Response to Public Comments Received for CMS- 10621

We received several comments related to the MIPS PRA package.

Comment: Several commenters agreed with CMS's effort to streamline multiple reporting programs under one single program to save both time and cost for healthcare providers in tracking and reporting quality to CMS. Several commenters recommended further streamlining and simplifying data reporting to reduce the burden of reporting.

Response: In response to public comments, we have further streamlined reporting in the quality, advancing care information, and improvement activities performance categories between the proposal and the final rule with comment period. In part because of this additional streamlining, the total burden estimate has been reduced between the proposal and the final rule with comment period. The gross burden estimate in the proposal was 12,493,654 burden hours and a burden cost of $1,327,177,693 (81 FR 28362). The finalized burden estimates are 10,947,453 burden hours and a burden cost of $1,311,245,806. This finalized burden estimate includes both the MIPS PRA package and the CAHPS for MIPS PRA package.

Comment: Several commenters disagreed with the proposed rule and urged that it be withdrawn. The commenters stated that the proposals were unethical and would jeopardize patient confidentiality through the sharing of patient data with the government by submitting measures data.

Response: Patient confidentiality is very important to us. Please note that we will collect and disclose personally identifiable information (PII) and/or individually identifiable health information only in accordance with applicable privacy and security laws, including, but not limited to, the Privacy Act of 1974 and the Health Insurance

Portability and Protection Act of 1996 (HIPAA) Privacy Rule. We have updated the language on confidentiality in response to this comment.

Comment: One commenter stated that the proposed rule underestimated data submission costs because it did not include the fees paid to registries.

Response: The potential financial costs of fees paid to registries are discussed in the final rule with comment period's Regulatory Impact Analysis (section V.C). Because the burden estimates in this section addresses time costs, not direct financial costs, no changes were made to the burden estimate for data submission to registries and QCDRs as a result of this comment. In II.E.9.c(3) of the final rule, we are finalizing our proposal to post QCDR's self-reported costs for MIPS eligible clinicians or groups to use the QCDR on the CMS Website alongside their organizational contact information and the services and measures offered.

Comment: Several commenters disagreed with the assumption that a billing clerk could review proposed quality measures specifications due to their complexity.

Response: We agree with the commenters that due to the complexity of measure specifications, a broader range of occupational titles would need to be involved in reviewing measure specifications. In the proposal, we assumed that each practice would require 6 hours of a billing clerk's time and 1 hour of a clinician's time to review measure specifications. We have revised our burden estimates for the final rule with comment period to include a mix of staff needed to review quality measure specifications using calculations based on a recent Health Affairs article (http://content.healthaffairs.org/content/35/3/401.abstract). We assume that the skill mix necessary to review measure specifications includes: 3 hours of administrator time, 2

hours of clinician time, 1 hour of LPN/medical assistant time, 1 hour of computers system's analyst time, and 1 hour of billing clerk time.[1]

Comment: Several commenters believed that the proposal's burden estimates were too low because MIPS eligible clinicians would require extensive time to become familiar with the program. Specifically, the commenters believed that clinicians must develop familiarity with the data submission requirements in the program's transition year.

Response: As noted above, we have increased the estimated burden to become familiar with new quality measures from 1 hour of clinician time to 2 hours of clinician time for the transition year. After the transition year, we anticipate that the burden will be reduced as clinicians become more familiar with the quality measures and submission requirements.

In response to public comments, we have simplified the data submission requirements for improvement activities and advancing care information performance categories for the final rule with comment period. We have reduced the number of recommended improvement activities from 6 to 4. Consistent with the reduction in improvement activities, we have reduced our estimate of the data submission burden from the proposed 3 hours to 2 hours per group or clinician.

In response to public comments, we have also reduced the number of required measures in the advancing care information category from 11 to 5. Accordingly, we

[1] Our burden estimates are based on prorated versions of the estimates for reviewing measure specifications in Lawrence P. Casalino *et al*, "US Physician Practices Spend More than $15.4 Billion Annually to Report Quality Measures," *Health Affairs*, 35, no. 3 (2016): 401-406. The estimates were annualized to 50 weeks per year, and then prorated to reflect that Medicare revenue is 30% of all revenue paid by insurers, and then adjusted d to reflect that the decrease from 9 required quality measures under PQRS to 6 required measures under MIPS.

have reduced our burden estimates for the advancing care information performance category for the final rule with comment period from 4 hours to 3 hours per respondent.

After the transition year, we anticipate a reduction in the burden of reporting improvement activities and advancing care information measures as clinicians and organizations submitting data on their behalf become more familiar with and adapt to the measure specifications.

Comment: One commenter noted the reduction in the number of quality measures compared to previous PQRS reporting requirements would reduce clinicians' burden.

Response: For most quality data submission mechanisms, MIPS eligible clinicians are required to report 6 quality measures under MIPS, a reduction from 9 measures under PQRS. Our revised burden estimates reflect the reduction in measures. Specifically, we prorated the Health Affairs articles' burden estimates for reviewing quality measure specifications to reflect that 6, rather than 9 measures were included. We expect that the quality reporting burden will decline after the transition year as MIPS eligible clinicians become more familiar with data submission requirements

Comment: One commenter requested that CMS provide time and cost estimates for determining which quality measures to report.

Response: As noted above, our burden estimates factor in 8 hours of staff time to review quality measure specifications, which includes evaluating which quality measures to report.

Comment: Two commenters believed that group data submission under advancing care information and other categories would reduce clinicians' burden.

Response: There is considerable uncertainty about the number of MIPS eligible clinicians that will report as part of a group, and no historical data on group reporting for the Medicare EHR Incentive Program. We have revised our burden estimates for the final rule with comment period to more appropriately reflect the reduction in burden due to group reporting by assuming that groups that submitted quality data to the 2015 PQRS would also do so under the advancing care information performance category. We assume that the burden of advancing care information data submission is the same for each respondent, whether that respondent is a group, individual clinician, or billing TIN in a MIPS APM. In the proposed rule, we assumed that all clinicians not in MIPS APMs would report as individuals. Due to the change in our assumptions about group reporting, our estimated burden of advancing care information for the final rule with comment period is lower than the proposal.

Comment: A few commenters noted that the removal of redundant eCQMs in the advancing care information category would reduce burden.

Response: We are striving to align the advancing care information performance category with other MIPS performance categories. For example, we believe submitting eCQMs to the quality performance category will streamline submission requirements and reduce MIPS eligible clinicians' confusion. In response to public comments, this final rule with comment period has further simplified data submission requirements by reducing the number of advancing care information measures from the proposed 11 measures to 5 measures. Consistent with the reduction in measures, we have reduced our burden estimates for the advancing care information performance category from the proposed 4 hours to 3 hours per clinician. Note that 3 hours is significantly lower than

the estimated 7 hours per MIPS eligible clinician estimated in the Medicare EHR Incentive Program – Stage 3 burden estimates. After the transition year, we anticipate a further reduction in the burden of submitting advancing care information measures as MIPS eligible clinicians and organizations submitting data on their behalf become more familiar with and have adapted to the measure specifications.