



August 21, 2017

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5522-P
P.O. Box 8013
Baltimore, MD 21244-8013

[Submitted online at: <https://www.regulations.gov/docket?D=CMS-2017-0082>]

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

Dear Ms. Verma:

The undersigned members of the Physician Clinical Registry Coalition (the Coalition) appreciate the opportunity to comment on the proposed rule on calendar year (CY) 2018 updates to the Quality Payment Program (QPP) established under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114-10) (the Proposed Rule).¹ The Coalition is a group of over 20 medical societies and other physician-led organizations that sponsor clinical data registries that collect and analyze clinical outcomes data to identify best practices and improve patient care. We are committed to advocating for policies that encourage and enable the development of clinical data registries and enhance their ability to improve quality of care through the analysis and reporting of these outcomes. Over 75% of the members of the Coalition have been approved as qualified clinical data registries (QCDRs) and most of the other members are working towards achieving QCDR status.

MACRA requires the Secretary of the Department of Health and Human Services (HHS) to encourage the use of QCDRs and certified EHR technology (CEHRT) for reporting measures under the Quality performance category of the Merit-Based Incentive Payment System (MIPS).² The Coalition greatly appreciates CMS's efforts to encourage the use of QCDRs for reporting MIPS data across the Quality, improvement activities and advancing care information (ACI) categories under MACRA. However, the Coalition still has significant concerns about several issues related to QCDRs and other clinical outcomes data registries.

¹ 82 Fed. Reg. 30,010 (June 30, 2017).

² Social Security Act (SSA) § 1848(q)(1)(E); SSA § 1848(q)(5)(B)(ii)(I).

First, while we greatly appreciate the steps CMS has taken to increase the flexibility and responsiveness of the QCDR program, we are concerned about several areas of difficulty that Coalition members have experienced during the QCDR measure review and self-nomination process for the 2017 performance period. The Proposed Rule includes some specific changes on the QCDR review process for topped out measures and measures without a benchmark, but it does not propose any changes or contain any discussion on the overall QCDR measure review process. In addition, although the Proposed Rule simplifies the QCDR self-nomination process, further improvements can be made to ease the administrative burdens imposed by the program.

We previously sent Pierre Yong, MD, MPH, MS, Director of the Quality Measurement and Value-Based Incentives Group, letters dated October 29, 2016 and July 11, 2017 regarding the unstructured and disorganized process that many of our QCDR members faced during the review of proposed non-Physician Quality Reporting System (PQRS) quality measures and the 2017 QCDR self-nomination and measure review process, respectively. The Coalition attended a very productive call with Dr. Yong and his team on August 1, 2017, where we discussed the concerns raised in our letter and possible solutions. As suggested by the QPP team, we are also submitting our concerns on the QCDR self-nomination and measure review process as comments to the Proposed Rule to continue dialogue with the QPP team about these important matters. In addition, we are submitting these comments to communicate our recommended changes with respect to specific issues within the Proposed Rule.

We urge CMS to implement the following changes and clarifications for the CY 2018 performance period to further encourage the use of QCDRs and other clinical outcomes registries:

- (1) Create an organized, transparent, and consistent QCDR measures review process and make other adjustments to the QCDR measure review program, such as increase flexibility for review of topped-out measures, delay the timeline for removing non-outcome and outcome measures without a benchmark, increase consultation regarding measure consolidations and approval time for new MIPS measures, and reduce provisional measure approval and limitations associated with the 30 non-MIPS measures cap;
- (2) Further simplify the QCDR self-nomination process by increasing the length of QCDR approval to at least two years, improving the tracking of measure ownership, and including all needed information on the self-nomination application;
- (3) In the ACI category, allow an eligible clinician to qualify for 5bonus points for using a specialized or clinical outcomes data registry under active engagement options 1, 2, and 3, and to qualify for full ACI credit when utilizing CEHRT to participate in a clinical data registry;
- (4) Clarify that QCDRs and other clinical outcomes data registries should be led and controlled by clinician-led professional organizations or similar entities focused

on quality improvement to receive credit under the improvement activities and ACI categories;

- (5) Create two separate benchmarks for reporting QCDR measures electronically and manually;
- (6) Allow QCDRs and other clinical outcomes data registries the option to assist virtual groups in aggregating measures and activities for reporting.

1. CMS Should Modify Various Aspects of the QCDR Measure Review Process

The Coalition urges CMS to consider making several changes to greater incentivize QCDRs to develop new measures.

A. The Coalition Recommends the Creation of an Organized, Transparent, and Consistent QCDR Measure Review Process

While the Proposed Rule sets out specific processes for review of topped out measures and measures without a benchmark (to be discussed in subsections 1.B and 1.C below), it does not contain any proposals or discussion about the overall processes CMS uses to review QCDR measures. As recommended by the QPP team during our August 1, 2017 call, we are detailing our request for a more structured and organized measure review process in these comments to the Proposed Rule.

Many Coalition members experienced an opaque, disorganized, and contradictory process during the 2017 QCDR measure review period. Members experienced frustrations with CMS during every aspect of the process, including inconsistent feedback and decisions on submitted measures, impractical timelines, a lack of rationale for rejected measures, and a lack of responsiveness to correct errors in measures. Overall, we request that CMS develop a standardized process for review of QCDR measures with structured timeframes for an initial review period, an appeals process, and a final review. We understand from our August 1, 2017 call with the QPP team that some of this confusion came from the multiple teams of contractors hired by CMS to conduct the measure review process. We request that CMS assign a coordinator for each QCDR and create an official database containing decisions on measures. Therefore, if multiple contractors and QPP staff are working on measures review in the future, there can be a central database to track previous reviews and decisions to ensure there are no conflicting messages.

- Inconsistent Feedback and Decisions. Coalition members have too often received conflicting responses and decisions from QPP contractors and staff during QCDR measure review process. For instance, one of our members reports that during fall 2016, a CMS contractor asked for significant changes to its proposed QCDR measures. The contractor did not engage in any discussion with the QCDR regarding the clinical importance of the measures or why the changes were needed, but simply demanded the changes. After the Coalition member scheduled a call with the CMS contractor to

explain the clinical justification for the measures, CMS approved the measures without changes. However, a few months later, a different CMS contractor notified the Coalition member that 5 measures were not approved, 2 of which were previously-approved by the first contractor. The 3 additional rejected measures were a shock to the Coalition member as CMS had not previously commented on the measures. After appealing to CMS and the contractor, CMS agreed to approve the 2 measures that were previously approved in fall 2016 and 1 of the 3 additional pending measures. CMS asked for additional information on the 2 remaining measures, and ultimately approved all but one measure. In addition, multiple Coalition members report that their proposed measures are still under review or their appeals of rejected measures are still pending. Several other Coalition members experienced similar problems with conflicting messages and decisions from QPP contractors, staff, and the JIRA system during this year's QCDR measure-approval process.

- Impractical Timelines. CMS has frequently set unreasonable deadlines for Coalition members to make changes to measures or replace certain measures. For example, CMS asked one member to combine two measures within a single day. CMS asked another Coalition member for additional information on 5 measures with a one-day deadline, even though the member already asked CMS for feedback on these measures in the months prior. CMS gave another member only a few hours to provide evidence supporting performance gaps for rejected measures. In addition, CMS has provisionally approved some Coalition members' QCDR measures for 2017 with the expectation that additional performance data would be included with the 2018 submission. However, this would not be feasible given that the 2017 submissions are not finalized until March 2018 and the deadline for the 2018 self-nomination application is November 1. We discuss this issue further below in Section 1.B, Provisional Measure Approval.
- Lack of Rationale for Rejected Measures. Coalition members report that CMS has rejected measures without providing any rationale. A few commenters on the "JIRA" review site appeared to not understand the clinical rationale behind some of the measures, but never asked for clarification. For example, one of the rejected measures involved peripherally inserted central catheter (PICC) placement in patients with Stage IV or V renal disease. CMS did not give a reason for rejecting this measure, but the rejection makes no sense because it is obvious to an interventional radiologist that placement of such catheters into peripheral veins should be avoided in patients who require a fistula or graft for optimizing safety. Another member reports that 3 approved measures were missing from the public posting for the QCDR. Upon inquiring about the status of the measures, CMS said they were either rejected or still under review. Shortly afterwards, CMS told the QCDR that the measures were denied for being "low bar" without any additional details or warning.
- Lack of Responsiveness/Communication. One Coalition member reports that it gave CMS edits to the final QCDR posting to ensure the correct measures were listed. When the postings were published, the member noticed that CMS ignored several of the corrections made to the posting. For example, CMS listed measures that the QCDR is

not offering and did not list some approved measures that it was offering. In addition, Coalition members report receiving contradictory emails about whether CMS approved or denied measures. For instance, a member reports receiving several emails for a single measure stating that the measure was rejected, and then approved, and then rejected again within the same hour. CMS also ignored a Coalition member's requests for changes to incorrect subspecialty measure sets and classification of measures as "process" or "outcome" measures.

B. Other QCDR Measure Review Considerations

The Proposed Rule describes a process for the removal of topped out measures and outcome and non-outcome measures without a benchmark.³ The Coalition requests modifications to these proposals and further changes regarding measure consolidations, approval time for new MIPS measures, provisional measure approval, and the 30 non-MIPS measures cap.

- Effect of Topped Out Measures. If CMS determines that many of a subspecialty's MIPS measures are "topped out"—*i.e.*, having reached 90% in average performance rate or greater, it may not be possible for the subspecialty to maintain a QCDR due to the lack of measures. In the Proposed Rule, CMS proposes the removal of a MIPS quality measure after a measure has been identified as topped out for 3 consecutive years and its removal is proposed during the 4th year through the comment and rulemaking process.⁴ For QCDR measures, CMS proposes removal after a measure has been identified as topped out for 3 consecutive years, but without going through the comment and rulemaking process.⁵ CMS' 3-year vetting of QCDR measures could reduce the ability of subspecialties to develop and strengthen new measures. Congress created the QCDR mechanism to fill critical gaps in the traditional quality measure sets and to ensure that clinicians have access to measures that are more meaningful and relevant to their specialty. The combination of topped-out measures and slow approval of QCDR measures creates an effect that is counter to the statutory purpose of QCDRs of being innovative and targeted to the needs of different specialties. Therefore, we request that QCDR measures that have been identified as topped out only be removed after going through the notice and comment rulemaking process.

CMS also proposes to cap the score of topped out measures at 6 measure achievement points during the second consecutive year the measure is identified as topped out.⁶ The Coalition strongly disagrees with imposing such a cap at this time, as QCDRs and other clinical outcomes registries are still grappling with how to adjust for topped out measures. A 6-point cap would especially disincentivize the use of QCDR measures because QCDRs have only begun to collect performance data and benchmarks that have been identified as topped out may be incorrect based on limited data. QCDRs need more

³ 82 Fed. Reg. 30,010, 3045-47 (June 30, 2017).

⁴ *Id.* at 30,046.

⁵ *Id.*

⁶ *Id.* at 30,104.

time to collect adequate performance data for their measures, and these measures should be promoted for at least several years to build a more robust foundation of data and better understand the trends related to these measures.

In addition, Coalition members report that CMS indicated during the 2017 performance period it would not approve QCDR measures which are similar to existing QPP measures. We are strongly against this policy, as it would limit the development and introduction of newly-created quality measures that could, in the future, serve as replacements to QPP measures that become topped out. QPP measures that have been modified could contain the characteristics of retired QPP measures that are important metrics to the specialty, but also contain new components that would show gaps in performance. We request that CMS demonstrate flexibility in approving QCDR measures that could serve as an alternative to current QPP measures to help QCDRs control when measures become topped out.

- Removal of Measures without a Benchmark. In the Proposed Rule, CMS asks for comments on establishing a timeline for removing non-outcome and outcome measures that cannot be reliably scored against a benchmark for 3 years.⁷ We request that CMS not establish a timeline until it gathers a better understanding of which MIPS quality measures create improvements in overall quality. In addition, the Coalition believes establishing a policy of removing measures based on the lack of a benchmark for 3 years is inappropriate because QCDRs have only existed for 3 years. QCDRs measures have not been widely used until recently because PQRS included more stringent reporting measures compared to other reporting mechanisms, such as qualified registries. In addition, some physicians with electronic health record systems did not report QCDR measures because they did not meet meaningful use clinical quality measures reporting requirements. Therefore, the Coalition requests that CMS table for at least several more years the proposal to set a timeline for removal of measures for which there is no benchmark.
- Inappropriate Measure Consolidations. Additionally, during the 2017 performance period CMS has rejected, otherwise opposed, or required consolidation of QCDR measures that appear too similar to existing QPP measures. However, the measures that have similar descriptions are often quite different, based on the nature of the condition and/or the area of the body affected. For instance, CMS asked the American Association of Neurological Surgeons to replace its Unplanned Reoperation Following Spine Procedure within the 30-Day Post-Operative Period measure with the generic PQRS #355: Unplanned Reoperation within the 30-Day Postoperative Period. This means that a surgeon repairing a hernia will be held to the same performance standard as a surgeon performing a multi-level spinal fusion on a patient with osteoporosis who has a higher risk of needing additional surgery due to non-union of weakened bones. Moreover, the QCDR program allows QCDRs to modify and update existing QPP measures on an

⁷ *Id.* at 30,047.

annual basis in an effort to improve and offer better alternatives to existing QPP measures. In many cases, it would be preferable for CMS to allow a QCDR to modify its measure than to force it to consolidate the measure with the measure of another QCDR.

Harmonizing QCDR measures does not ensure accurate benchmarking. In theory, harmonizing measures for use in the public domain facilitates cross-cutting comparisons. However, harmonizing quality measures across registries alone does not ensure accurate benchmarking due to inconsistencies in program implementation and data interpretation, including: the lack of standardized data definitions, lack of standardized risk adjustment/data analytics, inconsistency of data ascertainment methods, and lack of common normalization methods. This was demonstrated when the American College of Surgeons (ACS) harmonized the surgical site infection (SSI) National Surgical Quality Improvement Program (NSQIP) measure with the CDC National Healthcare Safety Network (NHSN) SSI measure. After harmonization, results showed that NSQIP participants had higher SSI rates compared to the CDC NHSN registry participants. Through further study, ACS found that this discrepancy was not because NSQIP participants had poorer surgical outcomes; instead, the discrepancy was due to the lack of rigor used to track patients and collect data for use in the NHSN registry when compared to NSQIP. ACS also found that standardized risk adjustment methodologies are critical when comparing clinical outcomes across different registries/cohorts. For example, in the ACS Surgeon Specific Registry, unadjusted SSI PQRS measure rates were compared to the risk-adjusted SSI PQRS rates and found that approximately 50% of cases were misclassified when risk adjustment was not performed.

- Approval Time for New MIPS Measures. Newly- proposed MIPS measures take approximately 2 years (i.e. the performance year after the next) to be incorporated into the MIPS program. For certain medical specialties that have a wide range of sub-specialization, this 2-year time frame coupled with the 30 reportable non-MIPS measure cap may be extremely limiting and stifle innovation. Vetted new MIPS measures add significant value to QCDRs and a 2-year delay is unnecessary. Therefore, we request that CMS consider a fast track for certain high-priority MIPS measures to be incorporated into QCDRs in CMS's discretion.
- Provisional Measure Approval. Some Coalition members report only provisional approval of their QCDR measures. According to these members, CMS requires QCDRs to provide data from the provisional measures during the 2017 performance year on the 2018 self-nomination form. However, the timing between the approval of the measures and the 2018 self-nomination process is too short to adequately capture data. One Coalition member reports that its measures were approved by CMS at the end of May and that it will take a few weeks for the measures to be incorporated into the QCDR. As the 2018 self-nomination application opens in September, the Coalition member will have only collected approximately three months of data from the measures before being required to report the data to CMS. If the measures are being reported through a web portal, data sometimes is not collected by the QCDR until after the conclusion of the calendar year. If CMS must collect data on provisionally-approved measures, we request

that QCDRs be permitted to collect such data for at least one full year. Therefore, data on the provisional measures from the 2017 performance year should be submitted on the 2019 self-nomination application.

In addition, another Coalition member reports that CMS expected the member's provisionally-approved measures to be included on the Measures Under Consideration (MUC) list so they can be used for the 2019 performance year. We disagree with requiring QCDRs to submit provisionally-approved measures for MIPS inclusion. Some Coalition members wish to keep certain measures as QCDR measures, not MIPS measures, due to concerns about how they might be implemented by other entities and to protect their intellectual property rights in such measures.

- Expansion of the non-MIPS Measure Cap. The 30 non-MIPS measure cap can restrict the ability of QCDRs to report on meaningful subspecialty-focused measures. This cap is particularly limiting for subspecialties that share a QCDR, as each subspecialty is effectively limited to 15 or fewer non-MIPS measures instead of 30. We request that CMS increase the measure cap to 30 non-MIPS measures per subspecialty for all QCDRs.

2. CMS Should Further Simplify the QCDR Self-Nomination Application

The Coalition greatly supports CMS's proposal to simplify the QCDR self-nomination process beginning in the 2019 performance period.⁸ Specifically, we strongly support the proposal that existing QCDRs in good standing may continue to participate in MIPS after attesting that there are no changes from the details approved during the previous year's self-nomination application. We also appreciate the proposal to submit minimal or substantive changes and new measures for CMS review and approval without completing the entire self-nomination process. These proposals will reduce the administrative burden on QCDRs, encourage the use and development of QCDRs, and allow for more time to be spent on developing new measures.

However, we still urge CMS to increase the length of QCDR approval from one to at least two years. Even with a simplified self-nomination process, it remains administratively burdensome to report changes on an annual basis. CMS's estimate that it requires a total of 10 hours to complete and submit the self-nomination application is significantly under-valued or incomplete.⁹ It is unclear whether this estimate included the follow-up changes and discussions QCDRs must also undergo subsequent the self-nomination application's submission. This is a very labor-intensive process and the potential technological changes required to gain approval can be very costly to the QCDR. Many registries may not seek QCDR status because of the escalating administrative burden required to participate on a long-term basis. This result could stifle quality measure innovation, which was the premise for creating QCDRs in the first place.

⁸ *Id.* at 30,159.

⁹ *Id.* at 30, 216.

The Proposed Rule also does not make any changes to the information QCDRs must provide at the time of self-nomination.¹⁰ During the 2017 self-nomination period, Coalition members experienced frustrations with the initial QCDR self-nomination process due to incomplete information requests on the application. First, the QCDR application currently does not ask about the ownership and licensing of non-MIPS measures. The Coalition greatly appreciates that the Proposed Rule makes progress on ownership and licensing issues by proposing that QCDR vendors must seek permission from another QCDR to use an existing measure that is owned by the other QCDR for the performance period.¹¹ We also support the proposal that such permission be granted at the time of self-nomination so the QCDR using the measure can include proof of permission in its application for CMS review and approval of the measure's use during the performance period.¹²

While the Coalition appreciates these proposals and believes this is a significant step in the right direction for protecting QCDR measure ownership, we believe further improvement could be made to properly record and track ownership rights. CMS should clarify what form of proof must be submitted to show permission to use another QCDR's measure. In addition, to ensure the smooth sharing of non-MIPS measures, CMS needs to properly record ownership of all approved measures to protect the intellectual property rights of the owner of the measure. It should make the ownership information it collects generally available to QCDRs to facilitate sharing of non-MIPS measures between these entities. Overall, the licensing of measures incentivizes organizations to invest in developing new and improved measures, and it is crucial for CMS to create a process to ensure other users respect the intellectual property rights of the measure developers.

Second, Coalition members report that CMS requested the details of a plan for risk adjustment several months after completing the 2017 self-nomination application. In fact, CMS asked one member why a description or attachment of the plan was not included with the application. We are surprised to learn CMS expected this information, as the self-nomination application does not ask for the details of a risk adjustment plan. Rather, the application simply asks the applicant to answer "yes" or "no" as to whether they have such a plan. We suggest that the QCDR self-nomination application include all of the information needed to determine QCDR status to avoid delays and frustration.

3. CMS Should Grant 5 Bonus Points in the ACI Category for Any Active Engagement with a Specialized or Clinical Data Registry and Full ACI Credit for Utilizing CEHRT to Participate in a Clinical Data Registry

The Coalition strongly disagrees with CMS's proposal to give 5 ACI bonus points to MIPS eligible clinicians for engaging with a specialized or clinical data registry only if the clinician is in "active engagement option 3: production."¹³ Option 3 requires eligible clinicians to have

¹⁰ *Id.* at 30,159-160.

¹¹ *Id.* at 30,160.

¹² *Id.*

¹³ *Id.* at 30,070.

completed testing and validating of the electronic submission and electronically submit production data to the registry.¹⁴ While all of the Coalition's members are aiming to be functioning at the option 3 level as soon as possible, there are often roadblocks that delay reaching that production stage. For example, some members have experienced delays caused by EHR vendors due to their specific technology requirements, deadlines, and reluctance to share data with a registry. In addition, some registries are still in the "testing" or "registration" stages of options 1 and 2 for technical reasons.

The Coalition requests clarification from CMS on how it distinguishes "test" data and "production" data. The Coalition also requests that CMS continue to allow active engagement of options 1 and 2 to qualify for 5 ACI bonus points for the registry measure. While a registry may not be in full production, a clinician in options 1 and 2 has made an effort to move towards full production, including registering with a registry and/or testing data submission. By moving forward with its proposal, CMS will be denying eligible clinicians that have registered and/or tested with registries ACI credit because of delays with the EHR vendor or registry that are likely beyond their control. Clinicians must invest significant time and money to use electronic reporting and registries, and are therefore are much more likely to pursue these means when there are more significant benefits to making the investment throughout the process.

Finally, we ask CMS to allow eligible clinicians utilizing CEHRT to participate in a clinician-led QCDR to receive full points for the ACI category. The 5 percent bonus provided to physicians participating in a specialized registry is not sufficient and compliance with the current ACI requirements creates significant burden on physician practices. There is limited evidence that the ACI requirements are relevant to physicians, practices and patients or have a positive impact on the quality of care and patient outcomes. By establishing this alternate pathway to achieving full ACI credit, clinicians will be incentivized to adopt EHRs and participate in clinical data registries, facilitating a culture of performance improvement that benefits patient care and patient outcomes. This would enable the physician - and specialty-led performance measurement that Congress intended with the passage of MACRA.

If CMS is opposed to our suggestions about including CEHRT in the ACI category, as an alternative, we urge CMS to modify the scoring policies to give greater weight to clinicians who meaningfully use clinical data registries to improve the quality of care. Under the current proposal, clinicians only receive 10 percentage points for fulfilling the Immunization Registry Reporting measure, or five percentage points for each other registry they use for reporting up to a maximum of 10 percentage points. These points greatly undervalue the contribution clinical data registries provide to the progress towards achieving greater quality improvement. For this alternative, the Coalition recommends awarding clinicians who do not use an immunization registry a minimum of 10 percentage points for reporting to another registry, or an even greater number of points for demonstrating use of a clinical data registry, such as to track performance and compare performance to benchmarks.

¹⁴ *Id.*

4. CMS Should Clarify that Registries Must Be Controlled by Clinician-Led Organizations or Similar Entities Focused on Quality Improvement to Receive Credit under the Improvement Activities and ACI Categories

The Proposed Rule does not propose any changes to the criteria required to become a QCDR.¹⁵ The current regulations at 42 C.F.R. § 414.1400(d) allows entities that do not meet the QCDR requirements on their own to collaborate with external organizations to qualify as a QCDR. In its comments on the proposed and final rules on the implementation of MACRA provisions related to MIPS and APMs, the Coalition discussed concerns about health information technology (HIT) vendors and other commercial entities qualifying as QCDRs without participation of clinician-led professional organizations focused on quality improvement.

While we agree that small specialty groups should be able to partner with outside entities to form a QCDR, we have begun to witness the creation of “registries” by commercial entities for their clients to receive credit for improvement activities and bonus points under ACI. These vendor-led registries do not have a primary purpose of improving quality or supporting population health management, do not have clinical expertise or in-depth understanding about quality measurement, and instead are only created for commercial purposes. We ask CMS to specify that QCDRs and other registries that qualify for the improvement activities and specialized and clinical data registries under ACI should be limited to those developed and led by clinician organizations and medical societies with goal of quality improvement and advancing public health. Without this clarification, the development of specialty-wide or procedure/disease-based registries may be impeded if commercial entities increasingly become involved in and control the priorities of registries.

5. CMS Should Calculate Two Separate Benchmarks for Electronic and Manual Reporting of QCDR Measures

In the Proposed Rule, CMS requests comments on how incentives for end-to-end reporting could be leveraged to incentivize more clinicians to report electronically.¹⁶ We request that CMS calculate two separate benchmarks for QCDR measures when they are reported both electronically (including with data electronically collected from an EHR, calculated and submitted) and manually (including through a web portal). Performance rates on a measure, including QCDR measures, will vary based on the reporting modality. The mode of reporting to the QCDR would differ depending whether the measure were calculated from data derived from the CEHRT, or manually reported through a web portal. By creating a separate benchmark for electronic reporting that is more flexible than the manual benchmark, QCDR participants will be incentivized to report electronically and qualify for the end-to-end reporting bonus.

¹⁵ *Id.* at 30,159.

¹⁶ *Id.* at 30,109-110.

6. CMS Should Allow QCDRs and Other Clinical Outcomes Data Registries the Option to Assist Virtual Groups in Aggregating Measures and Activities for Reporting

CMS proposes that individual eligible clinicians and individual MIPS eligible clinicians who are part of a taxpayer identification number (TIN) participating in MIPS at the virtual group level aggregate their performance data across multiple TINs in order for their performance to be assessed as a virtual group.¹⁷ The Coalition seeks clarification that QCDRs and other clinical outcomes data registries have the option to assist virtual groups by sharing in the responsibility for aggregating data. By not allowing the possibility for a virtual group to receive assistance from registries, such a group may be unable to successfully report its data. Aggregating data across various practices and EHR systems may be logistically difficult, as practices and EHRs have different ways of collecting and storing data. Therefore, data aggregation across various systems for a single quality measure may not be possible if registries do not have the option to assist clinicians. In addition, given the uncertainty of aggregating data across different practices with different EHR systems, CMS should not penalize virtual group participants when data aggregation is not possible due to technical challenges outside of their control.

Conclusion

The Coalition appreciates the opportunity to comment on the Proposed Rule. We strongly support the expansion of the use of QCDRs and other clinical outcomes data registries to help ease clinicians' burdens for submitting data under MIPS. While the Coalition greatly appreciates many of the improvements and changes suggested in the Proposed Rule, the considerations and additional changes that we have proposed will remove administrative burdens from the QCDR measure review and self-nomination process and create further incentives to use third-party submission mechanisms. We urge CMS to adopt the Coalition's suggested changes and continue to facilitate the use of QCDRs and other clinical outcomes data registries. These changes will allow the use of registries to grow and ultimately result in even greater improvements in the quality of patient care.

Thank you for the opportunity to submit these comments. If you have any questions, please contact Rob Portman at Powers Pyles Sutter & Verville PC (rob.portman@powerslaw.com or 202-872-6756).

Respectfully submitted,

AMERICAN ACADEMY OF OPHTHALMOLOGY
AMERICAN ACADEMY OF OTOLARYNGOLOGY-HEAD AND NECK SURGERY
AMERICAN ACADEMY OF PHYSICAL MEDICINE AND REHABILITATION
AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS/NEUROPOINT ALLIANCE
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

¹⁷ *Id.* at 30,033.

Seema Verma, MD, MPH, MS

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AMERICAN COLLEGE OF GASTROENTEROLOGY/GIQUIC
AMERICAN COLLEGE OF RHEUMATOLOGY
AMERICAN GASTROENTEROLOGICAL ASSOCIATION
AMERICAN JOINT REPLACEMENT REGISTRY
AMERICAN SOCIETY FOR GASTROINTESTINAL ENDOSCOPY/GIQUIC
AMERICAN SOCIETY FOR RADIATION ONCOLOGY
AMERICAN SOCIETY OF CLINICAL ONCOLOGY
AMERICAN SOCIETY OF NUCLEAR CARDIOLOGY
AMERICAN SOCIETY OF PLASTIC SURGEONS
AMERICAN UROLOGICAL ASSOCIATION
NORTH AMERICAN SPINE SOCIETY
SOCIETY OF INTERVENTIONAL RADIOLOGY
SOCIETY OF NEUROINTERVENTIONAL SURGERY
THE SOCIETY OF THORACIC SURGEONS