AMERICAN SOCIETY OF PLASTIC SURGEONS ®
THE PLASTIC SURGERY FOUNDATION ™

Executive Office
444 East Algonquin Road • Arlington Heights, IL 60005-4664
847-228-9900 • Fax: 847-228-9131 • www.plasticsurgery.org

September 17, 2019

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1715-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted Electronically via: www.Regulations.Gov

Re: File Code CMS-1715-P; CY 2020 Revisions to Payment Policies under the Physician Payment Schedule and Other Changes to Part B Payment Policies

Dear Administrator Verma,

The American Society of Plastic Surgeons (ASPS) is the world's largest association of plastic surgeons. Our over 7,000 members represent 93 percent of Board-Certified Plastic Surgeons in the United States. ASPS promotes not only the highest quality in patient care, but also in professional and ethical standards. Our members are highly skilled surgeons who improve both the functional capacity and quality of life for patients, including treatment of congenital deformities, burn injuries, traumatic injuries, hand conditions, and gender affirmation surgery. We appreciate the opportunity to provide feedback on the Centers for Medicare & Medicaid Services (CMS) Notice of Proposed Rulemaking (Proposed Rule) on the revisions to Medicare payment policies under the Physician Payment Schedule for calendar year (CY) 2020, published in the August 14, 2019 Federal Register (Vol. 84, No. 157 FR, pages 40482-41289).

The Proposed Rule includes several policy and technical modifications that could adversely impact a significant number of our members. This letter includes our recommendations and comments regarding the following:

I. Quality Performance Program (QPP)
II. MIPS Value Pathways (MVP)

Our specific comments can be found in the following pages.

I. Quality Performance Program (QPP)

QCDR Measures

Completion of QCDR Measure Testing

ASPS strongly opposes the requirement to have measures fully tested at the time of submission. Current testing methods (per the CMS Blueprint and NQF standards) require extensive time and costs. In August 2019, we sent a survey to specialty societies participating in the Council of Medical Specialty Societies (CMSS), the PCPI, and the Physician Clinical Registry Coalition (PCRC). Of 18 respondents, only three indicated they currently test their QCDR measures and five more indicated they do a "limited amount" of testing. Those that are testing indicated that their costs range between $20,000 to $165,000 (we presume this is per measure at the lower end and per measure set at the higher end, but we cannot confirm that based on the responses submitted). Most specialty society respondents engaged in testing have greater than 20,000 members.

Further, testing would likely take place at an academic medical center since it would be very difficult to incentivize a solo or small practice with limited staff or time to implement the measures and provide adequate data for testing analyses. The limited ability to use the BONNIE test deck also would contribute to requiring large facilities with extensive resources. However, most of our MIPS eligible members in plastic surgery work in solo or small ambulatory practices. Thus, methodologies employed by academic medical centers could cause our measures to fail external validity testing and would lack applicability to many plastic surgeons.

While we appreciate that CMS may need to reduce the number of measures and to increase the rigor and ability to monitor gaps in care toward improved population health, we recommend an alternative approach for measure testing. ASPS supports the requirement to implement measures in the QCDR prior to submission and use for accountability. It is our belief that a testing methodology that is less burdensome and supports more accurate clinical benchmarks could be developed from QCDR collected data, especially for specialty clinicians. The CMS recommendation to use NQF/Blueprint testing proposed requirements is unreasonable for smaller specialties in which measure testing cannot easily be operationalized. PCPI supports this concept and has stated their willingness to help develop this new methodology.

Overall, the central purpose behind the development of the QCDR process was to create a mechanism for specialty physicians to report measures that were not captured by existing PQRS/MIPS CQMs. These burdensome requirements would essentially drive specialty societies away from continuing their QCDR's and the development of specialty measures, which seems like a return to an outdated quality measurement model focused on primary care. Added to these changes are increases in performance thresholds and penalties for not meeting them, along with the removal of the few relevant surgical MIPS CQMs from the program. Specialty societies have invested significant time and money in building measure portfolios and maintaining their QCDRs. It would be extremely disappointing to lose all that work now due to requirements that do not necessarily improve the quality of the measures or represent actual clinical performance of specialists.

Finally, due to the financial burden of developing measures and supporting QCDRs, free licensing between societies may not be feasible and may result in new or higher user licensing fees. Creating these barriers

between clinicians in the development of measures is antithetical to the primary aim of CMS to encourage harmonization between clinicians to reduce gaps in care.

Linking Measures to Cost Measures and/or Improvement Activities

CMS has proposed that QCDR measures identify linkages to cost measures and/or IAs. While ASPS supports this overarching goal, there are no current cost measures for plastic surgeons and very few relevant IAs. CMS has stated "*We understand that not all measures may have a direct link. In cases where a QCDR measure does not have a clear link to a cost measure, improvement activity, or an MVP, we would consider exceptions if the potential QCDR measure otherwise meets the QCDR measure*

requirements defined above." **ASPS strongly recommends CMS recognize exceptions for specialties in which there are no relevant linkages.**

Audit

ASPS is concerned with the requirement for QCDRs to audit the PI and IA categories. Both are essentially attestations, as defined by CMS. While we can perform a randomized audit asking for documentation from the EHR on PI measure data to ensure accurate transposition and monitoring of errors, and we can ask for clinical documentation to ensure the IA was attested to correctly, any errors discovered will be errors on the part of the practice or physician, not the registry. Further there is a worry that EHR vendor companies will charge practices to run these reports when a third-party entity (such as a QCDR) requests them. The ONC Interoperability and Data Blocking Final Rules have yet to be published, so we do not have policies codified in rulemaking yet to point to when this situation would be considered data blocking. Overall though, QCDRs are limited in what they can do with regard to conducting a detailed audit on attestation categories. If CMS plans to require this, further guidance needs to be provided, especially for the required clinical documentation for the IA category. This guidance also should recognize the limitations that QCDRs face in validating this information, as described above.

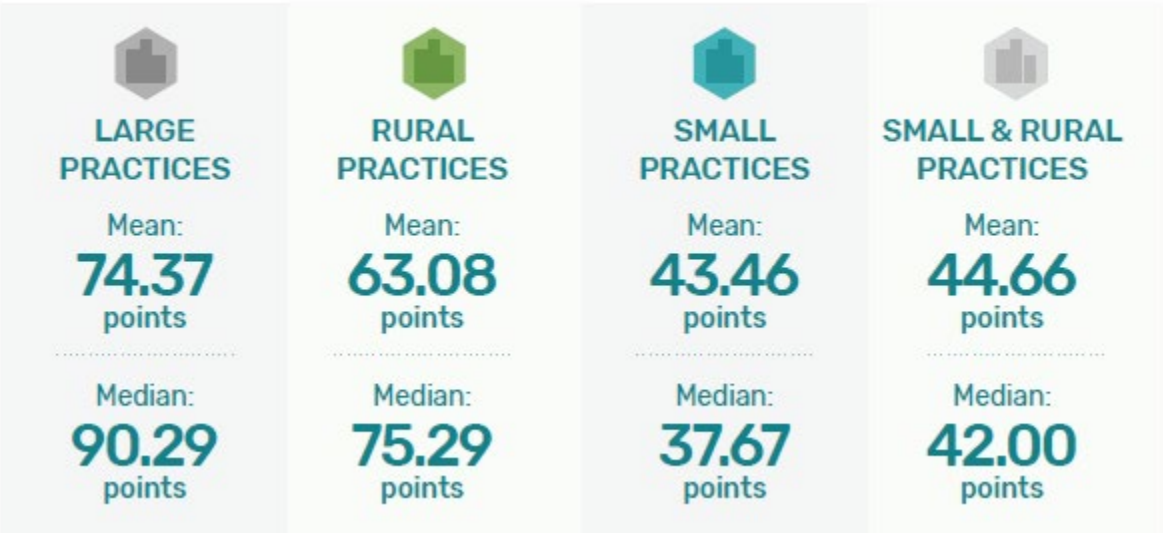
Submitting data starting April 1

ASPS supports this requirement if it remains optional. We remind CMS that most measures are designed for 12-month reporting and that data at 90 days may show significantly different performance than at one year. If the final score would continue to be calculated on the full year of data, and the early submission remains optional, we would support this proposal.

Performance thresholds increasing

CMS' estimated threshold for the 2024 payment year of 74.1 is extremely high for small and rural practices. Most ASPS MIPS eligible clinicians are in small practices. The proposed increases over the next 2 years are also problematic. As we have previously stated, there is a high clinician burden for practices reporting manually without an EHR. The goal of 45 points in 2020/2022 is more easily attainable if a hardship exemption from PI reweights the Quality category to 65, the small practice bonus is achieved, bonus points are awarded for seeing complex patients, and the IA category earns the full 15 points. Achieving 60 points in 2021/2023, however, will be extremely difficult, even with a Quality category with a maximum score of 60 and a PI exemption, particularly

if the points are redistributed between both Quality and Cost (please see our later comments on Cost for why this is problematic). This will require achieving more than 3 points on each measure, which is difficult as many of the measures relevant to our members are topped out or will be removed. If we are unable to offer relevant non-MIPS/QCDR measures due to burdensome testing requirements, our members will have a difficult time reporting. ASPS suggests that for small practices, 45 points should remain the maximum threshold for avoiding the penalty (30 points would be preferable), especially when the data CMS has publicly reported for the 2017 program years shows these practice types continue to lag behind large group practice types (see image below, from the 2017 QUALITY PAYMENT PROGRAM PERFORMANCE YEAR DATA, At a Glance fact sheet). Unfortunately, data are not available for small practices for 2018.



Additionally, it is unclear from the data presented in the proposed rule whether the average data completeness rates reflect Medicare only reporting or reporting across all payers. If the former, it might not be an accurate reflection of national reporting trends. It is also based on 2017 data, when the Pick Your Pace option was available, which might have distorted the results. The data that has been provided by CMS further fails to distinguish between practices reporting their data manually or through an EHR. Raising the data completeness threshold would specifically and adversely impact manual data entry clinicians who are already burdened by the lack of available EHR technology to complete this process and will now have to divert more staff time and financial resources to be successful in the program.

MIPS Scoring- Point Redistribution

ASPS opposes the proposal to redistribute the PI category to both the Quality and Cost components starting in the 2023 MIPS payment year. Many of our MIPS eligible clinicians are small and/or rural practices who lack any form of CEHRT. These practices claim the PI exemption each year and invest considerable staff time and resources to manually enter data for quality measures. In recognition that these practices already are at a reporting disadvantage compared to their colleagues with CEHRT, we feel CMS' proposal to redistribute some of this weight to the Cost category will further de-emphasize the importance of the Quality category. *As we note in*

the Cost section, many of our members have no reportable cost measures besides the MSPB measure. Transferring so much weight to this single, flawed measure diminishes our members' ability to be successful in the program and earn even a neutral payment adjustment. For these reasons, **we urge CMS to continue offering flexible options for small and rural practices without access to CEHRT to claim exemptions and, in these instances, to shift the weight of the PI category fully to Quality and not to Cost.**

Quality Performance Category

Removal of QCDR measures- Topped Out

ASPS would find it very helpful if, before a decision is made to remove a measure on the sole basis of it being topped out, **CMS would publicly report measure data stratified by specialty,** as well as practice size and type. Some measures, which are considered topped out, may still be valuable to certain specialists in which there is a potential gap in care or a paucity of relevant measures. For example, the scientific literature for Measure 23 (VTE Prophylaxis) shows that different specialties have widely varied performance. This measure is used routinely by plastic surgeons and represents an effort to reduce an important complication of surgery. However, this measure is slated for removal due to topped out status. We also believe there will be implications to specialists' successful participation in any quality component of MVPs based on CMS' proposals to remove topped out measures from the MIPS program. Historically, CMS has not allowed measure developers to re-tool measures removed from the program into specialty or procedure-specific measures, even when meaningful gap-in-care data can be provided and even though CMS does not analyze or publicly report data on topped out measures stratified by practice size, type, or specialty. We ask CMS to reconsider this perspective considering the dwindling selection of measures relevant to surgery.

Additionally, we again raise concerns around removing quality measures with high performance because of implications to patient care. Thankfully CMS has started to recognize the unintended consequences that can happen when every clinical episode is forced to be measured the same way. For example, the agency has proposed to change the measure decile scores for two quality measures, 1 and 236, in 2020 because of the concern that the current benchmarking methodology is encouraging inappropriate clinical care for some sub-populations. We feel that the agency should extrapolate this information and review the unintended consequences of continuing to remove measures with high performance in favor of measures for which there is a significant gap in care and many low performers. CMS is essentially incentivizing clinicians to have poor performance instead of recognizing and rewarding clinicians who can show years of consistently meeting or exceeding their score on clinically and specialty relevant measures. Removing these measures also does not consider the resource investments and time intensive practice changes necessary to improve performance in certain clinical areas. **Therefore, ASPS proposes that CMS incentivize the use of new measures, but retain topped out measures in the program by allowing topped out measures to be submitted only as "bonus measures." To earn points on these measures, a clinician or groups would need to demonstrate that performance was either consistent or has improved from year-to-year.** This change would also make Physician Compare more useful for consumers. For example, if a patient is trying to use this tool to make choices about their health care, we imagine they might be alarmed to see high performance on several measures for one year, but no data on performance in subsequent years and may draw inaccurate negative perceptions of the physician because of the missing data.

Data completeness threshold increasing

ASPS opposes the proposal to raise the data completeness threshold to 70% and recommends that CMS keep the minimum at 60%, particularly for manual entry practices. Practices without an EHR struggle with reporting quality. While we are grateful that CMS has granted small practices exemptions from the PI category, proposals like this one fail to understand the burden of Quality reporting for practices without an EHR. Expecting small manual practices to report 60% of all cases across all payers creates a burden and discourages quality reporting. Our practices are most definitely not "cherry-picking" their cases, as they barely understand how to even find the appropriate cases to include in the measure, let alone somehow choose only the high performers. Claims reporting currently only requires 60% of Medicare Part B cases. While we could support 70%reporting of Medicare Part B cases for QCDR reporting, when reporting is across all payers as it currently is for QCDR reporting, the increase from 60% to 70% is substantial. Practices with EHRs who integrate their data are already reporting 100% of cases. We would encourage CMS to consider requiring 100% for EHR practices, but leaving the minimum at 60% for manual entry practices.

Removal of Measures

ASPS opposes the removal of Measures 110 and 111 (influenza immunization and pneumococcal vaccination) in favor of a new measure combining multiple types of immunization. Our opposition is due to the fact that the new measure: a) was not recommended by the MAP; b) its specifications have not yet been released to the public, which means we cannot determine who could actually report this measure and whether the clinician would only need to confirm vaccination status or actually provide the immunizations; and c) it has not been previously implemented. We urge CMS to defer removal of these measures for an additional year until the new measure is proven and determined to be reportable by surgeons.

Cost Category of MIPS

ASPS recognizes CMS' statutory requirement to raise the cost category percentage weight to 30% by the 2022 performance period. However, ASPS opposes the agency's proposal to raise the cost category incrementally for performance years 2020 and 2021 *due to the lack of specialty reportable episode-based cost measures in the program*.

Cost Measures

For program year 2020, CMS has proposed to maintain eight episode-based cost measures, adopt revised versions of the Total Per Capita Cost (TPCC) and Medicare Spending Per Beneficiary (MSPB) measures, and add ten new episode-based cost measures. We are glad that the number of available cost measures is growing but remind CMS that there are still no plastic surgery-focused episode-based cost measures approved for the program, which will once again leave our eligible clinicians solely accountable for the modified MSPB measure, when applicable. The only episode-based cost measures that come close to the plastic surgery scope of care include the newly proposed measures for Lumpectomy Partial Mastectomy, Simple Mastectomy and Femoral or Inguinal Hernia Repair. However, after careful review of these specifications, we note that the former stops short of including the reconstructing surgeon, and the latter has such low utilization among plastic surgeons that none are expected to meet the case volume necessary to be held accountable for this measure (<1% utilization for 49505, 49507, 49520, 49521, 49525, 49550, and 49555 and 0% utilization for the remaining codes). This

leaves plastic surgeons with only one potentially applicable measure in the cost category, even as this category weight continues to increase.

Most clinicians still lack a clear understanding of these measures or how they capture attributable costs over which they have direct control or how they can be used to improve practices. Further, QCDRs with signed data user agreements have no means to access centralized cost data during the post-submission targeted review period, other than through manual contact of every practice. This is particularly frustrating given CMS' proposals to increase the requirements for QCDRs to act as quality improvement educators. QCDRs can't provide participants with a complete and accurate picture of their overall value since they don't have complete and ongoing access to claims data. ASPS feels plastic surgeons have been negatively impacted in situations in which 20-30% of their final score will be tied to one measure. CMS seems to be disregarding plastic surgeons in the MIPS program, erasing their ability to successfully participate and earn even just a neutral payment adjustment, given the proposal to increase performance and data completement thresholds, combined with historic data for lower small and rural practice score outcomes within the MIPS program in other categories of MIPS.

Additionally, ASPS is very concerned about CMS' proposals to implement measures against recommendations from the MAP Coordinating Committee. For the revised MSPB measure, ASPS notes the MAP's conditional support pending NQF endorsement. However, the committee found many other concerns with the measure, including the need for further testing to ensure validity and reliability at the TIN/NPI level. As the MAP and other organizations have pointed out, attribution and exclusion methodologies for the newly revised TPCC, MSPB, and episode-based cost measures have not considered how to ensure that double counting of clinician costs will not occur across measures. We additionally note the lack of NQF endorsement for 15 out of 18 episode-based cost measures proposed for 2020. It was also brought to our attention that 5 of the 8 measures currently used in the program for accountability purposes were brought to the NQF, but were not recommended to the Cost committee due to concerns held by the Scientific Methods Panel. Nevertheless, CMS has decided to include these measures in the program despite methodological concerns. As we consider CMS' 2021 proposal to mandate QCDR measure testing at the NQF/Blueprint standard, we are frustrated by the apparent double standard set by CMS to allow less rigorous measures into the program for the Cost category despite serious concerns, while small non-profit QCDRs are now being asked to potentially expend considerable resources to justify inclusion of these in the program.

Therefore, we encourage CMS to do the following:

(1) Maintain the cost category at 15% until rigorously tested and MAP Coordinating Committee approved cost measures can be included in the program *and reported by all specialties.*
(2) Provide further field test data to the public on attribution and exclusion methodologies, to ensure the same cost is not counted twice across multiple measures.
(3) Codify requirements for all cost measures to have MAP Coordinating Committee approval prior to implementation in the MIPS program or MVP pathway. MAP approval is specifically critical for cost measures, since they are more complex than quality measures and have been developed through a rushed process that did not include sufficient clinician feedback.

Promoting Interoperability Component of MIPS

ASPS supports the proposal to lower the threshold from 100% to 75% for the group hospital-based determination within the PI category, which will allow more practices to focus on meaningful participation in

other aspects of the program for which they have control. We appreciate that this proposal recognizes the burden hospital-based physicians have in dealing with institution-wide technology policies and departments that are not easily accessible, which at times make it difficult to access their EHR data for reporting purposes.

While the number of new and unique 2014 CEHRT edition products may be declining, there remain a significant number of legacy systems in use. As we have shared in previous comment letters, the costs associated with upgrading to the 2015 edition of CEHRT can be prohibitive for many solo and small practice providers, even though the administrative burdens associated with an upgrade may be lessened. Recognizing that 40% of physicians are not affiliated with a hospital, or have other access to 2015 editions of CEHRT, we respectfully request the Agency use their considerable influence with Congress to ensure that hardship exemptions for performance year 2020 include a carve-out for those clinicians without access to 2015 CEHRT along with continued hardship exemption flexibilities based on practice size and type.

Additionally, we would encourage CMS to work with the Office of the National Coordinator to ensure there are a sufficient number of surgery-specific apps and APIs that allow those apps to communicate with the EHRs commonly used by surgeons. Although 2015 Edition CEHRT offers enhanced functionalities, such as APIs, there are currently very few applications that are relevant to surgical specialists, which prevents them from really taking advantage of these improved functionalities and limits the incentive to invest in system upgrades.

We understand the agency has statutory requirements to increase the adoption and utilization of CEHRT among providers. We also acknowledge the changes CMS made last year to simplify the PI category. However, we are disappointed to see that CMS has again proposed to continue the confusing scoring methodology and individual exclusions for each measure in the Promoting Interoperability category. This puts an undue burden on physicians. ASPS recommends using simple attestation, or information that can be pulled directly from the EHR. We also encourage CMS to look at interoperability beyond CEHRT and the use of Patient Reported Outcome platforms for the PI category, even when these can't necessarily be connected to the EHR.

II. MIPS Value Pathways (MVP)

MIPS Value Pathways- Request for Information

ASPS is pleased that CMS has listened to the calls by many stakeholders to develop a more cohesive, alternative model to the currently siloed reporting pathways within the MIPS program. Like CMS, we hope this proposed model will reduce clinician burden. We have attended many feedback sessions with CMS during the proposed rule comment submission window to better understand the agency's expectations for this program. We thank the agency for holding these sessions and accepting comments and requests for information. However, we strongly recommend holding more formal in-person white boarding sessions early in 2020 with the express purpose of harmonizing and operationalizing the many diverse comments we expect CMS will receive during the current rulemaking period. We also remind the agency that the 2020 MPFS rule was substantially delayed this calendar year and conflicted with the QCDR self-nomination period. For this reason, we believe many commenters were left with little time to think about, let alone sufficiently comment on, the proposal to develop MIPS Value Pathways (MVPs).

MVP Approach, Definition, Development, Specification, Assignment, Examples

While ASPS appreciates the work CMS has done to develop draft MVP models during rulemaking, we recommend, along with many other organizations, that MVPs are developed around conditions or procedures as an alternative to large categories within healthcare such as surgery, and are inclusive of cross-cutting measures which would allow a clinician to earn points on many traditional components of the program at once (e.g. a procedure-related patient reported outcome measure captured in the EMR or through a secure online patient portal, which would earn points in Quality, PI, and IA). Many of the eligible clinicians that report MIPS data through our QCDR have chosen to do so out of a lack of relevant MIPS measures, which are overwhelmingly targeted to primary care or internal medicine rather than specialists.

Many surgical specialties are divided into sub-specialties that have important distinctions in terms of patient populations, procedures, and patterns of care. In plastic surgery, for example, we have developed measure sets covering the entire perioperative period, and reportable by clinicians whose diverse practices may focus on skin reconstructions after cancer resection, abdominal reconstruction after bariatric surgery/massive weight loss, or breast reconstruction to name a few. For these reasons, we believe any successful and meaningful iteration of specialty specific MVPs must include partnerships with QCDRs.

As an example, the surgical MVP proposed would utilize Measures 355, 356, and 357 (reoperation, readmission, and SSI). While these are all important surgical concepts, the specifications are written in such a way that there are virtually no plastic surgery codes included in the measures. Thus, plastic surgeons would not be able to participate in this MVP unless the measure owner, the American College of Surgeons, was asked to revise those measures to include more subspecialty procedures. However, this action would have the unintended consequence of negating the current benchmarks for these measures. The only other two MIPS CQMs relevant to plastic surgeons are the perioperative care measures (21 and 23), which CMS has designated as "topped out" and are slated for removal after the 2020 program year.

Above all, participation in an MVP must be incentivized relative to the current reporting options for investments in this new approach to be feasible for stakeholders and worthwhile for eligible providers. Whether this means cutting down on the overall number of measures required or opportunities to earn significant bonus points, CMS must ensure this program does not add further confusion to the already complex and burdensome reporting requirements. Further, the agency must analyze how separate participation tracks with different scoring methodologies might adversely influence its statutory requirement to set the 2024 performance threshold based on average final scores of previous program years.

Selection of Measures and Activities for MVPs

As stated earlier, it is critical that CMS consult with specialty society experts to develop specific MVPs and to ensure appropriate measure selection and benchmarking methodologies. ASPS is concerned about specialists' ability to successfully participate in any quality component of MVPs based on CMS' aggressive proposals to remove topped out measures from the MIPS program. Historically, CMS has not allowed QCDR measure developers to re-tool measures removed from the program into specialty or procedure-specific measures, even when meaningful gap-in-care data can be provided and even though CMS does not analyze or publicly report data on topped out measures stratified by practice size, type, or specialty. As recommended in our comments on Topped Out Measures, we strongly encourage CMS to publicly report data by specialty and to reconsider

their stance on allowing QCDRs to retool measures if there is a demonstrable gap in care for a particular specialty.

MVP Assignment

Because we believe MVPs should be condition- or procedure-based, rather than uniformly applied to one specialty or sub-specialty, we urge CMS to allow eligible clinicians to voluntarily elect their participation track at the beginning of the performance year, whether through an MVP or traditional MIPS pathway. Additionally, we believe MVPs will be most valuable to eligible clinicians with 2015 CEHRT. If CMS could guarantee that measures within an MVP could remain consistent for several years (to the extent possible), it would significantly help reduce the time and cost burden on practices and technology vendors, who must re-map their EHR annually due to the need to remove old measures and map new measures specific to that program year. Some technology vendors charge upwards of $3000 to map a practice's EHR for quality measure reporting and charge an additional $1500+ in subsequent years to keep the practice in maintenance. We have also heard of models that charge high integration fees *per measure*, which becomes financially burdensome for practices that annually lose "topped out" measures they were performing highly on, forcing them instead to select potentially more, less relevant, or newer measures without benchmarks. We have talked with many physicians who have conducted cost analyses and find it is more beneficial to just take a penalty, instead of attempting to report any data through the QPP.

Transitioning to MVPs

As previously mentioned, ASPS recommends that MVPs do not replace the current individual MIPS components for Quality, PI, IA, and Cost. Rather, MVPs should provide an alternative tool for value-based reporting, when applicable. ASPS would not support a full move to this model, since it would not be feasible to create procedure-based MVPs that suit the reporting needs of every sub-specialty or multispecialty group practices. We also remind CMS that the ongoing lack of specialty specific, especially surgery-specific, MIPS measures continues to hinder successful implementation of this program. We believe CMS will need to partner with QCDRs to build most of the specialty-specific MVPs to ensure this pathway offers meaningful measures for a wide range of specialties. For this reason, we urge CMS to transition to MVPs on the following timeline:

(1) Hold white boarding sessions with all relevant stakeholders within the first quarter of 2020 to harmonize and operationalize comments received during 2020 rulemaking.
(2) Propose the final, general structure for MVPs, including scoring methodologies and vendor requirements, in the 2021 MPFS rule*. Implement the first MVPs no earlier than the 2022 performance year.*

Every year new challenges to the development and implementation of QCDR measures are proposed, including the 2018 proposal for licensing and the current 2019 proposal for testing by 2021. We believe any successful iteration of specialty specific MVPs must include partnership with QCDRs, who typically rely on external technology vendors to support their registries. Additionally, there has been a paucity of valid and reliable surgery specific episode-based cost-measures during the first three years of the program, with no plastic surgery reportable episode-based cost measures at all. ***Therefore, we urge CMS not to implement MVPs until***

performance year 2022 in order to give QCDRs and their technology vendors ample time to implement the infrastructure, measure development, and work order changes necessary to support such a program.

Small and Rural practices participation in MVPS

CMS must continue to offer flexibilities for small and rural practices and afford them the opportunity to successfully participate in the program, regardless of how CMS chooses to set the final general structure of MVPs. Many of the small and/or rural practices the ASPS works with do not have CEHRT and have continuously needed to apply for a hardship exemption in the MIPS PI category. CMS has indicated that PI should be foundational for all MVPs, but ASPS recommends that CMS continue to offer a similar exemption for rural and small practices. At the very least, CMS should allow small and rural practices to alternatively attest to their use of non-CEHRT technologies, such as patient portals, electronic informed consents, or electronically captured patient reported outcomes.

Multispecialty practices participation in MVPS

Plastic surgeons are frequently a part of multi-specialty teams, performing vital surgical care within the care continuum. For example, plastic surgeons usually reconstruct large defects created by the resecting or excising dermatologist or Mohs surgeon in patients with skin cancer. Breast reconstruction after a mastectomy is another example. ASPS recommends MVPs encompass measures related to each phase of a care episode that are reportable by different specialists working together within the care continuum. For example, there might be a larger set a of measures related to cancer excision and skin reconstruction in the same MVP. The dermatologist or Mohs surgeon could report excision measures, and the plastic surgeon could report on reconstructive measures, and both could report any cross-cutting measures. Each specific surgeon type would report on 6 measures relevant to their piece of the care continuum, but every surgeon would not necessarily report on all the measures in the MVP. The entire surgical management of skin cancer could then be captured through one cost measure, with both providers accountable for costs associated with the overall outcome. In fact, this episode-based cost measure is already in development through Wave 3, which several ASPS members are assisting with. Ideally, IAs would also offer relevant reporting for all surgical specialists, whether the same IA would span multiple parts of the surgery or whether a set of relevant IAs could be offered and the physician would choose the relevant ones. MVPs structured in this way would broaden the scope of quality reporting for multispecialty practices (i.e. they would report on measures meaningful to their specialty, rather than measures representing only one specialty). This may add some reporting burden, but we believe a balance can be found.

Incorporating QCDR measures into MVPs

ASPS strongly recommends that QCDR measures be used to build MVPs. Surgeons should have choices for quality reporting, especially when there are few relevant MIPS measures available and each year more are proposed for removal. The current portfolio of primary-care focused MIPS measures effectively serves as a barrier for specialties in quality reporting and would not presumably change under MVPs. ASPS has taken the initiative to develop a roster of QCDR measures in conjunction with other specialties that could be useful in the creation of more sophisticated MVPs for plastic surgeons. As we have previously pointed out, CQMs that have been proposed as part of the agency's example MVP for Surgery lack plastic surgery relevant and reportable codes. We could update these measures to include the relevant codes, but again, this action would merit a

substantive change to each measure and have the unintended consequence of negating the current benchmarks for these measures.

Scoring MVP Performance

ASPS suggests a scoring model that is similar to the current MIPS component scores with the exception of the PI category. We suggest that clinicians are not scored on PI as a standalone category, but can accrue bonus points for meaningfully using CEHRT to participate in an MVP. Points for meaningful use of CEHRT and other secure electronic sources, such as patient portals, should be considered as part of Quality and Improvement Activities (e.g. remove the end-to-end reporting bonus and just give points in replacement of the PI category, or give points for integrating patient reported outcome tools into the work flow of the EHR or patient portal).

Population Health Quality Measure Set

ASPS opposes using the population health quality measure set. For the same reason we are calling for condition or procedure-specific MVPs, comparing diverse practice types and settings for accountability and reimbursement is not feasible, especially for surgeons who have limited control over longitudinal interventions at the population level.

Clinician Data Feedback

CMS expresses interest in providing more meaningful clinician performance feedback, but its proposed vision seems to focus on enhanced claims-derived feedback. While specialists would appreciate enhanced access to claims data, this data must be presented in a timely-fashion (preferably real-time) and in a manner that helps clinicians better understand their practice patterns in terms of both cost and quality so that they are better prepared to potentially transition to APMs. Data provided by CMS to date has been untimely and difficult to interpret. The current Cost Measures are a great example of this double standard set by CMS. Feedback is only provided by CMS once, and only during the post-submission targeted review period. This is in direct opposition to the program requirement for QCDRs to provide snapshots of quality measures at least four times during the performance period to allow reporting clinicians the chance to integrate quality improvement into their practice patterns and workflows. CMS should continue to work with stakeholders to refine the format in which this data is presented and to consider ways to merge claims data with existing clinical data collected from registries to ensure a more complete picture of care.

Patient Reported Measures

Patient Reported Outcome performance measures (PRO-PMs) are difficult to create and implement due to the lack of valid and reliable tools, and diversity of tools consistently used among clinicians. Further, CMS has consistently rejected QCDR measures where a ***validated*** PRO tool was not used. In the surgical field, we have some validated PRO tools, but many are generic, like S-CAHPS, and are not relevant to the outpatient setting. We do have plastic surgery specific PRO tools, such as BREAST-Q, BODY-Q, and FACE-Q, which we have been successful at building into our QCDR measure inventory. However, use of these PRO tools (and thus the companion PRO-PMs) is low among plastic surgeons in private practice due to complexity of implementation and perceived lack of value and difficulty of attribution. Because of this low adoption of our PRO-PMs among

our eligible clinicians, we will likely lose these measures in future program years because they lack benchmarks. Measure removal in this domain is again a problem CMS will have to grapple with while it considers how to structure MVPs.

ASPS believes that CMS can incentivize the use of PRO-PMs by increasing their point values relative to other quality measures, such as by offering 5 bonus points. As mentioned in our comments on the PI section, we also believe that PI credit should be awarded for more than just CEHRT. We ask CMS to revisit including PRO portals in the PI category.

Publicly Reporting MVP Performance information

ASPS strongly recommends that MVPs be implemented no earlier than the 2022 performance year. The 2022 performance year should also serve as a test run for the new MVP structure, similar to how 2017 was designated a MIPS "pick your pace" year. CMS should also perform substantial post-submission analyses to compare the final scores of clinicians electing to report through the MVP model to those reporting through the traditional MIPS pathway. The findings of this report should be made publicly available so stakeholders may aid CMS in refining any uncovered weaknesses of the program. We also ask CMS to refrain from publicly reporting any MVP data until at least the 2023 performance year.

Summary

In summary, ASPS is hopeful that CMS will continue to work with the medical community to ensure the fee-setting process remains transparent. We appreciate the opportunity to provide these comments and look forward to working with CMS to ensure quality is measured for plastic surgeons using measures that reflect their clinical work. Should you have any questions about these comments, please contact Carol Sieck, PhD, RN, Director Quality and Performance Measurement Programs, at csieck@plasticsurgery.org or at 847.228-3389.

Sincerely,

Alan Matarasso, MD – President, American Society of Plastic Surgeons

cc: Lynn Jeffers, MD – ASPS President-Elect
Greg Greco, MD - ASPS Board Vice President of Health Policy and Advocacy
Gayle Gordillo, MD - ASPS Board Vice President of Research
Michelle Manahan – Chair, ASPS Health Policy Committee
Paul Weiss, MD - Chair, ASPS Coding and Payment Policy Committee
Jon VerHalen, MD - Chair, ASPS Healthcare Delivery Committee