Public Comment Summary Report

Project Title: Electronic Clinical Quality Measures Development and Maintenance for Eligible Clinicians

Dates:

The Call for Public Comment ran from March 29, 2022 to April 28, 2022.

Project Overview:

The Centers for Medicare & Medicaid Services (CMS) contracted with Mathematica to develop the Preventive Care and Wellness composite measure. The contract name is Electronic Clinical Quality Measures (eCQM) Development and Maintenance for Eligible Clinicians. The contract number is 75FCMC18D0032/75FCMC19F000. Under this contract, Mathematica and its partners help develop, test, and maintain eCQMs and CMS-stewarded clinical quality measures. These measures are used in the Merit-Based Incentive Payment System (MIPS) program as part of the Quality Payment Program.

As part of its measure development process, Mathematica requested interested parties to submit comments on the candidate or concept measures that may be suitable for this project, specifically a Preventive Care and Wellness composite measure. Mathematica posted the composite specification, the rationale and intent of the measure, and the measure development history in its request for comments. Mathematica asked for feedback on the possible impact of the composite on accountability, performance improvement, and health disparities. Mathematica also requested feedback on any unintended consequences of including this measure in MIPS, barriers to implementing the measure, and potential drawbacks of reporting the components of the measure in aggregate versus separately.

Information About the Comments Received:

The measure developer solicited public comments by:

- Posting on the CMS public comment website
- Posting on the CMS Measure Management System's electronic mailing list
- Sending emails to the following stakeholders and stakeholder organizations:
    - Academy of Managed Care Pharmacy
    - Academy of Nutrition and Dietetics
    - Alliance of Specialty Medicine
    - Alteon Health
    - American Academy of Emergency Medicine
    - American Academy of Family Physicians
    - American Academy of Physician Assistants
    - American Association of Nurse Practitioners
    - American Board of Family Medicine
    - American Board of Internal Medicine

- American Board of Internal Medicine Foundation
- American Board of Medical Specialties
- American College of Cardiology
- American College of Emergency Physicians
- American College of Obstetricians and Gynecologists
- American College of Physicians
- American College of Preventive Medicine
- American Diabetes Association
- American Health Care Association
- American Hospital Association
- American Medical Association
- American Medical Group Association
- American Medical Women's Association
- American Nurses Association
- American Pharmacists Association
- American Psychiatric Association
- American Psychoanalytic Association
- American Psychological Association
- American Society of Hematology
- American Society of Nephrology
- America's Essential Hospitals
- ArborMetrix
- Endocrine Society
- Families USA
- Forward Health Group
- Galileo Consulting Group
- Hart Health Strategies
- Independent Healthcare Quality Consultant
- Infectious Diseases Society of America
- Meritus Health
- Mount Sinai Health System
- MyHealth Access Network
- National Council for Mental Wellbeing
- National Organization of State Offices of Rural Health
- National Rural Health Association
- Nebraska Health Information Initiative
- NorthShore University HealthSystem
- Optum
- Patient360
- Premier, Inc.
- Providence Health and Services Value-Based Care and Ambulatory Quality
- Purdue University Department of Public Health
- RAND Corporation
- ROLE Services, LLC
- Shirley Ryan Ability Lab
- Society for Post-Acute and Long-Term Care Medicine
- Society of General Internal Medicine

- Telligen
- Thomas Jefferson University Jefferson Center for Connected Care
- U.S. Wound and Podiatry Registries
- University of Chicago Pritzker School of Medicine
- University of North Carolina School of Medicine
- University of Oklahoma Health Sciences Center
- University of Washington School of Public Health
- Urgent Care Association
- Vituity
- Yale Center for Outcomes Research and Evaluation

We received six responses on this topic.

Stakeholder Comments

We received feedback on composite methodology and implementation, which we describe in the General Stakeholder Comments section. We also received feedback specific to the Preventive Care and Wellness composite, summarized in the Measure-Specific Stakeholder Comments section.

General Stakeholder Comments:

We received general feedback about implementation burden and composite methodology from six commenters.

Implementation burden

Six commenters expressed concern that the composite measure does not reduce reporting burden. One commenter (a physician organization) noted that if reporting the composite measure accounted for the same points as reporting an individual measure in the Quality Payment Program, it would disincentivize clinicians from reporting the composite measure because of the burden of implementation. Another commenter (a physician organization) said the benefit of the composite would not outweigh the burden if there was an increase in required reporting, as the composite would require reporting on all seven component measures. Similarly, one commenter (a physician organization) said the burden of reporting the composite versus the individual component measures would not be reduced because the number of clinical actions required would be the same for each component measure, but the complexity of reporting would increase. Another commenter (a health outcomes research center and measure developer) stated that the burden of reporting would be shared unequally among clinicians: small groups or solo practitioners with limited resources to devote to reporting might find it more difficult to report a composite.

Conversely, one commenter (a quality clinical data registry) said reporting a composite could be less burdensome, but only if the composite replaces the reporting required for all individual component measures.

Response:

Thank you for these comments. These concerns align with feedback from other stakeholders gathered during measure development. Stakeholders noted that reporting the measures as a composite might not reduce burden and might increase burden. CMS will consider these comments on implementation burden when determining how to implement composite measures in MIPS.

Quality improvement and composite measure scores versus component measure scores

Five commenters noted that the individual component measure scores would be more helpful for driving quality improvement than a composite measure. One of them (a physician organization) doubted that a composite measure would add utility in driving performance improvement beyond what the individual measures provide. Another commenter (a physician organization) said it was unclear if this composite score would be meaningful, given that it combines various populations into one general score while details on gaps in care remain unclear. Similarly, a commenter (a health outcomes research center and measure developer) stated that the providers would not receive feedback on the components that would be most helpful for improvement if only a composite score is reported. Finally, a commenter (a physician organization) asked if it would be possible to report both individual measure scores and the weighted composite score to provide targeted information about which components are lagging or limited in uptake.

Separately, one commenter (a physician organization) said although composite scores are not granular enough to drive improvement at the practice level, they might be beneficial at the larger health system level.

Response:

Thank you for these comments. Other stakeholders also expressed concern about the usefulness of a single composite score compared with individual component scores on quality improvement. CMS will keep this feedback in mind when determining how to implement composite measures in MIPS.

Measure-Specific Stakeholder Comments:

Six commenters provided feedback on the Preventive Care and Wellness composite regarding feasibility, health disparities, reliability and validity, composite weighting methodology, and the component measures.

Feasibility

Two commenters requested additional information from CMS on the feasibility of the composite so they could provide comments on its feasibility. Although one commenter (a physician organization) was generic in its request for additional information, the other (a physician organization) had more specific notes: this commenter questioned whether the composite would be feasible to collect and report, given the current selection of component measures and their corresponding patient populations. To the commenter's knowledge, no individual clinicians or practices currently collect and report all seven component measures to MIPS. This commenter said it would be unlikely for clinicians or practices to focus their quality improvement efforts on so many disparate clinical actions at one time. The

commenter urged CMS to complete evaluations of MIPS participants' ability to accurately collect and report on this composite.

Response:

Thank you for these comments. All the component measures of the Preventive Care and Wellness composite are implemented and reported in MIPS as registry-based measures, which supports the feasibility of the composite measure. Furthermore, four clinical sites successfully provided the data elements required for calculating and testing the composite.

Health disparities

Three commenters expressed concern about the impact the composite could have on health disparities. Two commenters (physician organizations) noted that it might be difficult to identify health care disparities and corresponding interventions if the measure is not stratified by socioeconomic status. Another commenter (a health outcomes research center and measure developer) said the composite might penalize providers supplying high-quality and accessible preventive care due to the socioeconomic characteristics of the geographic area they serve. This commenter suggested that CMS monitor the Preventive Care and Wellness composite for health disparities by stratifying performance by patient demographic characteristics and social risk factors.

One commenter (a physician organization) said the Preventive Care and Wellness composite measure would not significantly affect health disparities but expressed concern about health disparities in the MIPS program overall.

Response:

Thank you for these comments. Other stakeholders shared the concern during measure development that the Preventive Care and Wellness composite does not focus on addressing disparities. As noted in the CMS Strategic Plan[1], health equity is a priority for CMS. CMS is working toward the goal of expanding and standardizing the collection and use of patient demographic and socioeconomic data, which could be used to enhance measurement. CMS will take this health disparity feedback into consideration as decisions about composite implementation are made.

Reliability and validity

Two commenters (physician organizations) requested the release of reliability and validity results for the sake of transparency during the public comment process.

Response:

Thank you for these comments. CMS will take this feedback under advisement when conducting future comment periods for measures. The Preventive Care and Wellness composite measure underwent empirical reliability and validity testing during measure development, and the results were summarized

[1] Centers for Medicare & Medicaid Services. (n.d.). *CMS Strategic Plan Pillar: Health equity*. Retrieved July 14, 2022, from https://www.cms.gov/files/document/health-equity-fact-sheet.pdf

in the public comment notice. For reliability testing, we conducted signal-to-noise and test-retest analyses; results were high across the methods tested. For validity testing, we conducted several empirical validity analyses, with results that support the validity of the measure. Detailed reliability and validity testing results were included in the 2022 Measures Under Consideration (MUC) submission form; if CMS decides to include this measure in the MUC, the detailed testing results will be made publicly available through the Measure Applications Partnership review process.

Composite weighting methodology

Three commenters provided mixed feedback on the denominator weighting methodology proposed for the Preventive Care and Wellness composite. One of them (a health outcomes research center and measure developer) noted that weighting by the size of the population might unintentionally overweight less clinically impactful measures than others; this commenter recommended monitoring for this unintended consequence. Another commenter (a physician organization) said the current denominator weighting method should mitigate the unintended consequence of components with small denominators having the same impact on the overall score as components with large denominators.

Response:

Thank you for these comments. Other stakeholders have also noted the importance of using an appropriate weighting methodology throughout the measure development process. Denominator weighting was selected to decrease the likelihood that composite scores would be disproportionately affected by component measures that are less relevant to the clinician's patient population. CMS will keep these weighting methodology comments in mind as implementation decisions are made for the composite.

Component measures

Five commenters had mixed feedback on the component measures in the Preventive Care and Wellness composite. One commenter (a physician organization) did not support some of the component measures and therefore did not support the composite for the MIPS program. Another commenter (a physician organization) stated that the component measures are important and evidence based but questioned how each component adds value to the overall quality score. A third commenter (a physician organization) said preventive care measures that are particularly important for marginalized populations, such as HIV screening, are not present in the composite.

One commenter (a physician organization) requested additional information on the composite measure specifications and empirical analyses that support the inclusion of the selected component measures in the composite. A final commenter (a health outcomes research center and measure developer) had a similar request for additional information, while noting general support for the Preventive Care and Wellness composite.

Response:

Thank you for these comments. Other stakeholders also provided mixed feedback on the inclusion of these particular component measures in the composite. CMS recognizes that the measure does not cover all recommended preventive practices for all populations. As an initial composite for preventive care, the measure is intended to assess the delivery of selected age- and sex-appropriate preventive

screenings and wellness services by summarizing providers' actions to identify and manage a patient's health risks for preventable conditions. The seven component measures are based on recommendations for preventive care by the U.S. Preventive Services Task Force, Advisory Committee on Immunization Practices, American Association of Clinical Endocrinology, and American College of Endocrinology. In addition, measure testing showed that the Preventive Care and Wellness composite measure was empirically valid. CMS will take this feedback into consideration as it determines how the measure can appropriately fit within a group of measures for reporting in MIPS, particularly as CMS continues to transition to MIPS Value Pathways.

Preliminary Recommendations

As the public comments reiterate common themes from other stakeholder feedback previously received, we will continue working with CMS on these themes during the 2022 Call for Measures cycle and the Measure Applications Partnership review. CMS will take these comments into consideration as implementation decisions are made.

Overall Analysis of the Comments and Recommendations

The public feedback on the Preventive Care and Wellness composite measure is consistent with feedback received from other stakeholders during the measure development process. The feedback reinforces the significance of key themes—such as implementation burden and the importance of monitoring health disparities—as the composite implementation process moves forward. CMS will continue to consider public comments on this measure and on composite measures more broadly.

Public Comment Verbatim Report

Comment Number*	Date Posted/ Received	Name, Credentials, and Organization of Commenter	Type of Organization*	Email Address*	Text of Comments and Responses
1	4/20/2022	Amanda Lord Patient360	Quality clinical data registry	alord@patient360.com	**Verbatim Comment**: To what extent could potential audiences (for example, consumers, purchasers, providers, policymakers) use the Preventive Care and Wellness composite measure performance results for both accountability and performance improvement? People would use it if it doesn't make the program (whether MIPS or MVPS) more burdensome. So, as I alluded to, if it only replaces one measure, I doubt there would be interest. CMS already removed so many other incentives and the stakes are so much higher moving forward, if this would only replace one measure, I think groups would not be happy about that. Do you foresee any negative unintended consequences of CMS including this measure in the MIPS program? If so, do the benefits associated with this measure outweigh those negative unintended consequences? Per above, only negative consequences if the one measure is NOT "replacing" the 6 required measures. If it is, I am sure people would do it bc it means less burden. If not, it means more burden so no one would bother. CMS prioritized development of the Preventive Care and Wellness composite measure because, as a composite, it had several advantages for CMS and stakeholders compared to individual measures. Are there drawbacks of aggregating individual measures into a summary composite measure, as compared to reporting them separately?

Comment Number*	Date Posted/ Received	Name, Credentials, and Organization of Commenter	Type of Organization*	Email Address*	Text of Comments and Responses
1 (*cont'd)*	4/20/2022	Amanda Lord Patient360	Quality clinical data registry	alord@patient360.com	Again, drawback is only if it doesn't replace them having to report 6 measures. If it does, then it's less burden, more LEAN. Which is ideal. If it doesn't, then no one will want to bother since this program is already so burdensome, especially given they are now shifting it once again from MIPS to MVPs. Now everyone has to learn yet another iteration and "repackaging" of essentially the same program. And then we, the QCDR, have to spend more dev time and resources to implement it. So if it's easy to implement and replaces having to report 6, we are keen. If not, just another time/resource/$$$ project. **Response:** Thank you very much for your feedback. CMS will take these comments regarding implementation burden into consideration when determining how to implement composite measures in MIPS.
2	4/25/2022	American Medical Association	Physician organization	Koryn.Rubin@ama-assn.org	**Verbatim Comment:** The American Medical Association (AMA) appreciates the opportunity to comment on the Preventive Care and Wellness composite measure under development by the Centers for Medicare & Medicaid Services (CMS). We are unable to provide substantive comments at this time due to the lack of detailed information on reliability and validity testing and information on the feasibility of reporting the composite. As a result, we are concerned about the implementation of this measure and question the degree to which CMS will receive meaningful and useful feedback during this public comment period given the omission of this important information. While the AMA does agrees that the individual measures included in the composite are important and evidence based, we do not see sufficient justification and empirical analyses to support the inclusion of these seven measures in the composite, particularly information that supports how each measure fits within the quality construct and adds value to the overall quality score.

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2 *(cont'd)*	4/25/2022	American Medical Association	Physician organization	Koryn.Rubin@ama-assn.org	While the composite includes general statements indicating that the composite was reliable and valid, it does not provide enough information to justify implementation. For example, it is not clear whether each measure included in the composite had adequate sample sizes at the individual clinician level or if measure score reliability was further impacted (potentially negatively) when the weighting and aggregation rules were applied. Furthermore, we question whether validity was only demonstrated through an assessment of face validity and if so, the make-up of those persons surveyed and the results of these surveys. In addition, if empirical validity testing was performed, we are interested in the method used and results. Lastly, the AMA cannot stress how important it is that CMS fully evaluate whether this composite is truly feasible to collect and report at the point of care given the various patient populations and the current selection of measures in the Merit-based Incentive Payment System (MIPS). Specifically, to our knowledge and given the current reporting minimum of six measures, we do not believe that any individual clinician or practice currently collects and reports these seven measures for MIPS. Particularly, it would be unlikely for clinicians or practices to focus their quality improvement efforts on the many disparate clinical actions at one time. Aggregating existing data within MIPS, which we assume was the method used to evaluate feasibility, reliability and validity, does not provide an accurate view on how this composite could practically be implemented by an individual clinician or practice and we urge CMS to complete robust evaluations on a MIPS participant's ability to collect and report on this composite accurately.

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2 *(cont'd)*	4/25/2022	American Medical Association	Physician organization	Koryn.Rubin@ama-assn.org	Furthermore, the AMA does not believe that this composite reduces burden when reporting these measures as a composite because the number of clinical actions have not decreased, rather the complexity is further increased in this approach. It remains unclear how meaningful this composite will be to clinicians or patients since it combines various patient populations into one general score and important details on where the gaps in care remain are unclear. The AMA urges CMS to release the results from the testing of this composite, including data to demonstrate that individual clinician and practices can feasibly collect and report it, and further conduct a second public comment period. These steps should be taken before CMS considers proposing this measure for use in MIPS. **Response**: Thank you very much for your feedback. We appreciate your feedback about the selection of the component measures for this composite. As an initial composite for preventive care, the measure is intended to assess delivery of selected age- and sex-appropriate preventive screenings and wellness services by summarizing providers' actions to identify and manage a patient's health risks for preventable conditions. The seven component measures are based on recommendations for preventive care from the U.S. Preventive Services Task Force, Advisory Committee on Immunization Practices, American Association of Clinical Endocrinology, and American College of Endocrinology. In addition, measure testing showed that the Preventive Care and Wellness composite measure was empirically valid. CMS will take this public comment and other feedback into consideration.

Comment Number*	Date Posted/ Received	Name, Credentials, and Organization of Commenter	Type of Organization*	Email Address*	Text of Comments and Responses
2 *(cont'd)*	4/25/2022	American Medical Association	Physician organization	Koryn.Rubin@ama-assn.org	We appreciate your feedback about reliability and validity testing, as well as your desire to provide meaningful and useful feedback to CMS based on these testing results. The Preventive Care and Wellness composite measure underwent empirical reliability and validity testing during measure development, and the results were summarized in the public comment notice. For reliability testing, we conducted signal-to-noise and test-retest analyses; results were high across the methods tested. For validity testing, we conducted several empirical validity analyses, with results that support the validity of the measure. Detailed reliability and validity testing results were included in the 2022 Measures Under Consideration (MUC) submission form; if CMS decides to include this measure in the MUC, the detailed testing results will be made publicly available through the Measure Applications Partnership review process. We appreciate your concern about the feasibility of reporting this composite measure and the potential impacts of reporting seven component measures on quality improvement efforts. All the component measures of the Preventive Care and Wellness composite are implemented and reported in MIPS as registry-based measures, which supports the feasibility of the composite measure. Furthermore, four clinical sites successfully provided data elements required for calculating and testing the composite. CMS will take your quality improvement concerns into consideration. CMS appreciates your feedback about implementation burden and the difficulty of identifying gaps in care if just one score is reported. We will take these concerns into consideration during the measure implementation process.

Comment Number*	Date Posted/ Received	Name, Credentials, and Organization of Commenter	Type of Organization*	Email Address*	Text of Comments and Responses
3	4/26/2022	YNHH Center for Outcomes Research and Evaluation (CORE)	Health outcomes research center, measure developer	avis.harperbrooks@yale.edu	**Verbatim Comment**: Question/Topic 1 To what extent could potential audiences (for example, consumers, purchasers, providers, policymakers) use the Preventive Care and Wellness composite measure performance results for both accountability and performance improvement? CORE Team Responses: We support measuring Preventive Care and Wellness and CMS' and Mathematica's efforts to reduce measure complexity. In general, we are supportive of this approach, but offer the following comments to assist in development and implementation. The rate of preventative care varies and is associated with social determinants. If the score is more attributable to patient and demographic characteristics than to provider characteristics and performance, measure-based incentives may ultimately penalize providers providing high-quality and accessible preventative and wellness care due to socioeconomic variables/patient characteristics specific to their catchment area. It may be helpful to consider how the shift from individual measures to the PCW composite measure may impact measured providers. Will all providers be affected the same way and to a comparably similar degree? While there are advantages to a composite measure, especially for payors, many consumers and even some providers may still want to know the individual measure scores. Individual measure information offers consumers a better sense of quality information most relevant to them and similarly, providers may need more specific information to improve care. Payers can use this to measure adherence to preventive service recommendations in VBP programs.

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3 (*cont'd*)	4/26/2022	YNHH Center for Outcomes Research and Evaluation (CORE)	Health outcomes research center, measure developer	avis.harperbrooks@yale.edu	Question/Topic 2: Do you foresee any negative unintended consequences of CMS including this measure in the MIPS program? If so, do the benefits associated with this measure outweigh those negative unintended consequences? CORE Team Responses: Overall, the benefits do seem to outweigh any potential negative unintended consequences. Our comments mostly reflect limitations of the component measures and are not specific to the composite measure. It may be helpful to clarify the requirements for the documented follow-up plan for BMI, the tobacco cessation intervention, and the documented follow-up plan for high blood pressure. These three components have the risk of being "documented" but not carried out. For influenza immunization, pneumococcal vaccination, breast cancer screening, and colorectal cancer screening, providers can receive "credit" for these components even if they were initiated under the care of a different provider or independently by the patient. However, we agree that duplicative testing is both burdensome and wasteful and thus reasonable to use the existing approach. There are not additional details of what constitutes 'appropriate' screening in most cases. We think an assurance that these screenings are not overused, thus complicating, and lengthening medical visits, would be beneficial. Overall, though, the benefits of measurement outweigh the harm.

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3 (*cont'd*)	4/26/2022	YNHH Center for Outcomes Research and Evaluation (CORE)	Health outcomes research center, measure developer	avis.harperbrooks@yale.edu	Question/Topic 3: What is the potential impact on health disparities if this measure is implemented in MIPS? CORE Team Responses: We strongly recommend that the composite measure be stratified by social risk factors if possible. Additionally, potential avenues of how to measure improvement within and across groups should be explored. Social determinants of health (SDOH) should not have an influence on the appropriate administration of screening tools. However, many of these screening tools (particularly colorectal cancer screening), are associated with existing disparity along SDOH lines. We support measurement to transparently make stakeholders (providers, consumers, and payors) aware of disparities and enable tracking of disparities over time. Question/Topic 4: CMS prioritized development of the Preventive Care and Wellness composite measure because, as a composite, it had several advantages for CMS and stakeholders compared to individual measures. Are there drawbacks of aggregating individual measures into a summary composite measure, as compared to reporting them separately? CORE Team Responses: If only a composite score is reported, the provider will not receive feedback on the components that should be prioritized for improvement. It would be beneficial for the composite measure to have the ability to be decomposed into the individual component measures for specific audience and purpose as needed. This would allow for transparency and appropriate interpretation to identify gaps and opportunity for improvement.

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3 (*cont'd*)	4/26/2022	YNHH Center for Outcomes Research and Evaluation (CORE)	Health outcomes research center, measure developer	avis.harperbrooks@yale.edu	The composite measure can mask/hide weaknesses in specific measures, and this drawback is more pronounced when the provider/hospital's composite measure is close to the sample mean. For example, an average score for the PCW composite measure could mean that the provider is doing similar to the national average on almost all measures. Alternatively, the provider could be excelling on a few measures and doing very poorly on others, requiring a quite different quality improvement response. There are potential drawbacks with weighting. Measure weights are usually assigned based on expert opinion and consensus to reflect the clinical or public health importance of individual measures. Unfortunately, not everybody agrees on the values assigned to each measure. And sometimes, some weights are based on policy priorities (not clinical importance) or even on social/political pressure from various stakeholders' groups. Weighting by the size of the underlying at-risk population may unintentionally overweight less clinically impactful screening measures and underweight others. We recommend close monitoring for this potential unintended consequence. Results may differ depending on the compositing methodology used. For example, even for the same set of data, different methods of computing the composite measure may produce slightly different results. We recommend that the methods be aligned with other programs using composite measure, such as HVBP. Question/Topic 5: What are potential challenges to stakeholders for implementing the Preventive Care and Wellness composite measure in MIPS? CORE Team Responses: Below are a few questions and challenges that were surfaced during the review of this measure:

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3 (*cont'd*)	4/26/2022	YNHH Center for Outcomes Research and Evaluation (CORE)	Health outcomes research center, measure developer	avis.harperbrooks@yale.edu	Will the composite measure aggregation and reporting add burden (compared with reporting individual measure scores) for providers, especially for small groups or solo practitioners with limited resources to devote to reporting? What might the composite measure reporting look like and how might it address clinician burden and stakeholders concern that MIPS remain overly complex? **Response**: Thank you very much for your feedback. We appreciate your feedback about the intersection of health disparities and the unintended consequences related to the composite, as well as the importance of component scores. CMS will keep this feedback in mind during the measure implementation process. We appreciate your feedback on the component measures in the composite. CMS recognizes that the measure does not cover all recommended preventive practices for all populations. As an initial composite for preventive care, the measure is intended to assess the delivery of selected age- and sex-appropriate preventive screenings and wellness services by summarizing providers' actions to identify and manage a patient's health risks for preventable conditions. The seven component measures are based on recommendations for preventive care from the U.S. Preventive Services Task Force, Advisory Committee on Immunization Practices, American Association of Clinical Endocrinology, and American College of Endocrinology. In addition, measure testing showed that the Preventive Care and Wellness composite measure was empirically valid.

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3 (*cont'd*)	4/26/2022	YNHH Center for Outcomes Research and Evaluation (CORE)	Health outcomes research center, measure developer	avis.harperbrooks@yale.edu	We appreciate your feedback on the composite weighting methodology. Denominator weighting was selected to decrease the likelihood that composite scores would be disproportionately affected by component measures that are less relevant to the clinician's patient population. CMS will take this weighting feedback into consideration. We appreciate your feedback on the implementation burden of the composite. CMS will consider these comments when determining how to implement composite measures in MIPS.
4	4/28/2022	American College of Preventive Medicine (ACPM)	Physician organization	cmacmain-cage@acpm.org	**Verbatim Comment:** To what extent could potential audiences (for example, consumers, purchasers, providers, policymakers) use the Preventive Care and Wellness composite to measure performance results for both accountability and performance improvement? Preventive care and wellness composite measures would provide policymakers, researchers, and providers a powerful metric by which to measure the impact of preventive services on healthcare outcomes, quality, and efficiency. Do you foresee any negative unintended consequences of CMS including this measure in the MIPS program? If so, do the benefits associated with this measure outweigh those negative unintended consequences? Early intervention and prevention, particularly as relates to chronic cardiometabolic disease, tobacco use, and vaccination have routinely shown to be high-impact clinical and public health interventions that lead to greatly improved quality of life as well as reduced cost and increased health system efficiency. ACPM believes that measures to encourage more clinicians to address these factors as part of routine clinical encounters yield sizably positive benefits, that likely outweigh any potential negative outcomes.

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4 (*cont'd*)	4/28/2022	American College of Preventive Medicine (ACPM)	Physician organization	cmacmain-cage@acpm.org	What is the potential impact on health disparities if this measure is implemented in MIPS? A core driver of health disparities is the frequency of interaction with and access to the healthcare system – especially early screening and prevention. However, if this data is not associated or cross-referenceable by categories such as race, sex, gender, sexuality, income level, etc. it may be of limited use in identifying disparities in care and tailoring interventions to right them. Additionally, measures for preventive care that may be particularly important for marginalized populations, such as HIV screening, are not present in the composite score. CMS prioritized development of the Preventive Care and Wellness composite measure because, as a composite, it had several advantages for CMS and stakeholders compared to individual measures. Are there drawbacks of aggregating individual measures into a summary composite measure, as compared to reporting them separately? Depending on the reporting methodology, the composite score may be a limiting factor in academic and practice-based research taken on this subject. Would it be possible to report individual category scores in addition to the weighted score to provide greater insight into the specific preventive practices that may be lagging or limited in uptake? What are potential challenges to stakeholders for implementing the Preventive Care and Wellness composite measure in MIPS?

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4 (*cont'd*)	4/28/2022	American College of Preventive Medicine (ACPM)	Physician organization	cmacmain-cage@acpm.org	Physician burnout has been an immense challenge even before the COVID-19 pandemic. While additional quality measures are impactful tools to encourage utilization of core preventive services, they do add additional administrative requirements to already overworked clinicians. **Response**: Thank you very much for your feedback. We appreciate your feedback on the importance of measures that address early intervention and prevention as part of quality improvements. CMS will take this feedback into consideration during the implementation process. We appreciate your feedback on the importance of stratification for addressing health disparities. As noted in the CMS Strategic Plan, health equity is a priority for CMS. CMS is working toward the goal of expanding and standardizing the collection and use of patient demographic and socioeconomic data, which could be used to enhance measurement. CMS will keep your feedback in mind as decisions about composite implementation are made. We appreciate your feedback on the importance of including component measures that are relevant to marginalized populations. CMS recognizes that the measure does not cover all recommended preventive practices for all populations. As an initial composite for preventive care, the measure is intended to assess the delivery of selected age- and sex-appropriate preventive screenings and wellness services by summarizing providers' actions to identify and manage a patient's health risks for preventable conditions. The seven component measures are based on recommendations for preventive care from the U.S. Preventive Services Task Force, Advisory Committee on Immunization Practices, American Association of Clinical Endocrinology, and American College of Endocrinology.

Comment Number*	Date Posted/ Received	Name, Credentials, and Organization of Commenter	Type of Organization*	Email Address*	Text of Comments and Responses
4 (*cont'd*)	4/28/2022	American College of Preventive Medicine (ACPM)	Physician organization	cmacmain-cage@acpm.org	CMS will consider your feedback on the component measures as the measure implementation process continues. We appreciate your feedback on the importance of component scores for academic and practice-based research. CMS will keep this feedback in mind when determining how to implement composite measures in MIPS. We appreciate your feedback on physician burnout as a potential challenge. CMS will consider these comments on implementation burden when determining how to implement composite measures in MIPS.
5	4/28/2022	Amir Qaseem, MD, PhD, MHA, MRCP (London), FACP Chief Science Officer Senior Vice President, Clinical Policy American College of Physicians (ACP)	Physician organization	aqaseem@acponline.org	**Verbatim Comment:** The American College of Physicians (ACP) appreciates the opportunity to submit comment on Electronic Clinical Quality Measures (eCQM) Development and Maintenance for Eligible Clinicians project, specifically the Preventive Care and Wellness (PCW) composite measure. As the largest medical specialty organization and the second-largest physician group in the United States, internists are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness. ACP did not support the previous version of the measure, as the composite was calculated as an average of scores. ACP acknowledges a significant positive change to the PCW specifications, which now include the use of a denominator-weighted calculation. This denominator-weighting, in theory, should provide clinicians with a weighted score based on the services performed more often. This approach should mitigate the unintended consequence of having components with small denominators (e.g., mammography) have the same impact on the overall score as components with large denominators (e.g., flu, smoking).

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5 (*cont'd*)	4/28/2022	Amir Qaseem, MD, PhD, MHA, MRCP (London), FACP Chief Science Officer Senior Vice President, Clinical Policy American College of Physicians (ACP)	Physician organization	aqaseem@acponline.org	However, without the appropriate scientific acceptability information, ACP is unable to provide comments on the updated measure calculation. ACP urges Mathematica and CMS to release the results of the reliability and validity testing and the levels of attribution to allow for a more transparent public comment process. While ACP agrees that wellness and preventive care measures are important to improve outcomes, it is unclear how the PCW composite will provide meaningful outcomes on health disparities without any risk-adjustment or stratification information. Since the public comment period does not include information about how this measure would be used in the QPP program, ACP would be concerned if it is implemented in such a way that the composite accounts for the same points as any other individual measure. We believe this programmatic decision could be a disincentive for clinicians to report on any of the measures included in the composite. As a result, it would have the unintended effect of pushing physicians to report on the other preventive measures not included in the composite which one could argue are not as important as some of the individual measures included in the composite. Overall, ACP does not support the PCW composite for use in the MIPS program, given ACP's mixed support for the measures that are included within it. ACP requests more information on the scientific acceptability and feasibility of this measure to provide more robust comments on the potential for accountability at the individual and group practice levels and performance improvement results. ACP looks forward to continued discussions and collaboration with CMS and Mathematica.

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5 (*cont'd*)	4/28/2022	Amir Qaseem, MD, PhD, MHA, MRCP (London), FACP Chief Science Officer Senior Vice President, Clinical Policy American College of Physicians (ACP)	Physician organization	aqaseem@acponline.org	Please contact Samantha Tierney, Senior Scientist, Clinical Policy at stierney@acponline.org or 215-351-2433 should you have any questions. **Response:** Thank you very much for your response. We appreciate your feedback on the composite weighting methodology. Denominator weighting was selected to decrease the likelihood that composite scores would be disproportionately affected by component measures that are less relevant to the clinician's patient population. We appreciate your request for additional information on scientific acceptability. The Preventive Care and Wellness composite measure underwent empirical reliability and validity testing during measure development, and the results were summarized in the public comment notice. For reliability testing, we conducted signal-to-noise and test-retest analyses; results were high across the methods tested. For validity testing, we conducted several empirical validity analyses, with results that support the validity of the measure. Detailed reliability and validity testing results were included in the 2022 Measures Under Consideration (MUC) submission form; if CMS decides to include this measure in the MUC, the detailed testing results will be made publicly available through the Measure Applications Partnership review process. We appreciate your feedback on the need for risk adjustment or stratification information to generate meaningful outcomes on health disparities. As noted in the CMS Strategic Plan, health equity is a priority for CMS. CMS is working toward the goal of expanding and standardizing the collection and use of patient demographic and socioeconomic data, which could be used to enhance measurement. CMS will take this health disparity feedback into consideration as decisions about composite implementation are made.

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5 (*cont'd*)	4/28/2022	Amir Qaseem, MD, PhD, MHA, MRCP (London), FACP Chief Science Officer Senior Vice President, Clinical Policy American College of Physicians (ACP)	Physician organization	aqaseem@acponline.org	We appreciate your feedback on the implementation burden that composite reporting could create. CMS will consider these comments when determining how to implement composite measures in MIPS. We appreciate your feedback on the composite component measures. As an initial composite for preventive care, the measure is intended to assess the delivery of selected age- and sex-appropriate preventive screenings and wellness services by summarizing providers' actions to identify and manage a patient's health risks for preventable conditions. The seven component measures are based on recommendations for preventive care from the U.S. Preventive Services Task Force, Advisory Committee on Immunization Practices, American Association of Clinical Endocrinology, and American College of Endocrinology. In addition, measure testing showed that the Preventive Care and Wellness composite measure was empirically valid. CMS will take this public comment and other feedback into consideration. We appreciate your request for more information on the feasibility of the composite. All the component measures of the Preventive Care and Wellness composite are implemented and reported in MIPS as registry-based measures, which supports the feasibility of the composite. Furthermore, four clinical sites successfully provided data elements required for calculating and testing the composite.

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6	4/29/2022	Anders Chen, MD, MHS Chair, Clinical Practice Subcommittee of the Health Policy Committee Elizabeth A. Jacobs, MD, MPH Chair, Health Policy Committee LeRoi Hicks, MD, MPH President Eric B. Bass, MD, MPH CEO Society of General Internal Medicine (SGIM)	Physician organization	andersch@uw.edu Elizabeth.Jacobs@MaineHealth.org LeHicks@ChristianaCare.org basse@sgim.org	**Verbatim Comment:** Re: Electronic Clinical Quality Measures (eCQM) Development and Maintenance for Eligible Clinicians. On behalf of the Society of General Internal Medicine (SGIM), which represents 3000 of the country's leading academic general internists and primary care physicians, we appreciate the opportunity to provide the following comments on the proposed Preventative Care and Wellness composite measure. • To what extent could potential audiences (for example, consumers, purchasers, providers, policymakers) use the Preventive Care and Wellness composite measure performance results for both accountability and performance improvement? For individual physicians, SGIM does not feel the composite measure will add utility in driving performance improvement beyond the individual measures already in existence. Many of our members practice in the VA system and lead primary care services within the VA, where composite primary care and prevention measures have been in use for many years. While these composite scores may reflect a more stable and statistically reliable measure for accountability purposes, these composites do not provide enough granularity to drive actual improvement work at the practice level. SGIM believes that such composite measures may provide benefits to CMS and at the larger health system level for accountability but does not add value at the physician and practice level, and CMS should be transparent and clear in the reasons for adding such a measure. • Do you foresee any negative unintended consequences of CMS including this measure in the MIPS program? If so, do the benefits associated with this measure outweigh those negative unintended consequences?

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6 (*cont'd*)	4/29/2022	Anders Chen, MD, MHS Chair, Clinical Practice Subcommittee of the Health Policy Committee Elizabeth A. Jacobs, MD, MPH Chair, Health Policy Committee LeRoi Hicks, MD, MPH President Eric B. Bass, MD, MPH CEO Society of General Internal Medicine (SGIM)	Physician organization	andersch@uw.edu Elizabeth.Jacobs@MaineHealth.org LeHicks@ChristianaCare.org basse@sgim.org	SGIM's primary concern with a composite measure is regarding reporting burden. Given the lack of benefit at the physician/practice level described above, if the composite measure would lead to any additional reporting burden for physicians, our membership and organization would not feel that the benefit would outweigh the consequences. Given physicians can currently choose within MIPS which measures they report, if a composite measure would mean that physicians would need to report on all the measures included within the composite, this could impact reporting burden. • What is the potential impact on health disparities if this measure is implemented in MIPS? SGIM has long expressed concerns to CMS that MIPS is not an equitable program. Studies in the peer reviewed literature have consistently shown that MIPS and other CMS pay for performance programs that do not adequately account for social risk financially penalize safety net practices. These practices disproportionately serve disadvantaged populations including racial and ethnic minorities, leading to a "Reverse Robin Hood" effect of redistributing Medicare dollars from safety nets to better-resourced practices caring for patients of lower social complexity and risk. SGIM acknowledges the need to hold safety net practices to the same quality standards, but CMS must also provide adequate and fair financial support to these practices. SGIM does not feel that this composite measure would impact disparities significantly, especially in the context of the current impact that MIPS has on equity as described above. SGIM has recently drafted a position statement on equity in CMS' pay for performance programs and would be happy to share this and further discuss how to improve equity in MIPS, including the creation of direct health equity measures.

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6 (*cont'd*)	4/29/2022	Anders Chen, MD, MHS Chair, Clinical Practice Subcommittee of the Health Policy Committee Elizabeth A. Jacobs, MD, MPH Chair, Health Policy Committee LeRoi Hicks, MD, MPH President Eric B. Bass, MD, MPH CEO Society of General Internal Medicine (SGIM)	Physician organization	andersch@uw.edu Elizabeth.Jacobs@MaineHealth.org LeHicks@ChristianaCare.org basse@sgim.org	• CMS prioritized development of the Preventive Care and Wellness composite measure because, as a composite, it had several advantages for CMS and stakeholders over using individual measures. Are there any drawbacks of aggregating individual measures into a summary composite measure, as compared to reporting them separately? SGIM shares the concerns brought forward by the Patient and Family Workgroup and Technical Expert Panel that a single composite measure without also reporting individual measures would have significantly less meaning to patients and physicians. Other concerns are shared in responses to previous questions above. **Response:** Thank you very much for your feedback. We appreciate your feedback on the ability of the composite to drive quality improvements. CMS will keep this feedback in mind as implementation decisions are made for the composite. We appreciate your feedback on the implementation burden of reporting the composite. CMS will take these comments into consideration when determining how to implement composite measures in MIPS. We appreciate your concern about the ability of the composite to affect health disparities within the broader MIPS context. CMS will take this feedback into consideration as decisions about composite implementation and the MIPS program are made. We appreciate your feedback on the importance of individual component scores. CMS will keep this feedback in mind when determining how to implement composite measures in MIPS.