



AMERICAN SOCIETY OF
PLASTIC SURGEONS®



THE PLASTIC SURGERY
FOUNDATION®

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January 2, 2018

Ms. Seema Verma, Administrator
Centres for Medicare & Medicaid Services
Department of Health and Human Services
ATTENTION: CMS-5522-FC
PO Box 8016
Baltimore, MD 21244-8016

Submitted electronically via Regulations.gov

RE: CMS-5522-FC – Medicare Programs: CY 2018 Updates to the Quality Payment Program

Dear Administrator Verma,

The American Society of Plastic Surgeons (ASPS) appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services (CMS) final rule on the calendar year (CY) 2018 Quality Payment Program (QPP), published in the November 16, 2017 *Federal Register*.

ASPS is the largest association of plastic surgeons in the world, representing more than 7,000 members and 94 percent of all American Board of Plastic Surgery board-certified plastic surgeons in the United States. Plastic surgeons provide highly skilled surgical services that improve both the functional capacity and quality of life of patients. These services include the treatment of congenital deformities, burn injuries, traumatic injuries, hand conditions, and cancer reconstruction. ASPS promotes the highest quality patient care, professional and ethical standards, and supports education, research, and public service activities of plastic surgeons.

We are pleased to see the Agency has taken to heart the many requests ASPS and other societies have expressed about the Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) programs. This final rule contains many changes that impact small practices and solo providers, including a significant increase in the “low volume threshold,” which the Agency defines as the number

of patients seen or the dollars billed to the Medicare program as the determining factor for clinician's participation in the 2018 program.

We also appreciate the work the Agency has done over the last twelve months to increase awareness of the QPP and encourage the Agency to continue its work to provide educational events such as town-hall meetings, where additional information on CY18 reporting and scoring criteria for MIPS can be provided.

In response to the Agency's request for feedback, we offer the following observations.

Virtual Groups

For CY18, CMS has opened the door to virtual groups. ASPS has long believed that this type of reporting option would allow small practices an opportunity for success under MIPS. We therefore were disappointed to learn that the Agency has limited participation to only those clinicians who exceed the low volume threshold metrics. This is counter-intuitive to what we believe to be Congress' specific intent for encouraging rather than preventing small practices from participation in MIPS. Without this opportunity, clinicians in small practices risk falling behind on the path not just to MIPS, but also in the type of joint accountability inherent in APMs. Although we support exclusions for clinicians with low volumes in the Medicare program, we strongly believe that those clinicians should have a path to participation in Virtual Groups and eventually Advanced APMs.

Further, if these small practices are unable to participate in the MIPS whatsoever, they are not eligible for the annual adjustment for inflation. Small practices will therefore receive a zero percent adjustment under current regulation. We believe a minor adjustment to regulatory language, such as making low volume practices ineligible for MIPS "except in the case where such practices elect to participate in a Virtual Group," would fix this inconsistency. In addition, we believe that this problem could be solved if CMS follows through on its potential policy of allowing excluded clinicians (including those excluded under the low volume threshold) to "opt-in" to MIPS participation (see additional discussion below).

COST Component of MIPS

While we appreciate the fact that CMS will not require data submission for this component of MIPS, and will instead utilize historical data to calculate cost scores, ASPS believes the use of the Total Per Capita Costs (PCC) and Medicare Spending per Beneficiary (MSPB) measures and existing attribution methodologies will be difficult for small practices to understand. As the Agency is aware, small practices do not have the infrastructure and resources to appropriately analyze detailed cost data and take actions to directly influence costs.

In contrast, large facilities, with hundreds of eligible cases, may be able to identify patterns and trends via PCC and MSPB feedback, and develop new processes to reduce costs over time. However, a solo MIPS eligible clinician or small group (even those that exceed the low volume threshold) will most likely not be able to do so and may be unfairly penalized under the current attribution process.

As such, we respectfully request the Agency consider the following options for future years of the MIPS program:

- 1) Exempt specialty providers from general cost performance category such as PCC and MSPB until episode-based measures are fully developed and available for use.
- 2) Exempt all providers in 'small' practices (15 and fewer providers) from the Cost Category and distribute any weighting for this category between the other components of MIPS.
- 3) Increase the minimum case volume required to score a cost measure.

MIPS Opt-In

For CY 2018, an individual provider or group that meets either low volume threshold determinations—dollar amount of charges and number of beneficiaries – is excluded from participation in MIPS. CMS set both at higher numbers than in year one of MIPS, which by their own estimate will limit participation in the Year 2 program significantly.

While we appreciate the effort made to reduce the burden on smaller practices and practices in rural areas by raising the low-volume threshold, ASPS is concerned that by excluding providers who desire to participate, CMS prevents them from being eligible for payment incentives. This policy also appears to undermine the Agency's goal to have more clinicians engage in value-based care.

We would encourage the Agency to consider ways to allow clinicians and groups who wish to participate in MIPS the ability to opt-in, especially those that may in future years exceed the low volume threshold or are no longer considered newly-enrolled clinicians in the Medicare program

Performance Thresholds

For CY 2018, we note that CMS has finalized its proposal to set the performance threshold at 15 points. In future years, CMS has indicated it will set performance thresholds based on mean/median performance rates derived from data collected in previous years.

While this mathematical formula appears appropriate for clinicians who have experience utilizing the MIPS program, we remain concerned that clinicians new to MIPS may be inadvertently held to a standard that is unobtainable during a first year of participation. As such, we respectfully request the Agency develop a performance threshold "on-ramp," allowing those new to the program to be held to thresholds that are more reasonable for new participants.

QCDR Self Nomination Application Process

And finally, while we appreciate the work the Agency has done to reduce the administrative burden of the yearly QCDR application process, we feel it is important to share observations about our own experience to highlight the communication issues as well as deadline setting processes that remain, and are, in our opinion, detrimental to the future of the QCDR program unless CMS makes changes. Specifically, while ASPS was successful in meeting the November 1st deadline for submission of our QCDR application, we did not receive any indication of concerns with the application until November 29th. At which time we were given approximately 36 hours to request re-examination. While ASPS was able to complete the necessary paperwork on time, despite having six measures initially declined, we cannot help but wonder how, in future years, as our suite of non-MIPS measures grow and the

measures have to be resubmitted and re-defended early year, we can prepare for, and ideally avoid last-minute requests from CMS. Additionally, we experienced issues with the JIRA notification system and its lack of notification that there were issues. Luckily, we happened to check JIRA at the right time and were able to act. This however, is extremely problematic. Had we checked even 2 or 3 hours later in the day, we may not have been able to pull our experts together to complete the additional paperwork timely. We'd also like to bring to your attention the fact that the measures template that accompanies the initial application never asked for clinical rationale for the measures, but only for gap in care data. Including this as an application requirement, with subsequent review of the clinical rationale during the review process, might help CMS staff better understand the purpose of the measure and make more informed decisions.

After submission of additional paperwork, we were advised that a decision would be made by December 6th. On December 7th, and because no one from the Agency had reached out to us, we were forced to follow up on our own, reminding CMS staff that we had followed the necessary protocols, and were seeking an opportunity to discuss our concerns. Luckily, a conference call was granted, but with less than 4 days allocated for preparation - two of which were over a weekend - ASPS measures experts had very little time to formulate additional responses to questions we were expecting to be asked.

Perhaps most troubling was that during the 30-minute time-slot we were allotted, it was obvious that the CMS representatives had not read any background information shared via the original application nor information shared via the appeals process. As such, ASPS was forced to spend precious moments bringing everyone up to speed on the issues at hand. While we appreciate the fact that a final decision was shared that same day, we feel it is important to point out that one of the unintended consequences of the protracted application and appeals process was that our QCDR vendor was not able to begin revising specifications for several of our non-MIPS measures until after December 12th, when, after approving revisions to several of the measures, a final decision about our non-MIPS measures was made. With less than 10 working days remaining in 2017, this delay in the decision-making process will require our vendors to work extended hours to ensure each measure in the ASPS

QCDR is ready for reporting on January 1, as required by the specifications in the self-nomination process.

Recognizing that other applicants experienced similar issues during the 2018 application process, we respectfully ask that CMS update the checks and balances inherent in the application process, ensuring adequate time is allotted for feedback between applicants and reviewers. Ideally, a multi-year approach would be implemented. It may also be beneficial to prepare guidance documents and/or training in the months preceding the start of this yearly process.

Conclusion

ASPS appreciates the flexibility the Agency has included in the updated for the 2018 QPP, and looks forward to working with CMS to ensure future program requirements remain fair and adequate. We remain concerned however that there is a gap in clinician understanding of the quality scoring methodology and encourage CMS to consider partnering with societies to increase transparency and cooperation in educating and supporting specialty physicians to implement quality reporting. There is also a need to reimagine the purpose of “Virtual Groups,” and decrease the administrative burden for QCDR self-nominations.

Should you have any questions about our comments, please contact Catherine French, ASPS Health Policy Director, at cfrench@plasticsurgery.org or at (847)981.5401.

Sincerely,



Jeffrey E. Janis, MD, FACS
President, American Society of Plastic Surgeons

cc: Lynn Jeffers, MD – ASPS Board Vice President of Health Policy & Advocacy
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