 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%. \textit{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.

Incomplete data reporting will result in 1 point instead of 3, except in small practices, which will still get 3 points for reporting for less than 50% of eligible patients.

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\(^8\) 82 Fed Reg 30034.
CMS proposes to request that stakeholders consider whether measures are outcome based when submitting quality measures.\textsuperscript{9} While we agree that outcome based measures are preferable, we urge CMS not to reject measures that are outcome based. Many specialties have limited evidence to produce outcome measures.

CMS is proposing a bonus for taking care of complex patients. The AADA supports the complex patient bonus.

C. Cost Performance Category

Dermatologists and other 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 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 again ask that CMS 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 proposing more activities to choose from and 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 reach 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.

CMS is requesting comment on whether they should establish a minimum threshold (for example, 50\%) of the clinicians (NPIs) that must complete an improvement activity in order for the entire group (TIN) to receive credit in the improvement activities performance category in future years. In addition, they are requesting comments on recommended minimum threshold percentages and whether CMS should establish different thresholds based on the size of the group.\textsuperscript{10} Many of the IAs are appropriate for a small subset of the clinicians in a group. It is therefore inappropriate to require at least half of the clinicians to complete an IA in order for the group to get credit. We recommend that CMS use a threshold of 50\% of clinicians in a group who could complete an

\textsuperscript{9} 82 Fed Reg 30044.  
\textsuperscript{10} 82 Fed Reg 30053.
improvement activity, rather than 50% of all clinicians. In order for the group to get credit for the activity, 50% of clinicians with the same credentials should complete an IA.

The AADA supports Continuing Medical Education (CME) as a medium weighted IA.

E. Advancing Care Information (ACI) Performance Category

MACRA states that 25 percent of the MIPS final score shall be based on performance for the advancing care information performance category. CMS established that the score for the advancing care information performance category would 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.

The scoring methodology is too complex to explain simply, and too complex for most clinicians to understand. We recommend that CMS eliminate the three categories of scores in ACI and simplify the process so that physicians and other clinicians can understand it.

CMS proposes that if a MIPS eligible clinician fulfills the Immunization Registry Reporting Measure, the MIPS eligible clinician would earn 10 percentage points in the performance score. If a MIPS eligible clinician cannot fulfill the Immunization Registry Reporting Measure, CMS proposes that the MIPS eligible clinician could earn 5 percentage points in the performance score for each public health agency or clinical data registry to which the clinician reports for certain measures, up to a maximum of 10 percentage points. CMS is proposing that a MIPS eligible clinician may only earn the bonus score of 5 percentage points for reporting to at least one additional public health agency or clinical data registry that is different from the agency/agencies or registry/registries to which the MIPS eligible clinician reports to earn a performance score. A MIPS eligible clinician would not receive credit under both the performance score and bonus score for reporting to the same agency or registry. To earn the bonus score, the MIPS eligible clinician must be in active engagement with one or more additional public health agencies or clinical data registries that are different from the agency or registry that they identified to earn a performance score. We recommend that clinicians get 10 points for participation in a clinical data registry. Integrating an EHR with a clinical data registry should result in 10 bonus points or 10 performance score points, instead of 5 points.

There is no reason that those who are unable to participate in an immunization registry, but who participate in the clinical data registry, should receive less credit than those who participate in an immunization registry.

CMS is proposing that 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.
The AADA supports the proposal to allow use of 2014 Certified Electronic Health Record Technology (CEHRT).

CMS is proposing that 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. **We support the proposed exception for those whose CEHRT is decertified.**

The AADA supports all proposed exclusions for e-prescribing and health information exchange measures listed in II.C.6.f.(6)(c). We also support changing the exception application submission to December 31 from July 1.

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

CMS is proposing to simplify the application process for current QCDRs, allowing them to attest to the application if there are no or minimal changes to the core of the application, instead of completing the entire application again.

The application process requires significant staff resources to complete, especially for entities that self-nominate as a QR and a QCDR. Allowing this streamlined application process would be more efficient. **The AADA fully supports this proposed change.**

The application can be duplicated within the web portal for entities that choose to apply for QR and QCDR. A majority of the QR application questions were also on the QCDR application. **We recommend revising the application process to eliminate the duplication when applying for both QR and QCDR.**

CMS has proposed 2 year increments for QCDR approvals. Apart from measure and cost changes, there are minimal changes to the remainder of the applications. **The approval for QCDRs should be for a minimum of two years. We would also support a longer approval interval.**

CMS has proposed that QCDRs assist MIPS Eligible Clinicians (ECs) in updating their email addresses in the CMS systems, including PECOS and the Identity Access System. **The AADA opposes this proposal.** Although we believe that it is important that ECs have current contact information updated within CMS systems, this level of support would require significant additional resources. It is important that the AADA QCDR, DataDerm, focus on important functions of a registry.

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11 82 Fed Reg 30064.
such as data standardization and validation, benchmarking, reports, accurate submission, analytics, and policy. We have also found that an EC’s email address is often not the best means of communication. Office and administrative staff are frequently the main contacts in reporting. We recommend that ECs remain solely responsible for maintaining their current contact information.

CMS proposes that QCDR vendors be allowed to seek permission from another QCDR to use an existing measure owned by the other 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 for the measure to be used for 2018. The AADA supports this proposal. Developing and testing measures is a costly process. Our measures are AAD intellectual property and are copyrighted. In addition, the measure steward has the resources and clinical guidance to ensure appropriate use for consistency that will assist with reporting.

CMS is proposing to change the error rate of QRs from 3% to 5%. We support this proposal to make the inaccuracy rate consistent with QCDRs, so that both error rates thresholds are 5% for auditing.

III. ADVANCED ALTERNATIVE PAYMENT MODELS (APMs)

A. Performance Period and QP Determination

CMS has proposed that the Qualifying APM Participant (QP) performance period, which runs from January 1 through August 31, remain the same 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 is considering 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.

The AADA recommends maintaining the current 60-day performance period to encourage as much participation as possible. Increasing the performance period will discourage participation of small practices.

B. All-Payer Combination Option

In an effort to encourage more participation in advanced APMs, CMS is allowing participation in plans other than traditional Medicare, including Medicare Health Plans, Medicare Advantage,
Medicaid-Medicaid plans, 1876 and 1833 Cost Plans, and Programs of All Inclusive Care for the Elderly (PACE) plans to count as Other Payer Advance APMs as long as they meet the APM criteria.

The QP determination period for All-Payer QP is from January 1 to June 30 of the performance year, which is different from the Medicare advanced APM QP determination period. All-Payer Combination Option QP determinations would be made based on 2 periods: January 1 to March 31 or January 1 to June 30. QP determinations under the All-Payer Combination Option would be calculated at the individual eligible clinician level only, not at the APM Entity level.

CMS provided an additional nominal risk standard option for models in which risk for APM Entities is expressly defined in terms of revenue. This option applies a financial risk requirement of 8% of the total combined revenues from the payer of providers and suppliers in participating APM Entities. CMS is collecting comments on the benefits of lowering the revenue-based nominal risk standard for small practices and practices in rural areas that are not participating the Medicaid Medical Home Model for 2019 and 2020.

CMS will identify Medicaid APMs and Medicaid Medical Home models that meet the Other Payer Advanced APM criteria before the beginning of the performance period.

**The AADA applauds CMS’s effort to encourage more participation in APMs by allowing more ways for participation.** However, small and rural practices cannot withstand an 8% financial risk. **The AADA recommends that CMS lower the nominal risk requirement for small practices. We also believe that the risk should be at the APM entity level, not at the individual clinician level. Small practices do not have the human capital or enough data to sustain an APM.**

### C. MIPS/APMs Scoring

MIPS eligible clinicians who participate in MIPS APMs will be scored using the APM scoring standard instead of the generally applicable MIPS scoring standard at TIN/NPI level for each eligible clinician. CMS proposed to add a fourth snapshot date (December 31) that would be used only to identify APM Entity groups. This fourth snapshot date will not be used to make QP determinations and will not extend the QP performance period beyond August 31. This special standard reduces the burden for certain APMs (MIPS-APMs) participants who do not qualify as QPs, and are therefore subject to MIPS.

**The AADA believes the scoring should be done at the APM level. Scoring at the entity level allows the group to have a diverse set of patients and providers, where providers see a combination of both difficult and easy patients but achieve a reasonable score threshold.**
The reporting of all the required measures at the individual would be very burdensome for individual providers.

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

CMS outlined the review process of the physician focused payment models by PTAC and CMS in the proposed rule. CMS is seeking comments on guidance needed by stakeholders who are interested in developing physician focused payment models to help them meet CMS requirements. The AADA asks 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 proposed rule. We look forward to additional opportunities to discuss these issues and to provide feedback that may help guide policy development. 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

12 82 Fed Reg 30209