AMERICAN SOCIETY OF PLASTIC SURGEONS®
THE PLASTIC SURGERY FOUNDATION™

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November 17, 2015

Andrew M. Slavitt
Acting Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3321-NC
Submitted electronically via http://www.regulations.gov

Re: CMS-3321-NC; Request for Information Regarding Implementation of the Merit-based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models

Dear Administrator Slavitt:

The American Society of Plastic Surgeons (ASPS) appreciates the opportunity to provide input on the Centers for Medicare and Medicaid Services (CMS) Request for Information (RFI) on the implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) provisions related to the Merit-Based Incentive Payment System (MIPS) and incentive payments for participation in Alternative Payment Models (APMs).

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. ASPS promotes the highest quality patient care, professional and ethical standards, and supports education, research, and public service activities of plastic surgeons.

Below, we have organized our input to correspond to the specific questions CMS included in the RFI on which we are able to provide input at this stage. While we understand that CMS is under implementation time constraints and appreciate the extension for submissions past the original deadline, ASPS is still extremely concerned about the ability of stakeholders to develop responses to such a broad spectrum of questions requiring so much detail under the current timeline. We hope this is not indicative of CMS' receptivity to stakeholder input and that, beyond forthcoming notice and comment rulemaking, that CMS will provide additional opportunities for input, including open door forums, town halls, and potentially, other written submissions.

We would also like to encourage CMS to issue proposals on the "low-volume threshold" exemption it requested input on as part of the Calendar Year 2016 Medicare Physician Fee Schedule Proposed Rule. Plastic surgery practices experience significant variation in payer mixes, and many practices see a very low number of Medicare patients. We believe that CMS must develop workable low-volume thresholds given the resources that will be required to fully participate in the MIPS program. Medicare-enrolled physicians with low Medicare volumes should not be required to participate in MIPS to avoid penalties, and, to the extent participation is required or elected, CMS should create participation requirements that reflect the low number of Medicare patients seen in those practices. This will also be important in order for benchmarking in MIPS to reflect comparisons among practices that are truly similar.

Above all, we believe that CMS should ensure that the implementation of MIPS and the APM incentive

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bonus is transparent, straightforward, and provides a true opportunity for improvements in quality of care and resource use rather than becoming a series of meaningless steps that do not result in improvement for patients and only serves to increase administrative burden.

We look forward to providing additional input as CMS provides more information about its intent for both the MIPS and APM programs.

Sincerely,

David H. Song, MD, MBA
President, American Society of Plastic Surgeons

American Society of Plastic Surgeons (ASPS)
Response to CMS RFI on Implementation of MIPS and Promotion of APMs

Program	Category/Criteria	Question	Response
IMPLEMENTATION OF THE MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)			
MIPS	Eligible Professional (EP) Identifiers	Should CMS use a MIPS EP's TIN, NPI, or a combination thereof?	Given all of the changes required of physicians by MACRA, CMS should be seeking to simplify its identifier system rather than adding more complexity. ASPS strongly suggests that CMS utilize the current Medicare identification systems rather than creating an entirely new process only for MIPS. Given that the NPI can be used to identify individual physicians, we see little rationale for the creation of another registration and enumerations system.
MIPS	Eligible Professional (EP) Identifiers	Should a different identifier be used to reflect eligibility, participation, or performance as a group practice vs. an individual MIPS EP? If so, should CMS use an existing identifier or create a distinct identifier?	First, this is a difficult question to answer without knowing CMS final disposition on how groups will be allowed to organize for purposes of MIPS. However, while we disagree that adding new identification numbers will be beneficial, we can envision the use of modifiers that could signify necessary distinctions for purposes of MIPS reporting and payment updates.
MIPS	Virtual Groups	The virtual group option under the MIPS allows a group's performance to be tied together even if the EPs in the group do not share the same TIN. How should eligibility, participation, and performance be assessed under the MIPS for voluntary virtual groups?	If CMS proceeds with the Virtual Group concept, it will be necessary for those groups to receive an identifier. This could be administered via the NPI system, perhaps with an additional signifier denoting that the NPI is for a MIPS Virtual Group. CMS should assess Virtual Group performance in the same manner it would for any group: the analysis should be specialty specific, acuity-indexed

			and focused on outcomes and cost effectiveness so you are able to identify the highest value providers in a given specialty. ASPS believes that, if implemented correctly, Virtual Groups could be a powerful tool in improving quality and decreasing costs. If organized coherently and in a manner that conforms to the practical realities of actual care delivery, these groups can help de-fragment the work of individual physicians by creating clear, common standards, incentivizing the coordination of care, and encouraging the dissemination of successful clinical improvement efforts.
MIPS	Virtual Groups	Should CMS limit for virtual groups the mechanisms by which data can be reported under the quality performance category to specific methods (e.g. QCDRs or utilizing the web interface)?	CMS should strive for flexibility and simplicity in developing options for Virtual Group reporting. Within an individual group, though, individuals should all submit data under the same mechanism and group identifier.
MIPS	**Quality**: Reporting Mechanisms & Criteria	Should CMS maintain all PQRS reporting mechanisms currently available for MIPS?	CMS should maintain all of the current PQRS reporting mechanisms and open up QCDR reporting as it transitions to MIPS. To do otherwise could be tremendously disruptive. Regarding the reporting criteria for QCDRs, ASPS encourages CMS to allow measures groups to be reported through QCDRs in a manner that puts them on equal footing with the Qualified Registry mechanism. Because such QCDR reporting would allow eligible professionals to satisfy reporting requirements by reporting one measures group for a twenty patient sample rather than reporting 9 individual measures each for 50 percent of all applicable patients, this change will greatly facilitate participation in the program. Ultimately, though, the current PQRS system has not provided the quality outcomes desired, and CMS is

			misappropriating its concern by not accelerating measure development initiatives. CMS is seeking to add a second story to a house that still lacks an adequate foundation. CMS must focus more on the central shortcoming of the quality improvement effort in the United States – the lack of highly-relevant, high-quality measures for specialists. CMS needs to move swiftly and invest heavily to ensure that we develop a body of measures that are capable of supporting their fundamental purpose. The current body of measures **does not** meet this standard, and as a consequence, PQRS has failed. CMS should support the work of medical specialty societies and other stakeholders to improve upon the current, dismal set of measures available to specialists. Our first focus should be the development and implementation of process, outcome and resource measures that are relevant to the specific practice dynamics of various medical specialties.
MIPS	**Quality**: Reporting Mechanisms & Criteria	Should CMS maintain the same or similar reporting criteria under MIPS as under the PQRS? What is the appropriate number of measures on which a MIPS EP's performance should be based?	No. PQRS has been too burdensome, costly and ineffective in driving quality. While this question is entirely too broad to tackle in an RFI of this nature, ASPS provides the following input: In general – • Simplify reporting criteria, and make sure there are appropriate measures for each specialty. • Do a better job of incorporating risk-adjusted outcomes More specifically – • Patient Safety Indicator (PSI) measures and other measures will be far stronger in gaining the desired improvement in care

			and cost reduction. • Reporting criteria need to incorporate programs like Pre-Surgical Immunonutrition (which can reduce LOS by over two days and SSI by over 40 percent); pre-admission discharge planning (which can reduce length of stay by 20 percent); effective care paths for surgical and medical pre-habilitation. These types of programs should be rewarded for use and made standard while failure to use programs like Enhanced Recovery for Surgery should be penalized. • Reporting criteria for QCDRs should be restructured. CMS currently requires EPs to report on QCDR measures for 50 percent of all applicable patients (including both Medicare and non-Medicare). In order to achieve the 50 percent threshold, the requirement essentially forces physicians to report on their entire patient population, which is more than is required for traditional PQRS reporting. The result of this is that this pathway is so unappealing that it is essentially useless. ASPS believes the solution to this is the application to QCDR reporting of a methodology that will allow EPs to report only on a patient sample size that produces a statistically valid, reliable result for a specific measure focused on a specific clinical procedure.
MIPS	**Quality**: Reporting Mechanisms & Criteria	Should CMS require that certain types of measures be reported? (E.g, should a minimum number of measures be outcomes-based? Should more weight be assigned to outcomes-based measures?)	Again, the current PQRS program does not include many measures that are applicable to plastic surgeons or specialty providers in general. That is the first problem in this area that CMS should be addressing, and questions serving that end are the first that CMS should be asking. Because the availability of measures to report on in the MIPS program will have a large impact on EPs composite performance score, moving forward with the

			current body of measures will greatly disadvantage and undermine the viability of specialists within MIPS. In addition to surgically-relevant measures, CMS needs to take a broader view of what measure requirement adjustments can drive meaningful improvements to quality reporting programs. CMS can improve the breadth of effective measures by exploring areas such as community health, nutrition, ERAS, and pre-habilitation. Lastly, to the extent that CMS increases its reliance on outcomes measures, we implore it to take into consideration the unique factors – such as considering the reasonable timeframes under which an outcome can be known and whether the outcomes are patient-reported – that make outcomes reporting more difficult.
MIPS	**Quality**: Reporting Mechanisms & Criteria	What considerations should be made as CMS further implements CAHPS for all practice sizes? How can CMS leverage existing CAHPS reporting by physician groups?	ASPS again requests that CMS more formally integrate the CAHPS Surgical Care Survey (S-CAHPS) measures into its performance assessment system. We appreciate CMS encouraging surgical specialties to include the S-CAHPS measures in QCDRs as part of the CY 2016 physician fee schedule proposed rule, but the S-CAHPS should also be an individual measure in the PQRS program, consistent with the inclusion of the CG-CAHPS, as not all surgical specialties have established a QCDR and will be able to report the S-CAHPS through a QCDR. In addition, S-CAHPS was created specifically because the CG-CAHPS survey is largely irrelevant for reporting on surgical care. If S-CAHPS is included for individual reporting, it should be voluntary – as is reporting on other PQRS measures – which would allow physicians to select the patient experience of care survey that is most appropriate for their patient population. CMS has previously acknowledged the importance of inclusion of the S-CAHPS in PQRS, noting that the

			Consumer Assessment of Healthcare Providers and Systems Clinician and Group Survey (CG-CAHPS) would not accurately reflect the care provided by single- or multispecialty surgical or anesthesia groups, as well as how the S-CAHPS expands on the CG-CAHPS by focusing on aspects of surgical quality, which are important from the patient's perspective and for which the patient is the best source of information. However, CMS explained that due to the cost and time it would take to find vendors to collect S-CAHPS data, it is not technically feasible to include the S-CAHPS measure for the 2017 PQRS payment adjustment. This delay is not in the best interest of the surgical patient. The National Quality Forum's Measure Applications Partnership (MAP) has recommended the inclusion of S-CAHPS in PQRS for consecutive years. It is atypical that years later, CMS explains that it is not technically feasible to include the S-CAHPS, particularly when CMS has already identified vendors to administer and collect CG-CAHPS data. The S-CAHPS has broad support across surgical specialties—the S-CAHPS Technical Advisory Panel (TAP) included 21 members from various specialty societies, and nine surgical specialties participated in the main field test conducted during the development of the survey, which included colon and rectal, ophthalmology, general surgery, orthopedic, plastic surgery, otolaryngology, thoracic, urology, and vascular. Therefore, because the S-CAHPS follows the same collection mechanism as the CG-CAHPS/CAHPS for PQRS, we, once again, strongly encourage CMS to prioritize the time and resources needed to include the S-CAHPS as a measure.
MIPS	**Quality**: Reporting Mechanisms & Criteria	How should CMS apply the quality performance category to MIPS EPs that are in specialties that may not have enough measures to meet our defined criteria?	ASPS continues to work to develop measures that are valuable, meaningful, and actionable for our surgeons and patients. However, this takes time and resources, and PQRS has failed to ensure that

			there are available measures for all Medicare participating providers. Moreover, CMS has retained measures that have not proven useful. CMS should review measures to keep only those measures that demonstrate a validated, improved outcome and reduce cost.
MIPS	**Quality**: Reporting Mechanisms & Criteria	What are the potential barriers to successfully meeting the MIPS quality performance category?	The current PQRS system has provided little incentive for specialist participation. Even where specialists are participating, the lack of highly-relevant measures has made the purpose of the program – assessing the quality of care delivered – unattainable. As a result, the very form of the program undermines its function. Simply put, CMS needs to realize that successful programs require more than good ideas and good intentions. They require an architecture capable of actualizing those ideas, and in that respect PQRS has consistently fallen short. Not only has the time and expense of reporting outweighed the risks and rewards of the bonuses and penalties, but the data yielded from reporting has offered little to surgeons to improve quality or drive efficiency in the care delivered. So, to answer the question posed, the most readily identifiable – and, frankly, most likely – potential barrier to successful MIPS quality reporting is that CMS will make the category a continuation of PQRS. Troubling early indications of this have already come about, as CMS has thus far ignored calls from the medical community to release the Section 102 funds included in MACRA for measure development. As stated, and restated, and restated above, the success of MACRA and MIPS will depend on the availability of measures for specialties. Given the likely 2017 performance year for the first year of MIPS, it is imperative that CMS quickly utilize these funds to ensure that measures are available.

MIPS	**Resource Use**	Apart from the cost measures currently utilized as part of the Physician Value Based Payment Modifier, are there additional cost or resource use measures (such as measures associated with services that are potentially harmful or over-used, including those identified by the Choosing Wisely initiative) that should be considered? If so, what data sources would be required to calculate the measures?	ASPS is concerned with CMS' intention to use the current Value Based Payment Modifier cost measures. Instead, CMS should develop and test episode-based cost measures that focus on specific conditions and/or procedures that are legitimately within the control of individual physicians. It is our contention that this is the only way CMS can ensure that cost measures are applied appropriately. ASPS recommends that CMS take into consideration, once again, the specialty adjustments currently applied to cost measures, and make specialty adjustments more granular through mechanisms that account for subspecialty cost variance driven by commonly treated conditions or cost variance driven by place of service. ASPS looks forward to seeing a drive toward such granularity in the information and data CMS is required to publish under MACRA related to episode groupers for purposes of future resource use measurement.
MIPS	**Resource Use**	What peer groups or benchmarks should be used when assessing performance under the resource use performance category?	Again, granularity is key here, and the fundamental purpose should be to make any benchmarking or peer group comparisons as accurate and appropriate as possible. It is imperative that CMS avoid combining providers of all specialties to be assessed at the same standard, and in many cases it could also be inappropriate to assess all providers within a single specialty at the same standard. We believe that a tiered approach to performance assessment in resource use could have many benefits: • Tier 1: Specialty- specific, acuity indexed analysis • Tier 2: Providers grouped by common procedures, with sub-groupings based on things like geography, place of service, and patient demographics

			Lastly, ASPS also proposes that CMS coordinate specialty society surveys of costs, which could provide a national benchmark for purposes of resource use performance assessment.
MIPS	**CPIAs:** Data Collection	Should EPs be required to attest directly to CMS through a registration system, web portal or other means that they have met the required activities and to specify which activities on the list they have met? Or alternatively, should qualified registries, QCDRs, EHRs, or other HIT systems be able to transmit results of the activities to CMS?	Critically, CMS needs to allow the current reporting mechanisms to incorporate a CPIA reporting function so that providers are not forced into a new "registration" or separate reporting mechanism just for CPIAs. ASPS recommends CMS take a multi-faceted approach. • The new system should strongly support the development and maintenance of qualified registries. This brings the ability to manage and monitor to the point of care within the EP groups, • The EHR should also be able to report this, with no additional steps or registering for the EPs. • Registries should be able to report directly to CMS so that providers only have to enter data once
MIPS	**CPIAs:** Performance Assessment	What threshold or quantity of activities should be established under the clinical practice improvement activities performance category? • Should performance in this category be based on completion of a specific number of clinical practice improvement activities, or, for some categories, a specific number of hours? • If so, what is the minimum number of activities or hours that should be completed? • How many activities or hours would be needed to earn the maximum possible score for the clinical practice improvement activities in each performance subcategory? • Should the threshold or quantity of activities increase over time? • Should performance in this category be based on	We believe there are opportunities to align the criteria for CPIAs under MIPS with activities already taking place with board maintenance of certification (MOC) activities. At the very least, MOC activities should suffice for each specialty. However, non-certified physicians would have to have an alternative system set up. In addition, CMS should strive to create a system which seeks documented performance improvement, not just participation. In doing so, CMS needs to recognize that improvements resulting from QI activities do not materialize in the

		demonstrated availability of specific functions and capabilities?	initial implementation year (or years), and CMS needs to find a way to incorporate and give credit for internal QI initiatives that physicians have already put in place. Finally, ASPS also believes that CMS should create a mechanism under the "Expanded Practice Access" category of activities to take into account surgeons who provide emergency department call coverage. In many communities, plastic surgeons provide these services without compensation, and, given the clear benefit to patient access to services, we believe the CPIA category is an appropriate place to ensure that surgeons who provide these services are given credit for it. This will ultimately incent more physicians to provide these services, which will have a direct patient benefit.
MIPS	**CPIAs:** Small Practices in Rural Areas and HPSAs	How should the clinical practice improvement activities performance category be applied to EPs practicing in these types of small practices or rural areas?	Every patient should have the opportunity for quality care, whether they are seen in a geographically isolated area, in a large practice, or by a single physician practice. Our profession neither trains nor certifies providers in different levels of competence, and thus we should hold a higher level of performance for all. The individual areas should be attainable by all, and there are excellent documented efforts that will improve health and reduce costs. In addition, for most physicians, any geographic barriers can be overcome for this performance category via MOC, which can be done in small communities and rural areas via online education and is already in place and reported by many.
MIPS	**CPIAs:** Small Practices in Rural Areas and HPSAs	Should a lower performance threshold or different measures be established that will better allow those EPs to reach the payment threshold?	As mentioned above, we see little reason for holding differently situated providers to different standards for purposes of clinical practice improvement activities. The MIPS system must drive the culture of improvement. In addition, for those who are able to qualify for CPIAs via MOC there is no reason to set different performance standards.

MIPS	**Meaningful Use**	Should the performance score for this category be based be based solely on full achievement of meaningful use? (For example, an EP might receive full credit (e.g., 100 percent of the allotted 25 percentage points of the composite performance score) under this performance category for meeting or exceeding the thresholds of all meaningful use objectives and measures; however, failing to meet or exceed all objectives and measures would result in the EP receiving no credit (e.g., zero percent of the allotted 25 percentage points of the composite performance score) for this performance category).	ASPS continues to have significant concerns about EHR products on the market and the validity of the objectives and measures in the EHR Meaningful Use program for plastic surgery practices. While we urge CMS to remedy these issues, we also believe that CMS has the opportunity to mitigate the negative impact of EHR vendor failure to create EHR products applicable to specialty practices by (1) adopting a scoring system under MIPS that does not require full achievement of Meaningful Use and (2) utilizing a sliding scale that at least gives credit practices that have attempted to incorporate the utilization of certified EHR technology. This can be made even more equitable by creating specialty-specific benchmarks, which will have the added benefit of providing a roadmap to CMS for those areas where greater development is needed from the EHR vendors to create products that can be meaningful used by all. However, we continue to maintain that EHR products are too expensive to ask practices to implement them without appropriate specialty-specific modules, and that the Meaningful Use Incentive program relies on objectives and measures that do not reflect the care deliver by many specialty practices. Because of this, CMS should also issue exemptions from the Meaningful Use portion of the MIPS performance calculations.
MIPS	**Meaningful Use**	What alternate methodologies should CMS consider for this performance category?	Rather than focus on the methodology associated with parsing variable performance in this category, CMS should be questioning the very nature of what it considers "performance" in the context of the meaningful use of EHRs. CMS needs to recalibrate its conception of this area so that it better aligns with the ways in which physicians meaningfully use

			this technology in the reality of practice. For many of our members' practices, the simple introduction of an EHR system into their workflow sparked meaningful improvements in the delivery of care that are simply not accounted for in the current incentive program, such as using an EHR to populate a clinical data registry. Consequently, ASPS believes that, as a first step in this recalibration, CMS should be giving physicians credit under MIPS simply for having and using and EHR in any fashion.
MIPS	**Meaningful Use**	How should hardship exemptions be treated?	If a physician qualifies for a hardship exemption in any year, they should be given full credit under this performance category.
MIPS	"Other Measures": Measures from Other Medicare Payment Systems (**Quality** or **Resource Use**)	What types of measures (that is, process, outcomes, populations, etc.) used for other payment systems should be included for the quality and resource use performance categories under the MIPS?	Again, CMS needs to begin by focusing on measure development that improves upon the current lack of highly-relevant, high-quality measures for surgeons. A clear direction on the type of measure used will be useless until the measures populating those types are sufficient. ASPS has joined a host of other organizations to ask for CMS to release the Section 102 funds included in MACRA for measure development as well as additional funding (Section 101) for technical assistance to help small practices comply with requirements of MIPS and/or transition to an alternative payment. We have thus far been ignored. The success of MACRA and MIPS will depend on the availability of measures for specialties, and, given the likely 2017 performance year for the first year of MIPS, it is imperative that CMS quickly utilize these funds to ensure that measures are available.
MIPS	**Performance Standards**: Historical Performance	Which specific historical performance standards should be used? • For example, for the quality and resource use performance categories, how should CMS select quality and cost benchmarks?	As mentioned regarding CPIAs, ASPS believes that standards should be national and group size should have no bearing. CMS should take steps to ensure

		• Should CMS use providers' historical quality and cost performance benchmarks and/or thresholds from the most recent year feasible prior to the commencement of MIPS? • Should performance standards be stratified by group size or other criteria? • Should CMS use a model similar to the performance standards established under the VM?	that sample sizes are valid based on the number of providers being assessed, but other than that we believe that standards should be straightforward and constant.
MIPS	**Performance Standards:** Improvement	How would different approaches to defining the baseline period for measuring improvement affect EPs' incentives to increase quality performance? • Would periodically updating the baseline period penalize EPs who increase performance by holding them to a higher standard in future performance periods, thereby undermining the incentive to improve? • Could assessing improvement relative to a fixed baseline period avoid this problem? • If so, would this approach have other consequences CMS should consider?	Continuous improvement is a goal of ASPS members, so whatever rules CMS develops in this area, there is little to no risk of undermining the incentive to improve the care we deliver. That said, CMS should be developing a straightforward system that yields information that allows practices to improve care and lower costs: • Measurement requirements should be upfront and known. • Any changes should be annualized and better if in a 3-5 year cycle, rather than changing every year. • Particularly if reporting is based on software, changing frequently could have expense associated if the software has to be repurchased/updated
MIPS	**Performance Standards:** Improvement	Should CMS consider improvement at the measure level, performance category level (i.e., quality, clinical practice improvement activity, resource use, and meaningful use of certified EHR technology), or at the composite performance score level?	Without knowing the exact details of the programs and measures, this is a difficult question to answer. However, improvement assessment should certainly be based on risk-adjusted national level benchmarks (for quality as well as cost). In addition, depending on the dashboard of measures, we believe that there is value creating a composite performance score, rather than separately for each performance category. In addition, the EHR meaningful use incentive program has proven largely meaningless to ASPS membership because the EHR vendors have little incentive to provide products that can be used by

			surgeons. To remove this obstacle, ASPS believes that CMS must find a way to put EHR vendors at real risk for failure to provide effective and efficient EHRs. As CMS does this, it should also include safeguards to ensure that any financial penalties incurred by the EHR vendors are not passed on to the users.
MIPS	Weighting Performance Categories	Are there situations where certain EPs could not be assessed at all for purposes of a particular performance category? If so, how should CMS account for the percentage weight that is otherwise applicable for that category? Should it be evenly distributed across the remaining performance categories? Or should the weights be increased for one or more specific performance categories, such as the **quality** performance category?	The fact that CMS is concerned that some physicians will be incapable of participating in one quarter – or more – of this program is deeply disturbing. It is our contention that this question illustrates both the failure of those programs that MIPS purports to replace (PQRS, VBM, and meaningful use) and, amazingly, CMS' clear intention to design MIPS as little more than a consolidated continuation of those programs. With MIPS, CMS has an opportunity to move past previous missteps. Please take that opportunity. Make the necessary investments to ensure that each specialty has access to its own quality measures, to appropriate resource use measures, and to useful EHR products for which they are rewarded for ***actually*** meaningfully using. If you do these things, the basis of this question will become of less concern.
MIPS	Weighting Performance Categories	Generally, what methodologies should be used as we determine whether there are not sufficient measures and activities applicable and available to types of EPs such that the weight for a given performance category should be modified or should not apply to an EP? Should this be based on an EP's specialty? Should this determination occur at the measure or activity level, or separately at the specialty level?	Begin by creating an inventory of current measures, and work with medical societies – particularly specialty societies – to identify gaps. In doing so, CMS and medical societies should seek to elevate and replicate measures where their associated outcomes are tied to acuity, diagnoses, and procedural bases among like and common providers.
MIPS	Public Reporting	What should be the minimum threshold used for publicly reporting MIPS measures and activities for all of the MIPS performance categories on the Physician Compare website? (For example, CMS is currently using a minimum 20 patient threshold for public reporting	This question will need to be answered differently for the different MIPS performance categories. For example, we are concerned with the current CMS

		through Physician Compare of quality measures (in addition to assessing the reliability, validity and accuracy of the measures). An alternative to a minimum patient threshold for public reporting would be to use a minimum reliability threshold).	proposal to begin reporting EHR Meaningful Use Incentive Program attestation on the website, as we believe electronic medical record usage has yet to be adopted by many small practices. Perhaps most importantly, we are not convinced this type of data will be meaningful for patients without extensive guidance on how to interpret and utilize the information. As such, we strongly encourage CMS to reconsider the sharing of quality or meaningful use indicators via the Physician Compare website without first developing a tutorial that allows the public to better understand the data. We also encourage CMS to recognize improvements by individual providers and groups over time.
PROMOTION OF ALTERNATIVE PAYMENT MODELS (APMs)			
APMs	"**Qualifying APM Participant**": Revenue Approach	What policies should the Secretary consider for calculating incentive payments for APM participation when the prior period payments were made to an EAPM entity rather than directly to a QP (For example, if payments were made to a physician group practice or an ACO?) • What are the advantages and disadvantages of those policies? What are the effects of those policies on different types of EPs (that is, those in physician-focused APMs versus hospital-focused APMs, etc.)? • How should CMS consider payments made to EPs who participate in more than one APM?	Many plastic surgeons are in solo or small group practices, which do not have EHRs, and consequently, will not be able to participate in Alternative Payment Models. For many specialties, and plastic surgery in particular, there is not enough time or the appropriate infrastructure to create Alternative Payment Models by the proposed implementation date of 2019. Very few physicians will want to take on any financial risk without first having access to data, which will verify that the risks will either be small or can easily be mitigated.
APMs	**Eligible APMs**: "Nominal Financial Risk"	What is the appropriate type or types of "financial risk" under section . . . to be considered an EAPM entity?	CMS needs to drive the development of a new quality-driven care model. This will include step wise positive growth balanced with appropriate short term and long term risk.
APMs	**Eligible APMs**: "Nominal Financial Risk"	What is the appropriate level of financial risk "in excess of a nominal amount" . . . to be considered an EAPM entity?	CMS needs to be sure that whatever its definition of "in excess of a nominal amount" becomes, it should be modeled to be eventually recoverable. The process should not shut providers down early and starve them of resources without being affording

			the opportunity to improve. The threshold CMS utilizes should focus on whether one fails to meet the quality and cost demands over time.
APMs	**EAPM Entity Requirements:** Definition	What entities should be considered EAPM entities?	This is a broad question that ASPS looks forward to providing input on when CMS develops a proposed definition. We hope that happens soon, as this is a critical, foundational part of the APM path under MACRA. That said, recent comments from CMS staff that it is under no statutory obligation to incorporate APMs recommended by the Physician-Focused Payment Model Technical Advisory Committee are at best, concerning to organized medicine. For many medical specialties, like plastic surgery, where the APM options are severely limited, these comments are actually closer to infuriating. Taken in light of this question, they are also baffling. Why is CMS asking this in an RFI if it is not willing to listen to a panel of experts that it appoints?
APMs	**EAPM Entity Requirements:** Use of CEHRT	What components of certified EHR technology (as defined in section 1848(o)(4) of the Act) should APM participants be required to use? Should APM participants be required to use the same certified EHR technology currently required for the Medicare and Medicaid EHR Incentive Programs or should CMS other consider requirements around certified health IT capabilities?	As previously mentioned, EHR vendors must finally be put at significant risk for their failure to provide effective products. And while all EPs should be under very similar use and support requirements to the EHR, no provider or provider group should be at risk for the failure of an EHR vendor. The lack of effective EHR products has been a national failure, and it is time to stop punishing physicians. That said, any provider who has the capability of electronically transferring medical information should qualify until there is a true national EHR system. APMs already have systems in place for the most part, and so CMS should work with those systems.
APMs	**Physician-Focused Payment Models:** Delivery Reform Requirements	Should CMS propose that PFPMs should primarily be focused on the inclusion of participants in their design who have not had the opportunity to participate in another PFPM with CMS because such a	No.

		model has not been designed to include their specialty?	While this might be an appropriate criterion for solicitations of PFPMs, it should not be an approval criterion. For surgical specialties in particular, it could also be difficult to say that the *entire* "specialty" is included or excluded from an existing PFPM. CMS should support flexibility and plenty of options, especially for specialists who do not often fit well into current APM structures. CMS policy should encourage the proliferation of these models and support as much participation as possible. Consequently, ASPS again states its displeasure with recent CMS comments that it is under no statutory obligation to incorporate APMs recommended by the Physician-Focused Payment Model Technical Advisory Committee. Please listen to experts.
APMs	**Physician-Focused Payment Models:** Delivery Reform Requirements	Should proposals be required to state why the proposed model should be given priority, and why a model is needed to test the approach?	This could be an appropriate question to ask of PFPMs so that CMS and the PTAC have a well-developed dashboard of available PFPMs, but we caution CMS from developing prioritization or approval criteria too strict, as the system should encourage multiple models and support participation.
APMs	**Physician-Focused Payment Models:** Delivery Reform Requirements	Should Proposed models be required to aim to directly solve a current issue in payment policy that CMS is not already addressing in another model or program?	Again, no. While this might be an appropriate criterion for solicitations of PFPMs, it should not be an approval criterion. For surgical specialties in particular, it could also be difficult to say that the *entire* "specialty" is included or excluded from an existing PFPM. CMS should support flexibility and plenty of options, especially for specialists who do not often fit well into current APM structures. CMS policy should encourage the proliferation of these models and support as much participation as possible. Consequently, ASPS again states its displeasure with

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