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June 27, 2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-5517-P
P.O. Box 8011
Baltimore, MD 21244-1850

RE: Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models

Dear Mr. Slavitt:

On behalf of the over 80,000 members of the American College of Surgeons (ACS), we appreciate the opportunity to submit comments to the proposed rule: *Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models* (Proposed Rule) published in the *Federal Register* on May 9, 2016. The ACS was founded in 1913 to improve the quality of care for the surgical patient by setting high standards for surgical education and practice.

The ACS wishes to be a partner during the implementation of both the Merit-based Incentive Payment System (MIPS) and alternative payment model (APM) initiatives. In formulating a replacement to the much maligned Sustainable Growth Rate formula (SGR), Congress recognized the importance of working closely with physician stakeholders to create a strong, clinically sound program that would receive buy-in from participants. MIPS for example, is intended to integrate and streamline the existing Centers for Medicare & Medicaid (CMS) quality programs to reduce administrative burden, improve payment accuracy, and ensure that measures being reported are meaningful to providers and stakeholders. To that end, the legislation created new opportunities for stakeholders to develop measures, provide feedback on attribution, and numerous other areas. Congress also wished to incentivize a transition toward APMs but wisely recognized that there is not currently a one-size-fits-all solution and empowered specialty societies and others to create models suitable to their members. The strength of an APM is its flexibility to create incentives for care coordination, quality improvement, and efficiency not easily achieved in traditional fee-for-service (FFS) payment systems. The ACS greatly appreciates the opportunity to develop a payment

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model suitable for surgeons, and we are working diligently to have a proposal ready for submission by late 2016.

In addition, the ACS has long supported policy changes that improve the value of patient care, and we commend CMS' efforts toward that goal. The mission of the ACS is to put patient welfare first above all else. We urge CMS to view these and other new payment policies through the lens of any potential impact on patients by focusing first on the care delivery model and then developing appropriate payment model requirements within those models. Given that there is potential for beneficiaries to be faced with increasingly complicated choices and value judgements about where to seek care as these new models develop, it is important that patients are educated and informed about their options. As CMS, along with providers and other stakeholders, develop criteria, quality metrics, payment methodologies, and the model design for MIPS and APMs, we appreciate CMS' efforts to put patient interests first.

We also urge CMS to continue to dialogue with stakeholders after the proposed rule comments have been submitted to facilitate rapid cycle ongoing refinement and improvement of the implementation of these initiatives. In addition, we believe that both initiatives would be helped immeasurably by CMS encouraging true and widespread electronic health record (EHR) interoperability. As with any substantial change in policy, we ask that CMS monitor the total regulatory burden being placed on individual practitioners. **The requirements of multiple programs demand time and energy thereby taking away from patient care, which is an unintended consequence for providers and beneficiaries.**

While we acknowledge the scope of the challenges faced by CMS in implementing a program change as massive as MIPS and appreciate the many efforts made to integrate existing programs and the opportunities for stakeholder input, we are afraid that the overall program remains extremely complex and will be difficult for busy physicians to understand and incorporate into their clinical practices. An overarching theme of our comments is the need for further simplification of the program, particularly in the early years of its implementation. With respect to the APM policy set forth in the proposed rule, we appreciate areas in which CMS has taken a reasonable approach to implementing the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) provisions for Advanced APMs. Unfortunately, there are currently very few options for surgeons to participate in Advanced APMs or MIPS APMs. We therefore ask CMS to take steps promptly to expand current APM options and to create new opportunities for surgeons to participate in APMs.

In our comment letter we highlight the following high-level issues:

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1. **Amend Performance Period.** Modify the performance period for both MIPS and APMs to July 1– December 31, at least in the first year.
2. **Reduce Complexity.** The complexity of the MIPS program should be drastically reduced to engage physicians and groups, allowing them to build the infrastructure for the program’s requirements and change workflow in a way that best suits their practice.
3. **Increase Reliability and Validity; Reduce Misclassification.** Many measures that have been proposed are not tested, the proposed thresholds for reliability and validity are very low, and the proposed rule does not provide specific benchmarks for measures. For the overall success of the program, it is critical that CMS does not prematurely implement measures that could result in misclassification of care. Time will be needed to test and implement measures across programs. We need simplicity and transparency with appropriate risk adjustment.
4. **Include Meaningful Measures which Follow the Phases of Surgical Care.** Measures proposed for each MIPS category (Advancing Care Information (ACI), quality, resource use, Clinical Practice Improvement Activities (CPIA)) have been created in siloes and are not fit for alignment across the various components of care delivery. Quality measures are singleton not meaningful; episode-based measures are not tied to complementary quality measures; CPIA activities do not align with quality for a cycle of improvement. The MIPS program should follow a similar framework to the ACS four guiding principles of quality improvement: setting clinical standards, building the right infrastructure, using the right data, and verifying with outside experts. CPIA, quality measures, and episodes should all follow the five phases of surgical care—operative, perioperative, intraoperative, postoperative, and post-discharge for a comprehensive and meaningful cycle of improvement.
5. **Reduce IT Costs.** Frequent new requirements to upgrade EHR technology often do not result in a demonstrable benefit such as improved outcomes or better use of data. The costs of IT in medical practice need to be linked to the actual benefit to the patient and clinician.
6. **Improve Public Reporting.** Public reporting must including accurate, risk-adjusted, clinically meaningful information, subject to appeal. It

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must be meaningful not just from a medical perspective, but also meaningful to patients.

7. **Reduce Thresholds for Clinician Engagement.** There must be clinician engagement for both MIPS and APMs with a reporting system that is not overly burdensome, a scoring system that is simple and transparent, attainable thresholds, and a short enough quality/payment feedback loop in order to change clinician behavior.
8. **Promote Widespread Interoperability.** The objective of ACI should be the attainment of widespread health data interoperability not only between meaningful users of certified EHR technology (CEHRT), but more broadly throughout the wider clinical data ecosystem.
9. **Modify current models to meet Advanced APM requirements so surgeons can participate.** Both the Bundled Payment for Care Improvements Initiative (BPCI) and the Comprehensive Care for Joint Replacement (CJR) models should be adapted to make them both MIPS APMs and Advanced APMs.
10. **Create pathways for new APMs for surgeons.** CMS should allocate substantial resources to expediently review new models as soon as the Physician-Focused Payment Model Technical Advisory Committee (PTAC) makes its recommendations. Ensure that the process for APM development and adoption remains open and accessible for specialty societies and other stakeholders.

THE MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

The MIPS program, as envisioned in the MACRA legislation holds great promise for improving physician payment, not only through elimination of the SGR, but by addressing many common complaints about the prior system. MIPS was meant to build in positive incentives for performance while simplifying reporting requirements through consolidation of multiple existing programs into a single composite score and providing recognition for practice improvement activities that physician societies were undertaking to improve care to the patient. Unfortunately, that great promise is not yet met because the legislation lacked granularity of detail and clarity in how to implement these reforms.

While we recognize the immense amount of work that CMS has put into the proposed rule and appreciate the opportunity to provide feedback throughout implementation, we fear that as drafted the proposal is far too complex and

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confusing. These details are especially daunting given the extremely short time period that will be available to educate our members on the intricacies of the new program.

As an example, it was relatively easy for ACS to explain that in the first year of MIPS, a physician would receive a composite score with 50% of its value derived from quality, 10% from resource use, 25% from meaningful use of EHR technology and 15% based upon activities undertaken to improve their clinical practice. However, as proposed, we have to explain that to receive the highest score of 15 on the CPIA component you must accrue 60 points through participation in between one and six individual activities, depending on the weight of each activity. To receive the highest score of 25 points in ACI, you must score between 100 and 130 points by first reporting on all six individual objectives in the base score, for which you will receive 50 points and then accrue at least 50 of a possible 80 additional points in the achievement portion of the score and so on for the other categories. **The multiple competing scoring mechanisms add up to a performance measurement system that will be difficult for even the most engaged physician to understand.**

Furthermore, similar to past programs, the MIPS programs are siloed and unaligned; do not follow clinical workflow (such as the five phases of surgical care); propose low levels of reliability and validity; and have too long of a lag in timing between clinical action, feedback and incentive to be meaningful. **To the practicing surgeon, this translate to yet another program which requires reporting for the sake of reporting, creates mistrust that their care could be misclassified, and requires huge investments to implement...all while not providing them with timely information on how to improve AND while taking time away from patient care.** Without meaningful information from MIPS, surgeons will continue to rely on real-time, risk-adjusted clinical outcome data such as the ACS National Surgical Quality Improvement Program (NSQIP) to learn about care delivery and where there are opportunities to improve. To this end, in order to achieve the goals of MACRA, the path forward has to include collaborative efforts with specialty societies to provide simplistic and implementable solutions.

MIPS Eligible Clinician Identifier

CMS currently uses a variety of identifiers to determine individual or group reporting across the various CMS programs. For PQRS individual reporting, CMS uses both the tax identification number (TIN) and the national provider identifier (NPI) to assess eligibility and participation, whereas only the TIN is used to assess eligibility and participation for the Physician Quality Reporting System (PQRS) Group Practice Reporting Option (GPRO). For the EHR Incentive Program CMS uses the NPI, and for the Value Modifier (VM) the

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TIN is used.

For the MIPS program, CMS proposes to use a combination of clinician identifiers (TIN/NPI) to allow MIPS eligible clinicians to be measured as an individual or collectively through a group's performance, and the same identifier would be used for all four performance categories: quality, resource use ACI, and CPIA. Based on this proposal, if a group is submitting information collectively, then it must be measured collectively for all four MIPS categories. Therefore, a clinician cannot report as an individual for some performance categories and as a group for others. CMS proposes that when applying the payment adjustment CMS will use the TIN/NPI.

Individual and Group Identifiers

CMS explains that using both the TIN/NPI for assessing eligibility and participation of an individual allows them to match MIPS performance and payment adjustments with the appropriate practice, particularly for clinicians who bill under more than one TIN. MIPS performance would be assessed separately for each TIN under which an individual bills. We believe that the use of both the TIN/NPI allows for greater accountability of individual clinicians. To assess a group, CMS proposes to use a group's TIN which would significantly reduce the participation burden that could be experienced by large groups. ACS supports the flexibility that CMS proposes to allow for group reporting as well as focus on reducing reporting burden. Additionally, we request that, in the final rule, CMS specifically state that if participating in the MIPS as a group, all NPIs in that TIN will receive the same Composite Performance Score (CPS) for purposes of assessing the MIPS adjustment.

However, we seek clarity on the application of this proposal at the group level. Specifically, we request further information on how individuals will be held accountable at the group level across all MIPS categories. Will CMS evaluate each individual across the four performance categories and then roll that into the CPS, or does CMS envision a group-based collective set of objectives that could be met by any combination of individual eligible clinicians inside the group? We also request that CMS clarify how, given that the CPIA and ACI performance categories rely on individual attestation, this translates to group-level reporting. For CPIA and ACI, will each individual within the group be required to attest to these activities for an individual score and then have that score contribute to the group's score? For both the CPIA and ACI activities, we recommend that CMS consider a policy that would require a majority of the group (50%) meet the full CPIA and ACI requirements in order for the group to get full credit. Additional clarity on these issues will help ACS provide more meaningful feedback on the expanded group reporting option. **We look**

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forward to working with CMS on innovative ways to achieve a balance between reduced burden and appropriate accountability.

Exclusions

Low Volume Threshold

CMS proposes to define those who do not exceed the low-volume threshold as an individual MIPS eligible clinician or group who, during the performance period, has Medicare billing charges less than or equal to \$10,000 AND provides care for 100 or fewer Part B-enrolled Medicare beneficiaries. CMS explains that they believe this strategy is value-oriented as it retains those MIPS eligible clinicians who are treating relatively few beneficiaries, but engage in resource intensive specialties, or those treating many beneficiaries with relatively low-priced services. However, ACS is concerned with the equity of this proposal because the threshold does not distinguish between individuals or groups, thereby making it very easy for groups to exceed the threshold compared to individual providers. Based on this assessment, we believe that the threshold should be higher for groups. We strongly encourage CMS to analyze group data to determine an appropriate low-volume threshold for groups.

Virtual Groups

The statute requires the establishment of a process that allows an individual MIPS eligible clinician or a group consisting of 10 or less MIPS clinicians to form a virtual group with at least one other individual MIPS clinician or group of 10 or less MIPS clinicians for a performance period. By statute, MIPS eligible clinicians are required to make elections as a Virtual Group prior to the MIPS performance period and cannot change their election during the performance period. CMS notes that they will aim to implement a Virtual Group web-based registration system for 2018, instead of 2017.

As CMS begins to develop policies for Virtual Groups in the coming year, CMS should consider more than one application of a Virtual Group to allow for maximum flexibility based on care delivery and the use of the most meaningful measures for a given group. Virtual groups could be organized similar to the current PQRS GPRO, with the flexibility to select both quality and eventually resource use measures, once they are further developed.

ACS recommends against restrictions for geographic location, specialty, or the number of groups that can form a Virtual Group. For example, rural surgeons may want to join groups with other surgeons across state lines for more meaningful peer-to-peer comparisons. An example which illustrates the

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importance of allowing for flexibility for specialties is a vascular surgery group may want to form a Virtual Group with interventional radiologists. Allowing surgeons the opportunity to partner with other surgeons in quality improvement and cost reduction efforts will provide a care improvement opportunity previously unavailable to these providers.

Examples of how virtual groups could be organized include:

- Registries: ACS recognizes virtual groups as an opportunity for eligible clinicians who participate in clinical data registries to allow for meaningful and cross cutting comparisons across specialties.
- Clinical service lines (also known as Clinical Affinity Groups (CAG)): Virtual groups could be organized across clinical service lines such as a cancer group, cardiac care group, or chronic disease management in a primary care medical home (PCMH) group—or more broadly in an integrated clinical group practice.

We recommend that CMS conduct a Virtual Group pilot test prior to the proposed 2018 implementation. Clinicians and groups who participate in the pilot could receive a positive or neutral adjustment. ACS also encourages CMS to host listening sessions on the Virtual Group option to allow specialty societies and other stakeholders the opportunity to discuss different options and applications for Virtual Groups.

MIPS Performance Period

CMS proposes that for 2019 and subsequent years, the performance period under MIPS would be based on a calendar year occurring two years prior to the applicable MIPS payment adjustment, January 1 – December 31. Therefore, CMS proposes to use the 2017 calendar year for the 2019 payment adjustment. By statute, the Secretary must establish a performance period for a year prior to, beginning with 2019, and the performance period must “begin and end prior to such year and be as close to the year as possible.” Therefore, CMS is not required to have a two year look-back period. CMS also notes that they must take operational feasibility, systems impacts, and education and outreach on participation requirements into account in developing technical requirements for participation. Based on feedback we have received from the surgical community, one of the biggest hurdles of the MIPS program will be to educate providers on the program, given the complexity of program requirements, the detailed scoring, and how to understand this complex information for each performance category: quality, resource use, ACI, and CPIA.

Given the timing of when we expect the MACRA final rule to be published in Fall 2016, neither surgeons NOR registries will report MIPS data

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will be ready starting January 1, 2017, as currently proposed. This start date is simply not feasible. MIPS not only requires providers to understand the programmatic differences of MACRA, but it will require large investments in technology (registries, EHRs), changes in workflow, and new ways to engage patients and other providers. We strongly believe that engaging physicians in the first year of the program will be critical to the overall success of the quality payment program (QPP) for years to come—losing the trust of the physician community could have long term impact on the overall success of the MIPS program. To this end, **we strongly support a shortened performance period for the 2019 payment year. We believe the performance period of July 1, 2017 – December 31, 2017 will allow for a sufficient amount of data to assess clinicians while giving CMS and member organizations much needed time for outreach and education, and registries to prepare for the capture and submission of MIPS data from a technological standpoint.**

We note that CMS has previously established a shortened performance period for the start of a program, the PQRS (then known as the Physician Quality Performance Initiative or PQRI). For the first year of the program, CMS implemented a six-month reporting period (from July 1, 2007 through December 31, 2007) for the first PQRS incentive.

ACS understands that a six-month reporting period may result in lower sample sizes compared to a 12-month reporting period. To address sample size issues, ACS proposes two resolutions:

1. **An optional look-back period.** For the early years of the program, an optional look-back period starting January 1st of the reporting period will give registries the option to report additional cases to increase validity and reliability. This will be most relevant to registries that report outcome measures and anticipate low case volume. This will also allow registries that have been in existence in previous years to more accurately benchmark their data to previous performance periods. Once the MIPS program stabilizes, it may be possible to return to a 12-month reporting period, but CMS must allow registries more time to analyze their data from the previous year and build new functionality into the registries based on those changes.
2. **An extension of data submission for registries and Qualified Clinical Data Registries (QCDRs) to April 31st following the performance period; or 4 months after the reporting period to allow for the capture and analytics required for the use of risk-adjusted outcomes data.** Currently, QCDRs are required to submit data by March 31st following the reporting period. Because many surgical measures are outcome measures, many cases have a 90 day “lock date,” which means a case is not complete until 90 days after a

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procedure.

ACS also continues to assert that a 2-year look back period is simply not actionable and meaningful to surgeons. The 2-year look back period seems to contradict the priority CMS has put on the use of health information technology, including the increased adoption of EHRs, and the coming-of-age of clinical data registries—all of this information that is available is to help support the provider and patient at the point of care to help make real-time decisions to improve patient health. A penalty applied two years following performance is irrelevant and has only seemed to cause more frustration among the surgical community, instead of creating an incentive to improve. We have heard from our members that they do not receive feedback in enough time to correct deficiencies, to consider ways to improve care, or to change operational workflow.

MIPS Category Measures and Reporting

Performance Category Measures and Reporting

CMS proposes that MIPS clinicians and groups would be required to submit data on measures and activities for the quality, CPIA, and ACI performance categories. CMS does not propose any data submission requirements for the resource use performance category and for certain quality measures and CPIA performance categories because some of these measures can be calculated using administrative claims data. For data which clinicians and groups are required to report, CMS seeks comments for future rulemaking on whether it should propose requiring health IT vendors, QCDRs, and qualified registries to have the capability to submit data for all MIPS performance categories. **ACS does not support a requirement that health IT vendors, QCDRs, and qualified registries have the capability to submit data for all MIPS performance categories.** In theory, it seems like a reasonable goal to allow the provider to report all categories in one place in order to reduce reporting burden. However, this requirement is unnecessary because there will be a natural market incentive to build and encourage this functionality. This requirement could also have unintended consequences—it may not make practical sense for all registries to provide these capabilities thereby excluding certain registries.

CMS seeks feedback on whether it is advantageous to either (1) have a shorter time frame following the close of the performance period, or (2) have a submission period that would occur throughout the performance period, such as bi-annual or quarterly submissions; and (3) whether January 1 should also be included in the submission period. ACS believe QCDRs and qualified registries would be at a disadvantaged by having a shorter time frame

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following the close of the performance period due to the timing it takes to gather, audit, analyze, risk-adjust, and submit data. **As discussed above, ACS requests a deadline of April 31st following the performance period; or 4 months after the reporting period to allow for the capture and analytics required for the use of risk-adjusted outcomes data.** Submission periods throughout the performance period would be a hardship at this current time due to the amount of work needed to prepare data for submission.

Quality Performance Category

Overview

We thank CMS for responding to our comments to the MACRA RFI when developing the proposed rule. We generally agree with the goals for meaningful measurement outlined by CMS: measuring performance on measures that are relevant and meaningful; flexible scoring that recognizes all of a MIPS eligible clinician's efforts above a minimum level of effort and rewards performance that goes above and beyond the norm; measures that are built around real clinical workflows/data captured in course of patient care activities; measures and scoring that can discern meaningful differences in performance in each performance category and collectively between low and high performers. We would like to highlight that we believe that the goal of "maximizing the benefits of CEHRT" is shortsighted because CMS must look beyond the use of CERHT as the goal for data exchange. We discuss this in further detail in the ACI section. Although we can agree on these goals, the challenge will be in implementing the policies to achieve them. In general, the ACS believes the current proposals will make it hard to meet these goals because the quality program is overly complex, largely unattainable, lacks meaningful measures, lacks transparency, and lacks appropriate risk adjustment. If implemented as proposed, there will likely be very low levels of engagement from surgery. We encourage CMS to collaborate with specialty societies and consider policies which focus on the engagement of surgeons, including surgeons who were unable to successfully participate in PQRS.

An overview of our general recommendations and concerns for the quality performance category are as follows:

Reduce unattainable thresholds. The proposed rule increases the thresholds for reporting on quality measures from 50% on Medicare patients to 90% of all payers through QCDR, EHR, and traditional registry, and 80% of claims. These thresholds will be nearly impossible for surgeons to meet because the reporting burden is so high, it doesn't even allow for expected human error. Until we achieve a certain level of interoperability for data exchange across

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registries, EHRs and other data sources, CMS should maintain the 50% threshold.

Focus on meaningful measures that follow the phases of surgical care and encourage a cycle of improvement. In June 2015 ACS submitted a new PQRS Measures Group which includes measures that encompass the various phases of surgical care. However, these measures were not even included in the National Quality Forum's Measures Under Consideration (NQF MUC) list for consideration in 2017 rulemaking.

For some background, in March 2015 the ACS Performance Measurement Committee, a committee of surgeons with expertise in quality measurement representing the various sub-specialties of general surgery, conducted an extensive review of the currently available PQRS measures. Based on this analysis, they concluded that the current PQRS measure framework lacks meaningful and relevant metrics for surgical quality. In response, the Committee worked to define a set of metrics to span across the various phases of surgical care that align with a patient's clinical flow, including: preoperative preparation, perioperative final prep, intraoperative care, postoperative care and post discharge. Each of these phases involves key processes, critical care coordination to primary care physicians and anesthesia, as well as the technical side of surgical care that relates to safety, outcomes and avoidable harms. Together, these metrics translate into patient reported outcomes and patient experience of care. This framework broadly applies to surgical care for cross-cutting comparisons and was constructed to allow for more detailed, procedure-specific metrics to be added when necessary.

These metrics are different from the current PQRS/MIPS measures because they span across the various phases of surgical care and when measured together they can have a real impact at the point of care. ACS firmly believes that the current measure approach is narrow, complex, costly and sluggish. The current approach will likely slow down the ability to drive quality and improvement, which seems inconsistent with the goals of MACRA. ACS supports clinical metrics that are meaningful and actionable for improving care and matter to surgeons and their patients. This framework also aligns with the CMS goals for the MIPS quality component. We have spoken to various stakeholders who have shared their support for this framework. **We look forward to working with CMS on the inclusion of the phases of surgical care framework for the measurement of surgeons in the MIPS program. Instituting measures that surgeons find meaningful would incentivize better coordinated care and shared accountability, and aligns with population-based APMs.**

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Additionally, based on our experience with the submission of these measures, we urge CMS to employ a more transparent approach to measure selection for the MIPS program, including a detailed rationale on why certain measures are not selected. It is very frustrating for providers and provider organizations to commit the resources to improve participation by solving measure challenges identified in the CMS programs and then have their measures rejected without any communication from CMS.

Reduce number of measures required to report. CMS requires six measures, including one outcome measure and one cross-cutting measure. Although CMS has reduced the number of measures required from nine to six, the administrative bar is still too high for this program, given the additional requirements of MIPS. CMS must encourage meaningful engagement and measurement that drives improvement in patient care rather than reporting for the sake of reporting. As described above, MIPS measures are generally irrelevant to surgical care; identifying a single set of measures for general surgery within the current MIPS list of measures is difficult due to the diversity of procedures, patient population, and geographical location of general surgeons. Even more, the quality measures do not align with ACI, resource use, or CPIA. It is especially important that quality measures align with cost measures so that clinicians and groups have the information they need to increase value—without this information they should not be penalized. The inclusion of the ACS phases of surgical care measure framework would reduce administrative burden, allow for the use of meaningful measures that follow clinical workflow, would be reportable across most of surgery, and would align with the CPIA component of MIPS.

Increase transparency and equity. CMS has described the scoring methodology but does not provide any information on actual benchmarks for measures or which measures they deem as “topped out.” Additionally, for the specialty measure sets, CMS states that clinicians have the option to report only the measures that apply to them, even if it is less than the required six measures. However, it is not explained how reporting on fewer measures will impact their score, and if they are still eligible for bonus points. **It is critical that all eligible clinicians and groups have the same opportunity to successfully participate in the quality program, including the ability to achieve a bonus.**

Allow for appropriate risk adjustment. ACS is extremely concerned with CMS’ ability to implement outcome measures in MIPS and APMs due to their current inability to accept risk-adjusted data as part of the PQRS program. Part of the challenge is the capability to compare different populations across different data sources (such as different registries) due to a lack of defined risk variable definitions and statistical methods. These problems were recently

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demonstrated in CMS' inability to accept risk-adjusted metrics for the American College of Surgeons PQRS General Surgery Measures. CMS accepted risk-adjusted rates for PQRS performance of the General Surgery Measures for the 2014 performance year but explained that because of the 2015 Value Modifier—and the need to rate performance across individual providers—they could not accept risk-adjusted rates for 2015. This is because not all providers who reported this measures group submitted risk-adjusted results even though the measures were specified as such (these measures are currently included in the MIPS general surgery specialty-specific measure set).

Following this discovery, ACS ran a comparison of the Surgeon Specific Registry (SSR) 2015 raw data vs 2015 risk-adjusted data for the surgical site infection (SSI) measure in the PQRS General Surgery Measures Group. **The results of our analysis indicate that 50% of the poor performers were misclassified when risk adjustment is not applied.** ACS is currently working with CMS to find a solution to the technical issues regarding risk adjustment by sharing our methodology and variable definitions. However, this has raised a red flag, and **we strongly encourage additional resources and engagement of stakeholders to help CMS implement risk-adjusted rates in short order, given the quick timing of MACRA implementation.**

ACS also strongly urges the inclusion of sociodemographic status (SDS) risk adjustment for measures used in accountability applications (e.g., public reporting and pay-for-performance) on a case-by-case basis. Without the use of appropriate risk adjustment for certain measures, clinical outcomes will be less reliable due to SDS confounding variables and can result in the misclassification of care. We recommend that CMS closely follow the National Quality Forum (NQF) two-year pilot project titled *Risk Adjustment for Sociodemographic Factors*, which aims to provide recommendations on the appropriate application of risk adjustments to performance measures data. Additionally, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) is conducting research to examine the impact of SDS on quality measures. CMS should also examine the findings of the APSE reports and consider how these can apply to the MIPS quality measures.¹

National Quality Strategy Domains

CMS proposes to remove the National Quality Strategy Domains requirement for the MIPS program, noting that commenters find that NQS domains in the PQRS program are arbitrary and make reporting more difficult. ACS supports CMS' proposal to remove the NQS domains for the MIPS program because the

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¹ 81 FR 37175 (2016).



NQS domains were arbitrary and added complexity to successful quality reporting.

Quality Data Submission Criteria

Individual and Group Reporting

For the 12-month reporting period for the QCDR, EHR, tradition registry and claims (excluding Web Interface and CAHPS for MIPS), CMS proposes that MIPS eligible clinicians report at least six measures including one crosscutting measure and at least one outcome measure, or if an outcome measure is not reported another high priority measure (appropriate use, patient safety, efficiency, patient experience, and care coordination measures); if less than six measures apply then report on each measure that is applicable. CMS proposes that data completeness for claims is 80% of MIPS clinician's Medicare Part B-only patients; for QCDR, EHR, traditional registry 90% of MIPS clinician's or group's Medicare and non-Medicare patients (with at least one quality measure for at least one Medicare patient).

In general, although we appreciate the effort CMS has made to relieve the administrative burden of the quality performance category by reducing the number of measures, the administrative burden is still extremely high because providers would have the added burden of having to report on CPIA, and the proposed 90% and 80% measure thresholds are unattainable for most surgeons. For claims reporting, it was not foreseeable that CMS would increase the data threshold to 80%, as it has always maintained a 50% threshold under the PQRS. We note that the claims reporting option is the most burdensome for eligible clinicians, as clinicians must proactively attach quality data codes (QDCs) for each applicable claim. For registry reporting, CMS previously established a data completeness threshold of 80% under the PQRS. However, this threshold was still lower than the 90% currently being proposed for registries under the MIPS, and EPs were only required to report on three measures at the time the data completeness threshold for registries was at 80%. In addition, CMS lowered the data completeness threshold to 50% when requiring reporting on more measures (from three to nine) because of the high reporting burden it imposed. **Based on the extreme complexity of the MIPS program and the short implementation timeframe, we strongly urge CMS to keep the data completeness threshold at 50% until eligible clinicians gain experience with this new requirement.**

QCDRs have consistently been required to report on 50% of their patients. Given the changes CMS is proposing to the QCDR functionality, such as allowing the option to report for additional performance categories, requiring providing clinicians feedback at least six times a

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year, etc., we believe it is important to reduce the system changes QCDRs need to make by maintaining the 50% threshold. To make the data completeness threshold consistent with all reporting mechanisms, we suggest CMS also implement a 50% data completeness threshold for EHRs.

Topped Out Measures

ACS would like to thank CMS for maintaining process measures within the MIPS measure set (including measures the perioperative care measures), because this will provide surgeons with additional options when identifying measures to report. However, as mentioned above, we seek immediate clarity on which measures CMS will deem “topped out”; many process measures may fit into the definition CMS outlines for topped out measures, thereby putting physicians who report on those measures at a distinct disadvantage due to the lower points that will be assigned to these measures. To resolve this issue we strongly urge CMS to determine which measures will be topped out in future years, but **for the first few years of the program allow the topped out measures to earn the full point value, similar to the current PQRS system. Due to the lack of transparency regarding the identification of topped out measures, coupled with the complex scoring of the six MIPS measures, we believe this request is reasonable.**

Specialty-specific Measure Sets

CMS proposes specialty-specific measure sets as a way to make reporting quality measures less burdensome—instead of providers having to search nearly 300 measures, specialists can report on six measures in the set, including one outcome, and a cross cutting measure, or if six measures do not apply, report on the measures that are applicable. The measure sets are the same measures that can be found in the list of MIPS measures, but sorted based on the American Board of Medical Specialty specialties. Some measure sets have fewer than six measures. In this case, CMS notes that MIPS clinicians would report on all of the measures.

CMS has created a specialty set for vascular and general surgery; the general surgery set has eight measures, including four outcome measures, three other high priority measures, and one process measure, listed below.

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2017 Proposed MIPS Specialty Measure Sets (21b. General Surgery Measures)					
MIPS ID Number	NQF/PQRS	Data Submission Method	Measure Type	National Quality Strategy Domain	Measure Title and Description
!!	0268 /021	Claims, Registry	Process	Patient Safety	Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second generation cephalosporin prophylactic antibiotic, which had an order for a first OR second generation cephalosporin for antimicrobial prophylaxis
!	0271/022	Claims, Registry	Process	Patient Safety	Perioperative Care: Discontinuation of Prophylactic Parenteral Antibiotics (Non-Cardiac Procedures) Percentage of non-cardiac surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics AND who received a prophylactic parenteral antibiotic, who have an order for discontinuation of prophylactic parenteral antibiotics within 24 hours of surgical end time
!	0239 /023	Claims, Registry	Process	Patient Safety	Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients) Percentage of surgical patients aged 18 years and older undergoing procedures for which VTE prophylaxis is indicated in all patients, who had an order for Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated heparin (LDUH), adjusted-dose warfarin, fondaparinux or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time
* !	N/A/ 354	Registry	Outcome	Patient Safety	Anastomotic Leak Intervention Percentage patients aged 18 years and older who required an anastomotic leak intervention following gastric bypass or colectomy surgery
* !	N/A/ 355	Registry	Outcome	Patient Safety	Unplanned Reoperation within the 30 Day Postoperative Period Percentage of patients aged 18 years and older who had any unplanned reoperation within the 30 day postoperative period
* !	N/A/ 356	Registry	Outcome	Effective Clinical Care	Unplanned Hospital Readmission within 30 Days of Principal Procedure Percentage of patients aged 18 years and older who had an unplanned hospital readmission within 30 days of principal procedure

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* !	N/A/ 357	Registry	Outcome	Effective Clinical Care	Surgical Site Infection (SSI) Percentage of patients aged 18 years and older who had a surgical site infection (SSI)
!	N/A/ 358	Registry	Process	Person and Caregiver- Centered Experience and Outcomes	Patient-Centered Surgical Risk Assessment and Communication Percentage of patients who underwent a non-emergency surgery who had their personalized risks of postoperative complications assessed by their surgical team prior to surgery using a clinical data-based, patient-specific risk calculator and who received personal discussion of those risks with the surgeon

Note: Existing measures with proposed substantive changes are noted with an asterisk (*), high priority measures are noted with an exclamation point (!), and high priority measures that are appropriate use measures are noted with a double exclamation point (!!), in the “MIPS ID Number” column.

CMS proposes that MIPS clinicians and groups reporting on the general surgery specialty-specific measure set would either have the option to report on all measures within the set or could select six measures from the set and since these MIPS eligible clinicians are patient-facing one of their six measures must be a cross-cutting measure. We note that, for those who choose to report via claims, only three measures apply. Although we understand and appreciate that CMS developed these groups so that clinicians and groups can report on fewer than six measures, **we are unclear as to how these set of circumstances will impact a surgeons’ MIPS quality score if they choose to report via the subspecialty sets.** As an example, if a surgeon chooses to report based measures in the specialty set via claims, then chooses a cross cutting measure, would they earn fewer points because there is not a claims-based outcome measure for them to report? What is further confusing is that these measures are classified as high priority, but based on past reporting statistics they may also be topped out. We request clarity on what these factors mean for the individual’s score. Even more, **without benchmarks surgeons don’t know how to improve based on their current performance.**

We also seek clarity on how general surgeons can work to achieve the full 60 possible points for six measures selected (or fewer than six if that is all that is applicable and available via the clinicians’ selected reporting mechanism), as well as how they can achieve bonus points. **It is critical that every single MIPS clinician and group have the ability to achieve the maximum number of quality points, as well as earn bonus points. If this opportunity is missed, and certain subspecialties are at an inherent disadvantage, clinician and groups will feel mistrust which could result in the failure of the MIPS program.** Later in the letter, we further discuss the lack of transparency regarding points assigned to measures and topped out measure designation, but we would like to reiterate that due to the lack of information

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on measure point values, we cannot provide exact and meaningful comments on the measures chosen for these groups, or any MIPS measures in general.

Lastly, we note that CMS only included surgical specialty measure sets for general surgery and vascular surgery. As a result, many surgical subspecialties will not have the opportunity to choose an applicable specialty measure set to ease reporting burden. **Therefore, ACS strongly encourages CMS to work with surgical specialty societies to identify additional specialty measure sets.**

CAHPS for MIPS Reporting Option

We strongly urge CMS to allow groups to choose the Surgical CAHPS (S-CAHPS) survey as an option in addition to the Clinician and Group CAHPS because the S-CAHPS expands on the CG-CAHPS by focusing on aspects of surgical quality, which are important from the patient perspective and for which the patient is the best source of information. We remind CMS that the S-CAHPS is endorsed by the National Quality Forum (NQF) and the Measure Applications Partnership (MAP) recommended the inclusion of S-CAHPS in PQRS for two consecutive years, starting in 2013. Additionally, CMS has included the S-CAHPS in the Comprehensive Core Measure set for Orthopedic Measures. In the CY 2016 Medicare Physician Fee Schedule, CMS acknowledged that the CG CAHPS does not accurately reflect the care provided by single- or multispecialty surgical or anesthesia groups. There is multi-stakeholder consensus that the S-CAHPS should be included in physician quality reporting programs. **We do not believe the use of the CG CAHPS is in the best interest of the surgical patient and strongly urge CMS to work through the operational limitations associated with the use of the S-CAHPS as an alternative to CAHPS for MIPS as soon as possible to follow the recommendations of the NQF and the MAP.**

Application of Additional Systems Measures

In the proposed rule, CMS explains that it will consider an option for facility-based MIPS eligible clinicians to elect to use their institution's performance rates as a proxy for the MIPS quality score. They are not proposing an option for year one of MIPS because there are operational considerations that must be addressed before this option can be implemented. CMS is requesting comments on the following issues:

1. Whether it should attribute a facility's performance to a clinician for purposes of the quality and resource use performance categories and under what conditions such attribution would be appropriate and representative of the clinician's performance;

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2. Possible criteria for attributing a facility's performance to a clinician eligible for purposes of the quality and resource use performance categories;
3. Specific measures and settings for which CMS can use the facility's quality and resource use data as a proxy for the MIPS eligible clinician's quality and resource use performance categories; and
4. If attribution should be automatic or if a MIPS eligible clinician or group should elect for it to be done and choose the facilities through a registration process

ACS strongly supports facility-based measures that are aligned with a physician's goals and have direct bearing on their practice. The option to report on facility-level measures could greatly decrease reporting burden and increase quality improvement and reporting alignment across settings. If this is adopted, individual clinicians and groups should have the *option* to choose facility level measurement; it should not be required. The major implementation challenge ACS anticipates is that clinicians and groups often function across multiple facilities and CMS would need to determine how to address this challenge. Regarding CMS' questions about attribution for quality metrics, CMS should allow for hospital-level risk-adjusted outcome measurement attributable to the principal physician or groups of physicians for the primary diagnosis.

Resource use for facility-based measures poses other challenges regarding accountability which requires further study. We recommend that CMS conduct an attribution analysis to define resources and assign accountability for measurement at the individual provider level. For example, can the system determine which specialist ordered an unnecessary positron emission tomography (PET) scan for a cancer patient? Or how will we account for the surgeon who "costs" more up front but has better long-term outcomes? Another important consideration is the correspondence between the measurement and reporting interval and the timeline of the disease itself.

We can imagine an example where a breast cancer patient is seen in December when resource use may be very high because of necessary tests (magnetic resonance imaging, genetic testing) but without outcome data because it is too early in treatment. Another scenario is how to assess the first year's high cost for the primary treatment of the diagnoses which then results in a significant reduction in cancer reoccurrence in the long run. In this case, the overall cost—including the cost of salvage therapy—would be saved. In summary, the measurement window of time must match the state of time for a given disease to truly measure value. **In these cases, it will be critical to consider patient**

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care assessed over extended periods of time depending on the disease or condition. ACS welcomes the opportunity to work with CMS on this issue.

In regard to measures and setting for which CMS can use the facility's quality data as a proxy, we recommend that CMS use nationally validated, risk-adjusted, outcome-based registries such as the ACS NSQIP. The ACS has always sought to strengthen data reliability and validity through adequate registry design and appropriate sample size. We recognize the burden of data aggregation with data integrity. In order to optimize these features, we have used NSQIP standards as the benchmark for sampling. Our work demonstrates that with a robust validation strategy and critical attention through audits to verify the rigor of the data, the ACS has been able to maintain highly effective measurement in its registries using less than 50% of the patients in the sample.

Global and Population-based Measures

ACS strongly encourages CMS to give MIPS clinicians *the option to be evaluated on these measures, but that they not be a required component of the quality performance score, given the implications of payment and public reporting.* The measures proposed by CMS have shown to have low reliability when applied at the physician level—and even low reliability at the group level. In general, ACS believes that team based measurement for surgery should be attributed to the surgeon and the perioperative team. One example where surgeons have a large impact on population health is population-based screening. Population-based screening also encourages care coordination. For example, many breast surgeons work closely with various breast imaging groups to help ensure appropriate follow-up, especially for patients at high risk for breast cancer which is critical for managing resource use and ensuring optimal patient care. We encourage collaboration with CMS to identify meaningful metrics to measure surgeons' impact on global and population health.

AHRQ Prevention Quality Indicators (PQIs)

Section 1848(q) (2) (C) (iii) of the Act provides that the Secretary may use global measures, such as global outcome measures, and population-based measures for purposes of the quality performance category. Therefore, CMS proposes to use the acute and chronic composite measures of AHRQ Prevention Quality Indicators (PQIs) in the calculation of the quality measure domain for the MIPS total performance score. These are currently used in the Value-based Payment Modifier (VM) program. As proposed, MIPS clinicians will be evaluated on their performance on these measures in addition to the six required quality measures. CMS explains that based on their current use in the VM, CMS has found that these measures have been determined to be reliable

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with a minimum case size of 20. CMS states that they intend to incorporate clinical risk adjustment as soon as feasible to the PQI composites.

Because the chronic composite measures are not relevant to surgical care, ACS will focus this comment on the Acute Conditions Composite:

- Bacterial Pneumonia (PQI 11) (NQF 0279)
- Urinary Tract Infection (PQI 12) (NQF 0281)
- Dehydration (PQI 10) (NQF 0280)

These measures were recently reviewed by the NQF MAP which recommended “encourages continued development” of this composite to allow for testing at the clinician level with the new risk adjustment model that includes co-morbidities. In general, ACS is very unclear how the implementation of these measures would work—specifically, how attribution of patients to individual providers would be relevant for these intended as population or large cohort preventative care measures. Many of our concerns were also raised by commenters during the NQF MAP process:

- The reliability at volume of 20 patients is entirely unproven, and we seek clarity on the evidence base for this patient sample;
- These measures would hold providers accountable for events that are not typically treated by surgeons and for which they have little or no control;
- The measures include conditions that surgeons do not treat;
- The measures were developed as population-based measures and it is unclear how they would be used for clinician-level measurement;
- The potential impacts to the reliability and validity of the measure due to the modifications of the measure by CMS have not been to NQF for review;
- The need for review of the risk-model being developed. Currently each PQI is already individually risk-adjusted but not as a composite, and the measures are not adjusted for SDS;
- It is critical that an analysis of the potential unintended consequences for resource utilization is conducted.

ACS has major concerns regarding the reliability and validity of the proposed population health measures. Therefore, **we encourage CMS to continue to report on these measures and have them included in the QRUR, but they should not be included in the MIPS quality score for the first year until we have a better understanding what effect these measures will have on clinicians or groups MIPS score. Prior to use in the MIPS program, the updated measures should include appropriate clinical and SDS risk**

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adjustment, be tested for physician-level measurement, and reviewed by NQF for use in clinician programs.

All-cause Hospital Readmissions Measure

In addition to these measures, CMS proposes to include the all-cause hospital readmissions measure from the VM because they believe this measure also encourages care coordination. In the CY 2016 Medicare Physician Fee Schedule (PFS) proposed rule (80 FR 71296), CMS did a reliability analysis that indicates this measure is not reliable for solo clinicians or practices with fewer than 10 clinicians. CMS finalized this proposal to limit this measure to groups with 10 or more clinicians and to maintain the current VM requirement of 200 cases. Eligible clinicians in groups with 10 or more clinicians with sufficient cases will be evaluated on their performance on this measure.

For many years ACS has expressed concern regarding the hospital-wide readmission measure, noting that there are a multitude of factors that can contribute to readmission thereby making this a very difficult outcome to measure. We have generally questioned the validity and reliability of the measure because it does not account for SDS factors, community factors, and the plurality of care/care coordination. YALE CORE, the measure steward of this measure, acknowledges that SDS factors do play a small role, and they express that the effects of those factors should not be hidden for purposes of quality improvement. **Therefore, this is another example of CMS implementing a measure which is endorsed for another use**, and the measure steward has specifically acknowledged that the measure has not been specified for purposes of pay for performance. To this end, we are concerned that providers who serve disadvantaged populations may be unfairly impacted by this measure.

Additionally, it is important to note that physician level reliability of this measure is entirely unproven. Similar to the AHRQ PQIs, the current NQF approval of this measure is for facility-level measurement only, not for provider groups or individuals. Therefore, we have concerns about the use of this measure for physician-level measurement. Additionally, we seek clarity on how the triggering of an index episode and the attribution of an any-cause readmission to any particular provider or provider group larger than 10 will be relevant.

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Selection of Quality Measures for Individual Clinicians and Group

Call for Quality Measures

Similar to the historical PQRS “call for measures,” CMS proposes to continue the annual “Call for Quality Measures” in order to engage eligible clinician organizations and other relevant stakeholders in the identification and submission of quality measures. CMS states that it does not believe there should be any special restrictions on the type or make-up of the organizations developing quality measures since this could limit the scope and utility of quality measures, and encouraged the submission of measures regardless of NQF-endorsement. ACS agrees with this proposal.

CMS proposes a list of considerations when submitting quality measures for the MIPS program, which is consistent with the current PQRS expectations:

- Measures that are not duplicative of an existing or proposed measure.
- Measures that are beyond the measure concept phase of development and have started testing, at a minimum.
- Measures that include a data submission method beyond claims-based data submission.
- Measures that are outcome-based rather than clinical process measures.
- Measures that address patient safety and adverse events.
- Measures that identify appropriate use of diagnosis and therapeutics.
- Measures that address the domain for care coordination.
- Measures that address the domain for patient and caregiver experience.
- Measures that address efficiency, cost and resource use.
- Measures that address a performance gap or measurement gap.

ACS agrees with the proposed list, but encourages CMS to include the following additions:

- **Measures which span across the various phases of surgical care that align with a patient’s clinical flow, including: preoperative preparation, perioperative final prep, intraoperative care, postoperative care and post discharge. This focus also addresses patient safety and care coordination.**
- Measures based on validated, clinical data,
- Measures that can be risk-adjusted to include nuances of care and SDS factors (if applicable).
- **Process measures used in conjunction with outcome measures to provide a more comprehensive picture of clinical workflow and help link CPIA activities to the relationship between process**

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measures and outcome measures.

Peer Review

Section 1848(q)(2)(D)(iv) of the Act, requires the Secretary to submit new measures for publication in applicable specialty-appropriate, peer-reviewed journals before including such measures in the final annual list of quality measures. CMS requests comment on this proposal and on what mechanisms could be used, such as the CMS website, to notify the public that the requirement to submit new measures for publication is met.

ACS seeks clarity on this proposal. The process for journal submission can be a lengthy and we are concerned that this requirement may further delay the implementation of measures in the MIPS program. To this end, we strongly encourage CMS to ensure that the publication of measures will not go through the traditional lengthy peer review process for publication. We request confirmation that this process will not further slowdown the already sluggish, time-consuming process of getting measures into the MIPS quality program.

Cross-cutting Measures for 2017 and Beyond

As part of the MIPS program, CMS proposes to continue the PQRS requirement for clinicians and groups to report on a cross cutting measure. CMS explains that cross cutting measures help focus CMS efforts on population health improvement and allow for meaningful comparisons across MIPS clinicians. For the 2017 MIPS performance CMS proposes to remove measures which cannot be reportable by all MIPS clinicians. The measures they propose for removal are as follows:

- PQRS #001 (Diabetes: Hemoglobin A1c Poor Control)
- PQRS #046 (Medication Reconciliation Post Discharge)
- PQRS #110 (Preventive Care and Screening: Influenza Immunization)
- PQRS #111 (Pneumonia Vaccination Status for Older Adults)
- PQRS #112 (Breast Cancer Screening)
- PQRS #131 (Pain Assessment and Follow-Up)
- PQRS #134 (Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan)
- PQRS #154 (Falls: Risk Assessment)
- PQRS #155 (Falls: Plan of Care)
- PQRS #182 (Functional Outcome Assessment)
- PQRS #240 (Childhood Immunization Status)
- PQRS #318 (Falls: Screening for Fall Risk)

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- PQRS #400 (One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk)

Although ACS understands that CMS finds comparisons across all MIPS clinician meaningful, and therefore proposes the removal of certain cross cutting measures which are not reportable by all MIPS clinicians, ACS urges CMS to continue to classify the below measures as cross-cutting measures because these measures are generally comparable across all of surgery, and are more meaningful to surgical care than many more primary-care focused measures in the proposed 2017 MIPS cross-cutting measure set. **ACS encourages CMS to maintain the following measures in the “cross-cutting” measure set:**

- PQRS #046 (Medication Reconciliation Post Discharge)
- PQRS #111 (Pneumonia Vaccination Status for Older Adults)
- PQRS #131 (Pain Assessment and Follow-Up)
- PQRS #318 (Falls: Screening for Fall Risk)

Resource Use

CMS explains that measuring resource use is an integral part of measuring value. CMS proposes to start with existing condition and episode-based measures, a the total per capita costs for all attributed beneficiaries measure (total per capita cost measure) and the Medicare Spending Per Beneficiary (MSPB) measure. CMS explains that all resource use measures would be adjusted for geographic payment rate adjustments and beneficiary risk factors. In addition, a specialty adjustment would be applied to the total per capita cost measure, but CMS removed this adjustment for the MSPB measure. CMS proposes that all of the measures attributed to a MIPS eligible clinician or group would be weighted equally within the resource use performance category, and there would be no minimum number of measures required to receive a score under the resource use performance category. They plan to draw on standards for measure reliability, patient attribution, risk adjustment, and payment standardization from the VM and Physician Feedback Program. CMS will base all resource use measures off claims data.

ACS has major concerns with the many changes that CMS is proposing for the first year of the resource use component of the MIPS CPS. **Most notably, ACS is concerned with the low bar for reliability across all measures, including changes to the MSPB, the introduction of episodes that have not been tested for reliability and validity for ICD-10, and undetermined patient relationship codes and categories for attribution. Ultimately, we do not believe the program as proposed is ready for “prime time,” as there are too many undetermined factors.** We urge CMS to follow the same

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implementation timeline mandated for the inclusion of measures in the hospital programs, that the measures are not used for pay-for-reporting or public for at least one year of use in the applicable program. We strongly recommend that CMS re-specify and test the episodes based on ICD-10, collect historical data, and increase the reliability of the MSPB. Resource use measures should also be tied to quality measures and allow for the capture of long term outcomes, fit to a given condition or disease. **ACS believes the first year of the resource use category for MIPS should be simple and transparent. Until these measures are further refined, we recommend that CMS provide feedback to clinicians on these measures, but give all MIPS clinicians full possible points for the resource use program OR reweigh the category across the remaining performance categories.**

Weighing the Composite Performance Score

CMS proposes to weigh the resource use category as 10% in 2019, while incrementally increasing the weight by year: 2020: 15% ; 2021 and beyond 30%. ACS believes that this implementation schedule is too rapid; until we know more about how MIPS clinicians are being assessed based on the current proposals, we should continue to assign a low resource use weight to the CPS.

Resource Use Criteria

MSPB Measure

CMS proposes to use a 0.4 reliability threshold currently applied to measures under the VM. For the MIPS program CMS proposes to lower the reliability threshold to 0.4 in order to be able to apply this measure to a broader number of MIPS clinicians. CMS acknowledges that the “majority of clinicians and groups” who meet the case minimum required for scoring under a measure will have reliability above 0.4.

Specifically, CMS proposes to use a minimum of 20 cases for the MSPB measure. CMS explains that their analysis indicates that after making these changes to the MSPB measure’s calculations, the MSPB measure meets the desired 0.4 reliability threshold used in the VM for over 88% of all TINs with a 20 case minimum, including solo practitioners. They explain that while this percentage is lower than our current policy for the VM (where virtually all TINs with 125 or more episodes have moderate reliability), setting the case minimum at 20 allows for an increase in participation in the MSPB measure.

ACS has concerns that a 0.4 reliability threshold is extremely low when the minimum in the literature accepted is 0.7 for “acceptable” reliability. ACS believes that CMS should not accept the lower limit of “moderate” reliability

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(0.4). In fact, this proposal directly contradicts the rationale provided by CMS in Table 36 of the CY 2016 PFS proposed rule where CMS discusses the need to increase the minimum case number from 20 to 100 cases to obtain a 0.4 reliability threshold of 96.3%.² They reject 75 cases which provided a 0.4% reliability threshold of 91. To this end, we do not see the value in setting such a low bar for reliability. **Based on the importance of the success of the MIPS program, we strongly encourage CMS to demonstrate “good” reliability (0.8) for the MSPB measure to a so that MIPS clinicians have confidence in the program and can learn to improve the value of the care they deliver.**

CMS also proposes two technical changes to the MSPB measure: 1) removal of the specialty adjustment which accounted for the case-mix difference across the patient population; 2) modify the cost ratio used within the equation to evaluate the difference between observed and expected episode cost at the episode level before comparing the two at the individual or group level.

ACS strongly recommends against both of these proposals without further information from CMS on the evidence to support this policy. For the specialty adjustment CMS states that it is not necessary and may not be needed but CMS does not provide data to support this statement. However, it is unclear why CMS initially applied the specialty adjustment to all cost measures, publicly supporting their decision with evidence and educational materials, and now the agency is proposing it for removal without an explanation why it is no longer necessary. **Due to this lack of transparency, we cannot support the proposed changes to the MPPB measure. In general, we urge CMS to strengthen the measure reliability, validity and risk adjustment methodology for the MIPS program, not lower the bar.**

To this point, we also we also note the importance of the consideration of SDS factors and how these factors can impact the outcomes providers who care for patients of diverse SDS. The Office of the Assistant Secretary for Planning and Evaluation (ASPE) is conducting research to examine the impact of SDS on quality measures, and the ACS recommends that CMS should examine the findings of the ASPE reports and related Secretarial recommendations, to consider how this research can apply to measures included in the MIPS program.³ The ACS also recommends that CMS follow the work of the National Quality Forum (NQF) two-year pilot project titled Risk Adjustment for Sociodemographic Factors, which aims to provide recommendations on the appropriate application of risk adjustments to performance measures data. During the trial, measure developers are expected to submit information such

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² 80 FR 41906.

³ 81 FR 37175.



as analyses, interpretations, and performance scores with and without SDS factors in the risk adjustment model.⁴

Episode-based Measures Proposed for the MIPS Resource Use Performance Category

CMS proposes to calculate several episode-based measures for inclusion in the resource use performance category, and they introduce 41 clinical condition and treatment episode-based measures. They note that groups have received feedback on their performance on certain episode-based measures through the Supplemental Quality and Resource Use Report (QRUR), which are issued as part of the Physician Feedback Program under section 1848(n) of the Act. CMS adds that several stakeholders expressed in the MIPS and APMs RFI the desire to transition to episode-based measures and away from the general total per capita measures used in the VM; ACS submitted comment supporting the use of episode-based cost measures. Therefore, in lieu of using the total per capita cost measures for populations with specific conditions, CMS proposes the use of episode-based measures for a variety of conditions and procedures that are high cost, have high variability in resource use, or are for high impact conditions. However, these measures have not been used for the purpose of payment adjustments through the VM.

ACS asserts that physicians should not be held accountable for cost performance until CMS has developed and more carefully tested the proposed episode-based cost measures. We agree that specific episode-based cost measures will help ensure more fair comparisons and alleviate the need for many of the complex adjustments to data that are required with total per capita cost measures. However, these measures are not ready for “prime time,” as discussed above. It is important for CMS to ensure that practices are being compared to similarly situated practices (geography, specialty mix, patient mix, etc.). **We encourage the continued testing and development of the episode-based cost measures—including the testing of ICD-10 reliability and validity, and attribution-related issues. We also strongly urge CMS to align these measures with quality measures for a more comprehensive value measurement.**

Lastly, it is important that CMS implement a mechanism to account for all pharmaceutical costs when evaluating physician resource use. It is also important to identify scenarios where savings can be achieved by prescribing less expensive yet equally effective drugs.

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⁴ National Quality Forum. Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors Draft Report. March 18, 2014. Available at

<http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=77474>



Clinical Practice Improvement Activity (CPIA) Category

The ACS has a long and successful history in the development of accreditation and verification programs to improve the quality of care for surgical patients. In addition, the numerous quality programs developed by the ACS, including NSQIP, Trauma Quality Improvement Program (TQIP), and Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) are well recognized as promoting the highest standards of surgical care through evaluation of surgical outcomes in clinical practice. More information on these efforts can be found at:

<https://www.facs.org/qualityprograms>. **Because the goal of these programs drives to the heart of the intent of the CPIA component of MIPS, we firmly believe that surgeons who actively participate in ACS-sponsored accreditation and verification programs should accordingly receive CPIA credit for their efforts.** An active participant in one of these programs may be required to maintain certification, participate in defined quality improvement efforts to address specific deficiencies, provide access to care outside of normal business hours or on an immediate basis, report to a public health database, participate in a registry or participate in other meaningful activities.

The CPIA category of the MIPS program focuses on using a patient-centered approach to “better, smarter, and healthier care” through activities that have an association with improved health outcomes. CPIA activities also focus on establishing policies that can be scaled in future years as the bar for improvement rises, as well as to drive movement toward delivery system reform. CMS defines a CPIA as an activity that relevant eligible clinician organizations and other relevant stakeholders identify as improving clinical practice or care delivery, and that the Secretary determines, when effectively executed, is likely to result in improved outcomes. CMS proposes that the CPIA category count for 15% of the CPS.

As an organization that prides itself on striving toward continuous quality improvement, ACS is supportive of the concept of recognizing the activities developed by stakeholder organizations and rewarding providers who engage in them. However, given the unnecessary complexity of the overall MIPS program, and that the CPIA component is a new requirement, **ACS believes CMS should drastically reduce the complexity of the proposed CPIA component, particularly in the first years of the program.** The CPIA proposals are too complex in combination with the other components of the MIPS program thereby making it difficult for providers to figure out. Our comments below specify how CMS can make CPIA activities more meaningful and less burdensome for surgeons.

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Contribution to the Composite Performance Score (CPS): PCMH and APM Participants

CMS proposes that the CPIA component will account for 15% of the CPS. As required by statute, CMS explains that a clinician or group that is certified as a patient-centered medical home (PCMH) or comparable specialty practice will be given the highest potential CPIA score. CMS defines a PCMH as a nationally recognized accredited patient-centered medical home, a Medicaid Medical Home Model, or a Medicare Medical Home Model; the NCQA Patient-Centered Specialty Recognition will also be recognized.

Also required by statute, eligible clinicians participating in APMs receive 50% credit under the CPIA scoring methodology. While CMS lists APM participation in the list of CPIAs, we request additional guidance on which APMs would qualify under CPIA. **We believe that participation in any APM should qualify.** CMS went to great lengths to describe MIPS Qualified APMs for the APM Scoring Methodology and Advanced APMs for the APM payment incentive, and in order to provide guidance to our members we want to ensure that APM participation for purposes of CPIA credit is broader than those APMs listed under the MIPS Qualified and Advanced APM categories. Additionally, given that we assume CMS purposefully intended to distinguish between APM participation and medical home participation, we request that under CPIA scoring, while medical home participation will receive the highest potential CPIA score, APM participation will provide an eligible clinician with 80% of the potential CPIA score. If CMS maintains the current CPIA scoring proposals, this will require an eligible clinician who participates in and APM to successfully complete one high-priority CPIA. We believe that not only does the MACRA language allow for this but it will further encourage participation in APMs, a clear goal of MACRA. We discuss these proposals in further detail in the APM section of this letter.

CPIA Data Submission Criteria

CMS proposes to allow for the submission of the CPIA performance category using the following reporting mechanisms: qualified registry, QCDR, EHR, CMS Web Interface, and attestation. We appreciate CMS' efforts to allow for flexibility in reporting mechanism to make reporting easier on physicians. CMS notes that for the first year only, participants must designate a yes/no response (via their reporting mechanism of choice). ACS supports the yes/no designation for reporting on CPIA activities, but encourages CMS to reevaluate the type of response for year two and beyond to reduce reporting burden and encourage engagement.

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ACS agrees that in addition to annual attestation through a web-based portal, acceptable options should include QCDRs and EHRs, where applicable. There should also be an option of having participation in a CPIA reported by the certifying agency, rather than by the individual physician. This range of options would provide the opportunity for specialty societies and/or QCDR sponsoring entities to create what are essentially specialty-specific dashboards designed to provide feedback to EPs across all of the MIPS performance categories. This would allow measurement in one category to be tied to measurement in other categories, (e.g. ensuring that quality and resource measurement are occurring in the same clinical spectrum), reduce physician administrative burden related to reporting, streamline CMS efforts to receive performance data in each performance category, and allow for alignment of measure reporting with other non-Medicare reporting requirements such as those related to Maintenance of Certification (MoC) or private payer initiatives.

Weighted Scoring and Submission Criteria

CMS proposes a complex weighted scoring model for the CPIA component, which requires that each activity be performed for at least 90 days. As part of this scoring system, CMS proposes to weight CPIA activities as either “medium” or “high”. In order to achieve the highest possible CPIA score, clinicians or groups must achieve a total of 60 points; either three high CPIA activities which are 20 points each, six medium activities which are 10 points each, or a combination of both. Exceptions apply to clinicians and groups that are small, located in rural areas or geographic HPSAs, or non-patient facing providers—these providers are only required to report on any two CPIA activities to receive full credit, regardless of the medium or high designation.

CMS explains that they weighted activities as high based on alignment with CMS’ national priorities and programs such as the Quality Innovation Network-Quality Improvement Organization (QIN/QIO) or the Comprehensive Primary Care Initiative which recognizes specific activities related to expanded access and integrated behavioral health as important. CMS adds that programs requiring performance of multiple activities such as participation in the Transforming Clinical Practice Initiative, seeing new and follow-up Medicaid patients in a timely manner in the provider’s State Medicaid Program, or an activity identified as a public health priority were also weighted as high. CMS also notes that working with a QCDR would allow a clinician or group to meet multiple CPIA activities.

As stated above, the proposed CPIA scoring and criteria for participation may prove burdensome and confusing to providers, especially in combination with

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the other new MIPS reporting requirements. It is important for CMS to realize that providers will need to set up infrastructure and expend additional resources to meet these activities. Therefore, the CPIA program must have a slower phased-in approach. To this end, **ACS strongly recommends that all CPIA activities (other than participation in an APM or a medical home model) be weighted equally and that MIPS providers be required to attest to participating in not more than three CPIAs to receive full credit in this component.** The proposal for rural areas or geographic HPSAs should be maintained. As proposed, surgeons are frustrated with the requirement to meet the 60 point score for 90 days—this seems like bean counting to the practicing surgeon. And, it is unclear what 90 days means for some activities. For example, “Use of a QCDR to generate regular feedback reports that summarize local practice patterns and treatment outcomes, including for vulnerable populations.” Based on this activity, would the surgeon have to access feedback reports for 90 days? **ACS believes the requirement to attest to 90 days of performance is inapplicable to many activities and should be eliminated.**

For reasons of transparency, ACS requests additional information on how CPIA weights were determined. CMS provides the example of a “high” scored CPIA activity as being a PCMH, as well as an activity identified as a public health priority. However, there is not a clear distinction between medium and high which is why each activity should be weighted the same for the first year(s) of MIPS. Additionally, although we appreciate that participation in a QCDR can count for multiple activities, **instead of limiting credit to activities which focus on the CMS definition of a QCDR, CPIAs should be inclusive of nationally validated, risk-adjusted, outcome-based registries such as ACS NSQIP, MBSAQIP, the National Cancer Data Base, or the National Trauma Data Bank.**

CPIA Subcategories

The ACS has a long and successful history in the development of accreditation and verification programs to improve the quality of care for surgical patients. In addition, the numerous quality programs developed by the ACS, including NSQIP, TQIP, and MBSAQIP are well recognized as promoting the highest standards of surgical care through evaluation of surgical outcomes in clinical practice.

These programs follow the guiding principles of continuous quality improvement:

1. Set the standards. Standards should be individualized by patient and supported by research.

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2. Build the right infrastructure including the appropriate staffing levels specialists, equipment, and checklists.
3. Use the right data, including data continuously updated, backed by research, abstracted from medical charts, and including post-discharge tracking.
4. Verify with outside experts by external peer-review to create public assurance.

For example, The ACS Verification, Review, and Consultation (VRC) Program is a comprehensive program which follows the guiding principles of continuous quality improvement. The program is designed to assist hospitals in the evaluation and improvement of trauma care and provide objective, external review of institutional capability and performance. These functions are accomplished by an on-site review of the hospital by a peer review team, experienced in the field of trauma care. The team assesses commitment, readiness, resources, policies, patient care, performance improvement, and other relevant features of the program. Figure 1 illustrates that a trauma system itself consists of a variety of discrete components interacting in an organized, predetermined manner to perform core functions and accomplish defined goals—many of these individual activities are aligned with the proposed CPIA activities but applied in a more systematic organized and cyclical manner.

Numerous physicians and other trauma center staff commit to devoting significant time to meet the stringent requirements of the program. ACS believes that those participating in roles specified in Resources for Optimal Care of the Injured Patient, a guide for the Consultation/ Verification program, in verified trauma centers should receive CPIA credit for the appropriate related activities. For example, general surgeons caring for trauma patients must meet certain requirements in four categories: current board certification, clinical involvement, performance improvement and patient safety (PIPS), and continuing education. These requirements are quite rigorous and overlap with several designated CPIAs. There are also several positions with additional requirements such as the designated Trauma Medical Director and physician liaison positions. Documentation of holding one of these positions should earn CPIA credit for these physicians without additional reporting requirements since the requirements are independently verified.

Other ACS quality programs and their participating surgeons and other clinicians must meet similar requirements and should receive credit by the very nature of their formal participation in achieving and maintaining certification. More information on these efforts can be found at:

<https://www.facs.org/quality-programs>. We welcome the opportunity to discuss how best the practice improvement activities inherent in these

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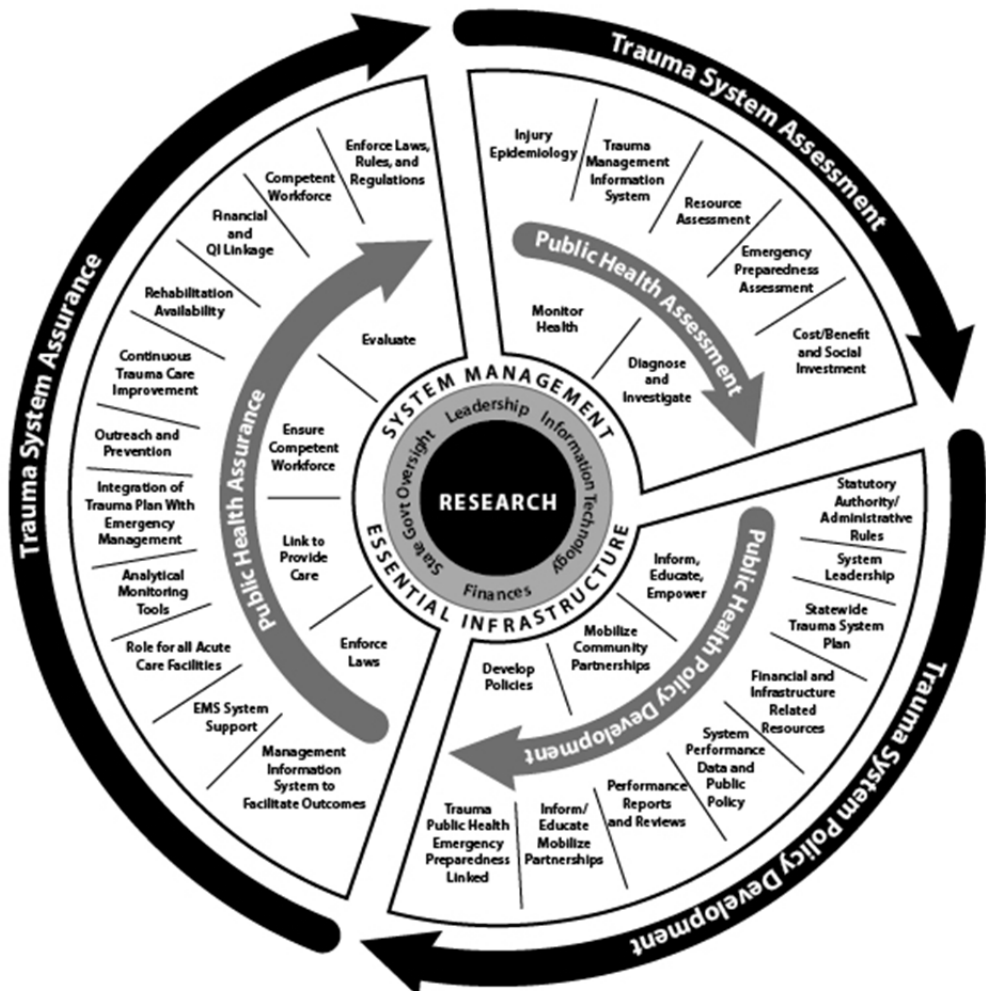
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verification and certification programs can be recognized. **Because the goal of these programs drives to the heart of the intent of the CPIA component of MIPS, and because these activities follow a set of processes that follow a cycle of improvement lined to quality, we firmly believe that surgeons who actively participate in this type of program should accordingly receive full CPIA credit under the category of Patient safety and practice assessment for their efforts.**

Figure 1: The Relationship Between Public Health Functions and Services and the Operations of a Trauma System⁵



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⁵ U.S. Department of Health and Human Services. Health Resources and Services Administration. Model Trauma System Planning and Evaluation. Rockville, MD: U.S. Department of Health and Human Services; 2006. Available at: www.facs.org/quality-programs/trauma/tsepc/resource



CPIA Inventory

ACS appreciates that CMS included a long list of CPIA activities. There are certain activities where we seek additional clarity, and some for which we have specific recommendations. The activities are listed based on their subcategory:

QCDR Activities Which Cross Many Subcategories

CMS includes many activities based on participation in a QCDR. ACS appreciates CMS' encouragement of the use of clinical data registries by the inclusion of registry activities.

However, we also believe that participation in other physician-led clinical data registries that might not (yet) be a QCDR such as public health registries, and registries implemented at local institutions, should be considered for CPIA credit. In recognition of the extra investment of time and resources that must be made by physicians who opt to collect and report data through a clinical data registry, we would ask that surgeons successfully reporting via QCDRs as well as physician-led clinical data registries receive specified CPIA credit in addition to receipt of credit under the quality measures category of MIPS.

Expanded Practice Access

"Provide 24/7 access to MIPS eligible clinicians, groups, or care teams for advice about urgent and emergent care." ACS respectfully asserts that surgeons who provide call coverage and make themselves available to emergency departments and other facilities providing after-hours access, whether on a voluntary or mandatory basis, should also similarly receive credit for their analogous efforts in providing such access to after-hours clinician advice and service.

Beneficiary Engagement

"Engage patients and families to guide improvement in the system of care." ACS requests that CMS clarify how this activity would be documented.

Achieving Health Equity

"Seeing new and follow-up Medicaid patients in a timely manner, including individuals dually eligible for Medicaid and Medicare." ACS requests that CMS provide clarification on how "timely manner" will be assessed.

Emergency Response and Preparedness

ACS strongly supports the creation of this additional subcategory as it would serve as a means of providing CPIA credit to surgeons who serve in the armed forces reserves and the National Guard. We believe the criteria for credit should be broad enough to include eligible clinicians who also participate in other state-based emergency and disaster preparedness activities and other

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volunteer initiatives sponsored by medical specialty societies such as ACS' Operation Giving Back: <http://operationgivingback.facs.org>.

Additionally, ACS seeks clarity on the two activities; "Participation in Disaster Medical Assistance Teams, or Community Emergency Responder Teams" and "Participation in domestic or international humanitarian volunteer work." In both cases, the description notes that activities that simply involve registration are not sufficient, yet require that MIPS eligible clinicians and MIPS eligible clinician groups must be registered for a minimum of six months as a volunteer for the appropriate volunteer activities. ACS seeks clarity on what criteria are required to actually receive credit. If being registered for the volunteer activity for at least six months in a reporting period does provide credit than the preceding sentence noting that activities that simply involve registration should be clarified. If a provider is required to actually participate in the volunteer activity to receive credit then the requirement for a minimum six month registration should be removed. Surgeons frequently choose to volunteer in times of disaster or emergency or to meet other unforeseen health needs when the opportunity presents itself. The six month registration requirement would seem arbitrary in this circumstance. Alternately, credit in this category could be earned *either* through being registered as a volunteer for at least six months *or* through active participation as a volunteer.

Patient Safety and Practice Assessment

As previously referenced, ACS has developed a quality measure set focused on the five phases of surgical care: preoperative, perioperative, intraoperative, postoperative, and post-discharge. ACS believes that for CPIA measures to be meaningful for surgeons, they should also be focused on the five phases of surgical care. As such, surgeons who participate in programs such as Strong for Surgery, a public health campaign to integrate checklists into the pre-operative phase of clinical practice for elective surgeries, designed to improve care in these areas, should receive credit. As another example, surgeons who utilize the evidence-based guidelines for decisions relative to surgical care found at <http://ebds.facs.org> are taking an important step toward improving quality at one or more of these critical phases and should also receive CPIA credit.

Additionally, surgeons and other providers who actively and regularly participate and document their participation in quality improvement conferences (sometimes referred to as Morbidity and Mortality or M&M conferences) should receive credit toward their CPIA score under the category of Patient Safety and Practice Assessment. The goal of such conferences is to review adverse outcomes, identify the issues and system failures that led to the adverse outcomes and commit to process improvements in all five phases of surgical care.

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Lastly, as part of the CPIA Patient Safety and Practice Assessment Subcategory of activities, CMS includes: “Participation in Maintenance of Certification Part IV for improving professional practice including participation in a local, regional or national outcomes registry or quality assessment program. Performance of activities across practice to regularly assess performance in practice, by reviewing outcomes addressing identified areas for improvement and evaluating the results.” CMS proposes that this activity would be “medium priority,” and thus worth only 10 of the 60 CPIA points needed to achieve the highest potential score.

ACS believes that, at the very least, CMS should re-designate this activity as a high priority. While we believe that participation in MOC Part IV should enable a physician to receive an even higher CPIA score, at the very least CMS should acknowledge the effort and resources that are dedicated to an activity that’s importance and value is recognized by every board and medical specialty. These activities, which are required by all member boards in the American Board of Medical Specialties (ABMS) and which require physician engagement in practice performance improvement efforts, are quintessential practice improvement activities and believe that should be reflected in the ability of participation in MOC Part IV to contribute to an eligible clinicians CPIA score. The types of activities which are appropriate for each specialty are determined by that specialty’s Board under the oversight and approval of ABMS, and we firmly believe CMS should acknowledge and defer to that expertise in its weighting of this activity.

We also recommend that to ensure that participation in MOC Part IV is accurately represented in the CPIA scoring proposals that CMS should utilize its approach to incorporating the various aspects of QCDR participation in the list of CPIAs by separately listing the MOC Part IV activities, thereby allowing eligible clinicians who demonstrate participation in all aspects of MOC are able to attest to each of those different MOC Part IV related activities in order to achieve a higher cumulative CPIA score beyond the 10 points CMS is now proposing to dedicate to engaging in MOC Part IV. This would not only be appropriate because of the intensity of MOC Part IV, but also because of its emphasis on clinical data registries.

We feel that these types of activities are exactly what was contemplated by Congress when it created CPIAs, and strongly request that the activities surrounding MOC Part IV should be given more value in the CPIA scoring proposals, similar to CMS’ CPIA approach with QCDRs.

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Additional Suggestions for CPIA Activities

In general, ACS requests that CMS remain open to proposals for inclusion of new, appropriate CPIAs on an ongoing or regular basis. The ACS strongly believes in continuous quality improvement efforts and regularly develops new initiatives to improve quality and delivery of care to the patient. There are numerous ACS initiatives in use that we believe will or should fit into the existing CPIA categories, particularly those that emphasize quality improvement in the five phases of surgical care. Additionally, ACS believes that participation in quality improvement collaboratives should be included for CPIA credit.

Request for Comments on Use of QCDRs for Identification of Tracking of Future Activities

CMS recognizes that QCDRs may provide the opportunity for longer-term data collection processes which will be needed for future submission on improvement, in addition to achievement. They also note that the use of QCDRs also supports ongoing performance feedback and allows for implementation of continuous process improvements. CMS asserts that in future years, QCDRs will be allowed to define specific CPIAs for specialty clinicians and groups through the QCDR submission and approval process. ACS agrees with CMS' assessment of the capability of QCDRs to track the cyclical nature of quality and improvement, and we agree that having these activities included in a central location will allow clinicians and groups to more effectively drive improvement in care, while providing an easier mechanism to report. By allowing QCDRs to define CPIA activities, specialties can closely link quality metrics with CPIA activities for a more meaningful and comprehensive set of standards to drive improvement.

CMS also notes that they intend, in future performance years, to begin measuring CPIA data points for all eligible clinicians and to award scores based on performance and improvement. CMS solicits comment on these potential future policies. ACS understands this is important, but we believe that CMS should prioritize a functioning program before beginning to incorporate improvement. To start, CMS must figure out a better way to provide feedback in a more relevant period of time. A 2-year lookback period is simply not actionable for purposes of quality improvement.

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Advancing Care Information Performance Category

Overview

ACS believes it is necessary to create an interoperable, digital health IT environment and we are working diligently to provide our Fellows with the tools to succeed in such an environment. The streamlining of the current CMS quality programs gives CMS the opportunity and the authority to broaden the ACI category to expand on the concept of communicating and utilizing health data using a wide variety of health IT, rather than focusing solely on the EHR. We appreciate CMS efforts to-date to expand the use of EHRs and the steps taken in the new ACI program toward these goals but feel they do not go far enough. The objective of ACI should be the attainment of widespread *health data* interoperability not only between meaningful users of certified EHR technology, but more broadly throughout the wider clinical data ecosystem, reaching all patients and providers across the country through a variety of technologies. “Advancing care information” is a laudable goal, which should extend beyond EHRs themselves as the sole source for defining this category. The value of HIT in contributing data to complete patient health records, informing care decisions to improve outcomes, increasing efficiency and reducing costs can be realized through use of registries, apps running analytics on platform technology, QCDRs, pop-up alerts, or other technologies not yet developed. An example of this is illustrated in the below patient-centric data map with bi-directional data streaming across multiple sources including data from the lab, a skilled nursing facility, home health, a national cancer database, clinical data registry, EHR, public health registry, and so on.

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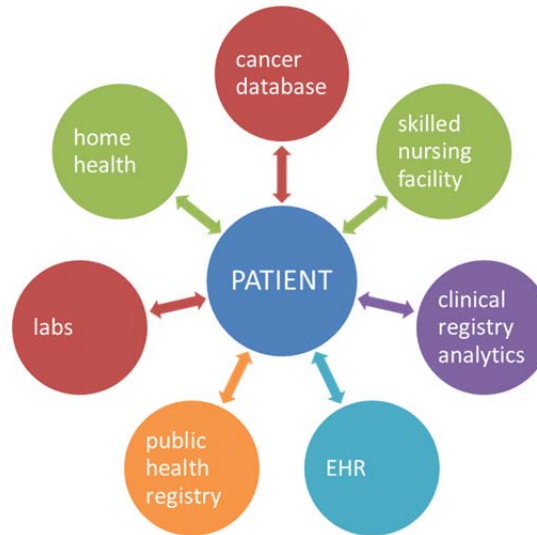
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PATIENT-CENTRIC DATA MAP



Once this degree of interoperability exists, the digital clinical information that is derived could be used to communicate with advanced surgical analytics and used for public reporting. The long term goal of ACI should not be limited to participation and transfer of static documents through the EHR. The goal should be the seamless use of data in patient care, for public reporting and in quality improvement. **ACS strongly believes that CMS should set the groundwork for a system that provides ACI credit for activities that demonstrate a provider's use of digital clinical data to inform patient care and their commitment to bi-directional data interoperability.**

Unfortunately, ACI proposals maintain a strong focus on the reporting of numerator and denominator data through the EHR which will unlikely improve patient care.

ACS is working to provide our Fellows with the resources to succeed in an interoperative data environment. As a testament to our commitment to interoperability, we have invested in an ongoing project to recreate all of our registries on one common data platform with a common data warehouse strategy. This will produce the ability to consume, map, and populate data from an EHR and other data sources (including financial data) into our registries or other applications. This will be a great benefit to patients and remove a large burden from physicians who are aiming to demonstrate achievement. Ultimately, ACS envisions registry-based patient dashboards with metrics

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tracking the five phases of surgical care. We believe this would be meaningful and important to both surgeons and surgical patients. Defining process measures along this continuum is an effective way to derive a single report for a single patient while encompassing impactful measures and patient-focused care. ACS believes it is necessary to incorporate digital information in a surgeon's workflow that is meaningful and actionable.

The ACI component, which replaces Meaningful Use (MU), includes a few key changes to the original EHR Incentive Program. The ACI category takes a step away from a pass-fail methodology by combining a base score and performance score into a total ACI score. The ACI category also reduces the number of measures that were previously included in the EHR Incentive Program. Additionally, to ease the reporting process, physicians can submit data as groups as well as submit through QCDRs. Despite these changes, **the ACS believes that the ACI category remains substantially similar to the current EHR Incentive Program and should be further modified.**

Considerations in Defining Advancing Care Information Performance Category

In general, the proposed measures included in the ACI category are adopted from the EHR Incentive Program which has failed physicians of many specialties. CMS claims to have disposed of the all-or-nothing approach that existed in the EHR Incentive Program. However, in order to achieve the ACI base score, eligible clinicians still need to report on all of the measures proposed. As demonstrated by the low attainment rate for MU Stage 2, the all-or-nothing approach is not effective because providers are not given the flexibility to choose measures meaningful to their practices. As of November 2015, only 49% of Stage 2 eligible EPs have achieved Stage 2.⁶

Allowing for partial credit for partial attainment is a needed improvement. As currently proposed, in order to receive even partial credit in this category, eligible clinicians will still need to successfully report on all of the measures included in the base score. **ACS believes that appropriate credit should be allotted for both partial success and for improvement in meeting the goals of the ACI category. We also strongly believe that physicians should be given the option to select measures that are relevant to their practices and clinical work flow (such as bi-directional sharing of data between EHRs, registries, clinical dashboards etc.) instead of being required to report on all of the base score measures that may not be meaningful to the care they deliver.**

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⁶ "Summary of the November 10, 2015, Meeting." Health IT Policy Committee. Office of the National Coordinator for Health Information Technology, n.d. Web. 9 June 2016.



Performance Period Definition

CMS proposes to align the performance period for the ACI performance category to the proposed MIPS performance period of one full calendar year. **ACS believes that the performance period should be shortened to 90 days, particularly in the early years of the program.** New participants in the EHR Incentive Program were given a 90-day reporting period and as the previous program has been converted into the ACI category, ACS believes eligible clinicians need flexibility and time to learn how to effectively participate. As mentioned above, ACS strongly supports a shortened performance period for the first performance year of MIPS. We believe a performance period of July 1, 2017 – December 31, 2017 will allow for a sufficient amount of data to assess clinicians while giving CMS and member organizations much needed time for outreach and education. The 90 day reporting period for ACI in the first year should coincide with this shortened MIPS reporting period.

Additionally, we believe that CMS should offer flexibility for all clinicians during the first year that a new edition of EHR technology is required, by allowing them to report for a 90-day reporting period. Providers who are trying to align reporting across multiple Medicare programs, should be given the option to report for one full CY if they choose to, but otherwise, would only have to report for a 90-day period within the CY.

Additionally, CMS is proposing that in CY 2018, eligible clinicians must only use technology certified to the 2015 Edition to meet the objectives and measures specified for the ACI category. This is a concern because we have heard that most of our members are still using 2014 CEHRT. As CMS is aware, the cost of upgrading to 2015 CEHRT is very high. Physicians may not be able to afford the upgrade because they would need to spend more money on upgrading their CEHRT than they would receive in payment adjustments. In addition, this upgrade would only compound the MIPS related burden. **For these reasons, ACS believes that CMS should not make the use of 2015 CEHRT a requirement and instead urges CMS to keep both 2014 CEHRT and 2015 CEHRT as viable options for successfully reporting ACI for more than a year.**

CMS also proposes that eligible clinicians that only have data for a portion of the year can still submit data, and be assessed and scored for the ACI performance category. ACS requests clarification from CMS on how this would affect the scoring of eligible clinicians with less than a year's worth of data. We believe that eligible clinicians who can only provide data for a portion of the year should not be penalized and that a 90-day reporting period could eliminate this risk.

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Advancing Care Information Performance Category Data Submission and Collection

Definition of Meaningful EHR User and Certification Requirements

For 2017, CMS is proposing that MIPS eligible clinicians would be able to use EHR technology certified to either the 2014 or 2015 Edition certification criteria as follows:

- A MIPS eligible clinician who only has technology certified to the 2015 Edition may choose to report: (1) on the objectives and measures specified for the ACI performance category which correlate to Stage 3 requirements; or (2) on the alternate objectives and measures specified for the ACI performance category which correlate to modified Stage 2 requirements.
- A MIPS eligible clinician who has technology certified to a combination of 2015 Edition and 2014 Edition may choose to report: (1) on the objectives and measures specified for the ACI performance category which correlate to Stage 3; or (2) on the alternate objectives and measures specified for the ACI performance category which correlate to modified Stage 2, if they have the appropriate mix of technologies to support each measure selected.
- A MIPS eligible clinician who only has technology certified to the 2014 Edition would not be able to report on any of the measures specified for the ACI performance category that correlate to a Stage 3 measure that requires the support of technology certified to the 2015 Edition. These MIPS eligible clinicians would be required to report on the alternate objectives and measures specified for the ACI performance category which correlate to modified Stage 2 objectives and measures.

ACS is concerned that providers who will use 2014 CEHRT to report on the ACI measures may be at a disadvantage. It is our understanding that the reporting options for surgeons using 2014 CEHRT are more limited than those available for surgeons using 2015 CEHRT as they can only report on some of the measures that correlate to Stage 3 measures. For example, in the proposed Stage 3 ACI measures under the Coordination of Care through Patient Engagement objective, the View, Download, Transmit (VDT) measure requires that during the performance period, at least one unique patient (or patient-authorized representatives) seen by the MIPS eligible clinician must actively engage with the EHR made accessible by the clinician. A MIPS eligible clinician may meet the measure by (1) view, download or transmit to a third party their health information; or (2) access their health information through the use of an API that can be used by applications chosen by the patient and

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configured to the API clinician's CEHRT; or (3) a combination of (1) and (2). The Advanced Health Models and Meaningful Use Workgroup pointed out that providers would need to use 2015 CEHRT to allow their patients to access their health information through the use of an application program interface (API)⁷. Based on this discussion, eligible clinicians using 2014 CEHRT are at a disadvantage. **The ACS requests more information on how providers using 2014 CEHRT would be scored versus providers using 2015 CEHRT. The ACS believes that CMS should adjust scoring so that physicians using 2014 CEHRT are not at a disadvantage compared to physicians using 2015 CEHRT.**

Method of Data Submission

For the purpose of reporting ACI performance category objectives and measures, CMS proposes to allow clinicians to submit ACI performance category data through any one of the following reporting options: qualified registry, EHR, QCDR, and CMS Web Interface submission methods. The ACS supports this proposal and thanks CMS for listening to our request to include the use of qualified registries, QCDRs, and Web Interface submission methods. Please note, however, that as previously stated above, we believe it should be optional for qualified registries and QCDRs to provide the capability to report ACI performance category objectives and measures.

Group Reporting

CMS proposes that MIPS eligible clinicians should be able to submit data as a group, and be assessed at the group level, for all of the MIPS performance categories, including the ACI performance category. **ACS supports this proposal and thanks CMS for including reporting mechanisms that help streamline the entire MIPS program thereby reducing administrative burden. We also recommend that CMS consider a policy that would require that a majority of the group (50%) meet the full ACI requirements in order for the group to get full credit.** As stated above, ACS requests more information in the final rule as to how the group option will differ from reporting as an individual MIPS eligible clinician for the ACI performance category.

Reporting Requirements & Scoring Methodology

CMS is proposing a new scoring methodology which is aimed at balancing the goals of incentivizing participation and reporting while recognizing

⁷ Tang P, Kimura J. Policy: Advanced Health Models and Meaningful Use Workgroup. Healthit.gov. Web. June 3, 2016.

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exceptional performance by awarding points through a performance score. In this methodology, CMS is proposing that the score for the ACI category would be comprised of a score for participation (referred to as the “base score”) and a score for performance at varying levels above the base score requirements (referred to as the “performance score.”)

Base Score

To earn points toward the base score, a MIPS eligible clinician must report on specific measures that account for 50% (out of a total 100%) of the ACI category score. Under this proposal, the base score would incorporate the objective and measures adopted by the EHR Incentive Programs with an emphasis on privacy and security.

CMS is proposing two variations of a scoring methodology for the base score, a primary and an alternate proposal. Both proposals would require the MIPS eligible clinician to meet the requirement to protect patient health information created or maintained by certified EHR technology to earn any score within the ACI performance category; failure to do so would result in a base score of zero, a performance score of zero, and an ACI performance category score of zero. The measures would require MIPS eligible clinicians to report the numerator (of at least one) and denominator (or a yes/no statement for applicable measures) for each measure being reported. CMS notes that for any measure requiring a yes/no statement, only a yes statement would qualify for credit under the base score.

For the primary proposal, in an effort to streamline and simplify the reporting requirements under MIPS, and reduce reporting burden on MIPS eligible clinicians, CMS proposes that two objectives (Clinical Decision Support and Computerized Provider Order Entry) and their associated measures would not be required for reporting the ACI performance category. **ACS supports the primary proposal which does not require Clinical Decision Support and Computerized Provider Order Entry.**

The alternate proposal would require a MIPS eligible clinician to report on all objectives and measures adopted for Stage 3 in the 2015 EHR Incentive Programs Final Rule to earn the base score portion of the ACI performance category, which would include reporting a yes/no statement for Clinical Decision Support and a numerator and denominator for Computerized Provider Order Entry objectives.

We would like to thank CMS for providing both a primary and alternate proposal for the base score. **ACS supports the primary proposal for the base**

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score to the alternative proposal because the reporting burden would be reduced on physicians. The EHR Incentive Program's burdensome reporting requirements have long been an impediment to successful participation.

Additionally we feel strongly that CMS should allow for partial credit in the base score. As proposed, the base score would remain all-or-nothing for those who fail to report all base score objectives. This proposal is perceived as burdensome by some because not all base score objectives are applicable to surgeons. **Therefore, providers should be able to receive credit for each objective reported in the base score.** If CMS believes strongly that a given measure in the base score is critical, that component could be weighted more heavily than other measures. This would be preferable to the current all-or-nothing nature of the base score.

Privacy and Security; Protect Patient Health Information

In the 2015 EHR Incentive Program's Final Rule, CMS finalized the Protect Patient Health Information objective and its associated measure for Stage 3, which requires EPs to secure electronic protected health information (ePHI), created or maintained by the CEHRT through the implementation of appropriate technical, administrative, and physical safeguards. CMS proposes that a MIPS eligible clinician must meet this objective and measure in order to earn any score within the ACI performance category. Failure to do so would result in a base score of zero under either the primary proposal or alternate proposal, as well as a performance score of zero and an ACI performance category score of zero.

According to CMS in the Electronic Health Record Incentive Program Stage 3 and Modifications to MU in 2015 Through 2017 Final Rule, audits conducted on participants in the EHR Incentive Program show that many physicians were unable to meet the requirements for MU because they were unable to appropriately conduct a security risk analysis and meet the Protect Patient Health Information objective.⁸ The ACS requests more robust guidance on what it means to conduct a security risk assessment successfully. **We also propose exclusions to allow physicians to report a null value for this measure and still meet the requirements for the category.** Finally, we reiterate our earlier statements that in order to reduce the administrative burden, it is essential that these reporting requirements be built into the functionality of all CEHRT.

⁸ Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 3 and Modifications to Meaningful Use in 2015 Through 2017; Final Rule, 80 § 62830 (2014). Print.

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Performance Score

A MIPS eligible clinician could earn additional points above the base score for performance in the objectives and measures for Patient Electronic Access, Coordination of Care through Patient Engagement, and Health Information Exchange. These measures have a focus on three objectives: patient engagement, electronic access and information exchange. CMS proposes that, for the performance score, the eight associated measures under these three objectives would each be assigned a total of 10 possible points. For each measure, a MIPS eligible clinician may earn up to 10% of their performance score based on their performance rate for the given measure.

All three objectives that make up the performance score include measures that require actions from a physician's patients. **ACS does not believe providers should be penalized on these measures because patient actions are out of the physician's control.** Although we recognize the importance of allowing patients to actively participate in their health care decision making, patient interest in engaging with the EHR is driven by issues of ease of use and functionality that are best addressed by the EHR vendors. In general, we encourage CMS to work closely with specialty societies and other stakeholders to develop meaningful measures that reflect the care they provide, including measures that reflect efforts to engage patients, even if patients ultimately fail to act.

Lastly, we believe that it is essential that these measures, all of which are documentation of use of the various aspects of a comprehensive EHR and data tracking system, be built directly into the EHR system. **We believe it is necessary that the EHR vendors monitor these reporting requirements and build the functionality to perform this reporting as an intrinsic component of the EHR itself. This functionality will increase data accuracy while decreasing data burden.**

Scoring Considerations

Section 1848 of the Act provides that in any year in which the Secretary estimates that the proportion of EPs who are meaningful EHR users is 75% or greater, the Secretary may reduce the percentage weight of the ACI performance category in the MIPS CPS, but not below 15%, and increase the weightings of the other performance categories such that the total percentage points of the increase equals the total percentage points of the reduction.

CMS proposes two different reweighting options. The first option proposed is to reweight the category if 75% of MIPS eligible clinicians earn an ACI

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performance category score of at least 75%. This would require clinicians to earn the ACI base score of 50%, and a performance score of at least 25% for an overall performance category score of 75%. Alternatively, CMS is proposing to reweight the category if 75% of physicians earn an ACI performance category score of 50% (which would only require the MIPS eligible clinician to earn the ACI base score).

ACS thanks CMS for providing more than one proposal for the scoring considerations of ACI. **ACS believes that until the ACI category is broadened to include the sharing of meaningful data across all platforms without being tied exclusively to an EHR, it should be weighted as low as possible. ACS supports the alternative proposal which requires 75% of physicians to earn a score of 50%.**

Advancing Care Information Performance Category Objectives and Measures Specifications

As we have stated previously, the measures in ACI category are not meaningful and/or applicable to all physicians. The ACS believes that physicians should be able to choose measures that are relevant to the care they provide. Additionally, CMS has not proposed a pathway for the inclusion of new measure which could be more meaningful and relevant, or the retirement of measures which may no longer be relevant. ACS requests more information on how CMS plans to update measures as necessary.

According to CMS in the Electronic Health Record Incentive Program Stage 3 and Modifications to MU in 2015 Through 2017 Final Rule, audits conducted on participants in the EHR Incentive Program show that many physicians were unable to meet the requirements for MU because they were unable to appropriately conduct a security risk analysis and meet the Protect Patient Health Information objective.⁹ **The ACS requests more robust guidance on what it means to conduct a security risk assessment successfully. We also propose exclusions to allow physicians to report a null value for this measure and still meet the requirements for the category.** Finally, we reiterate our earlier statements that in order to reduce the administrative burden, it is essential that these reporting requirements be built into the functionality of the EHR.

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Exclusions

CMS believes that the proposed MIPS exclusion criteria and scoring methodology together eliminate a need for the previously established EHR Incentive Program exclusions. By excluding clinicians who meet the low-volume threshold (MIPS eligible clinicians who have Medicare billing charges less than or equal to \$10,000 and provide care for 100 or fewer Part B-enrolled Medicare beneficiaries), CMS believes exclusions for most of the individual ACI measures are no longer necessary. CMS recognizes that some types of clinicians do not administer immunizations, and are therefore proposing to maintain the previously established exclusions for the Immunization Registry Reporting measure. They also propose that MIPS eligible clinicians may elect to report their yes/no statement if applicable, or report a null value (if the previously established exclusions apply) for the base score.

We reiterate that many physicians were unable to successfully participate in MU because they failed to appropriately perform the Protect Patient Health Information objective and measure. Once again, the **ACS proposes an exclusion to allow physicians to report a null value for this measure and still meet the requirements for the category.**

Additional Considerations: Support for Health Information Exchange and the Prevention of Information Blocking

CMS is proposing that MIPS eligible clinicians must attest to CMS the following:

- A. Did not knowingly and willfully take action (such as to disable functionality) to limit or restrict the compatibility or interoperability of CEHRT.
- B. Implemented technologies, standards, policies, practices, and agreements reasonably calculated to ensure, to the greatest extent practicable and permitted by law, that the CEHRT was, at all relevant times—
 - i. Connected in accordance with applicable law;
 - ii. Compliant with all standards applicable to the exchange of information, including the standards, implementation specifications, and certification criteria;
 - iii. Implemented in a manner that allowed for timely access by patients to their electronic health information; and
 - iv. Implemented in a manner that allowed for the timely, secure, and trusted bidirectional exchange of structured electronic health information with other health care providers, including

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unaffiliated providers, and with disparate CEHRT and health IT vendors.

- C. Good faith and timely responses. Responded in good faith and in a timely manner to requests to retrieve or exchange electronic health information, including from patients, health care providers, and other persons, regardless of the requestor's affiliation or health IT vendor.

ACS understands the importance of banning data blocking, and agrees it is appropriate for health systems to attest to the proposed statements. However, ACS has concerns about requiring all eligible clinicians to attest to this proposal considering the majority of EHR users are not blocking data because it adds additional reporting burden. ACS believes that CMS should consider an alternative option to directly address data blocking with those who are at fault.

APM Scoring Standard for MIPS Eligible Clinicians Participating in MIPS APMs

If CMS determines that an eligible clinician has met the appropriate Threshold Score for an Advanced APM and is therefore either a Qualified Advanced APM Participant (QP) or a Partially Qualifying APM Participant (Partial QP), then the clinician is excluded from MIPS payment adjustments. All other eligible clinicians participating in APMs are MIPS eligible clinicians and subject to MIPS requirements. **We generally support the concept of MIPS APMs and believe that there should be a pathway to help MIPS APMs participants transition to Advanced APMs** given that MIPS APMs are an important step toward Advanced APMs.

CMS also proposes performance category scoring and weights for MIPS APMs that are not part of the Shared Savings Program or Next Generation Accountable Care Organizations (ACO) model. CMS proposes that the quality performance and resource use categories be reweighted to zero. Additionally, CMS proposes that the CPIA and the ACI performance categories be reweighted to 25% and 75%, respectively. The proposal for the APM scoring standard for MIPS participants in APMs other than the Shared Savings Program and Next Generation ACO model should be modified so that the ACI performance category is not 75% of the physician's MIPS score. **We recommend that CMS weight the CPIA and ACI performance categories equally in this case (50% for CPIA and 50% for ACI).** First, we believe that eligible clinicians should have a CPS that is based on diversified measurement and not so heavily weighted toward a single category. Second, most MIPS APMs are Advanced APMs and given the potential for eligible clinicians participating in these APMs to be exempted from MIPS altogether, we believe that CMS should equalize the weights to reduce the emphasis

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placed on the ACI category, which we expect to have a very high administrative reporting burden.

With respect to CPIA, MACRA states that “participation by a MIPS eligible professional in an alternative payment model . . . with respect to a performance period shall earn such eligible professional a minimum score of one-half of the highest potential score for the performance category . . . for such performance period.”¹⁰ Therefore, the statute creates a floor for APM participation credit under CPIA and not a ceiling. It also states that participation in a certified patient-centered medical home or “comparable specialty practice” should count for the highest potential CPIA score. The proposed rule states that APM participation should count for 30 points, which is exactly half of the total, and is the minimum required by law. Especially in light of the narrow door that CMS has provided for APMs to be eligible as Advanced APMs, ACS believes that APM participation should receive a higher score than half the CPIA score. Given that we assume CMS purposefully intended to distinguish between APM participation and medical home participation, **we request that under CPIA scoring, while medical home participation will receive the highest potential CPIA score, APM participation should provide an eligible clinician with 80% of the potential CPIA score.** If CMS maintains the current CPIA scoring proposals, this will require an eligible clinician to successfully complete one high-priority CPIA. We believe that not only does the MACRA language allow for this but it will further encourage participation in APMs, a clear goal of MACRA.

The physician community has already expended an exorbitant amount of resources working to develop APMs. Particularly in the area of surgical care, a significant portion of that investment has gone toward the development of episode groupers or bundled payments. ACS was disheartened to see that the BPCI program was listed as neither a MIPS APM nor an Advanced APM. We remain concerned that the APM development work performed by the surgical community to date with MIPS and Advanced APM participation in mind could be jeopardized by the lack of a bundled payment vehicle to which those developed episode models can link.

CMS proposes the following criteria for MIPS APMs:

- (1) APM Entities participate in the APM under an agreement with CMS;
- (2) The APM Entities include one or more MIPS eligible clinicians on a Participation List;

¹⁰ Medicare Access and CHIP Reauthorization Act of 2015, 42 USC 1305, Pub. L. 114–10, 129 Stat. 87 (2015).

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- (3) The APM bases payment incentives on performance on cost/utilization and quality measures.

ACS requests that the third criterion be altered to state “and/or” so as to read “The APM bases payment incentives on performance on cost/utilization and/or quality measures.” While we encourage the development of comprehensive APMs that address both cost and quality, at least until programs like BPCI can be modified, we believe that defining a MIPS APM as one that bases payment incentives on either cost/utilization *or* quality measures is within CMS’ authority and would provide a more comprehensive approach to the incentives associated with APM participation as part of the QPP overall. We believe that by adding the “/or” would remedy part of the reason that BPCI models were not listed as MIPS APMs.

MIPS Composite Performance Score Methodology

Section 1848(q)(6)(D)(i) of the Act requires the performance threshold in year three and beyond to be equal to the mean or median of the CPS from a prior period, determined by CMS. For the initial two payment years (2019 and 2020), CMS has more discretion over the threshold. For the 2019 MIPS payment year, CMS proposes to set the performance threshold at a level where approximately half of the eligible clinicians would be below the CPS performance threshold and half would be above the performance threshold. CMS will finalize a methodology for determining the performance threshold in the final rule and intends to publish the performance threshold on the CMS website prior to the performance period.

To establish the overall performance threshold against which clinicians’ 2017 CPS will be compared for purposes of determining 2019 MIPS payment adjustment, CMS proposes to model 2014 and 2015 Part B allowed charges, PQRS data submissions, QRUR feedback data, and Medicare and Medicaid EHR Incentive Program data to inform where the performance threshold should be since it will not yet have historical MIPS data.

While we appreciate CMS’ effort to provide clinicians with an overall performance threshold prior to the start of the performance period, we caution against the use of non-MIPS data to set this threshold since many aspects of current quality mandates—including reporting requirements, measures, and eligible clinicians—are proposed to change under MIPS. **It does not seem fair to expect clinicians to perform under one set of rules and assumptions, but to hold them accountable to a performance standard that is based on another set of rules and assumptions.** ACS is extremely concerned about relying on pre-MIPS data to set the MIPS threshold and encourages CMS to work with professional societies and other stakeholders to identify alternative

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options.

Quality Measure Benchmarks

For performance assessment in each MIPS category, CMS intends to adopt baseline periods that are as close as possible in duration to the performance period. CMS proposes that the baseline period should be two years prior to the performance period for a MIPS payment year. For example, for the quality performance category, CMS proposes that for CY 2019 payment adjustments the baseline period would be calendar year 2015, which is two years prior to the proposed calendar year 2017 performance period. However, CMS proposes some exceptions to this rule. For instance, if a measure does not have baseline period information, (e.g., new measures) or if the measure specifications for the baseline period differ substantially from the performance period, then CMS would determine benchmarks based on the performance period. For resource use, CMS also proposes to set the benchmarks using performance in the performance period and not the baseline period.

In general, ACS supports providing clinicians with detailed benchmark data as early as possible prior to the start of the performance period so that they can understand exactly what goal they need to be working toward for the coming year. We oppose relying on the performance period for determining benchmarks since CMS would not be able to provide clinicians with a benchmark until *after* the performance period. We do not believe that clinicians should be held accountable for performance on a measure if CMS does not have comparable baseline data from a period prior to the performance period and cannot provide clinicians with a benchmark prior to the start of the performance period. **In this situation, CMS should give clinicians credit for reporting the measure, but not use it to calculate the performance score (i.e., assign it a null value, rather than a zero).** Adopting this approach, rather than other proposed alternatives such as lowering the weight of these types of measures, is important because it would continue to incentivize the reporting of data that can eventually serve as a baseline for future performance benchmarks.

Similar to our recommendation regarding the CPS, we also oppose CMS' use of 2015 data to set the 2017 performance category benchmarks since these newly proposed rules did not even exist at that time. CMS should not set benchmarks or hold clinicians accountable for performance until it has established an adequate foundation of MIPS data.

Assigning Achievement Points

For each set of benchmarks, CMS also proposes to calculate decile breaks based on measure performance during the performance period and assign

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points for a measure based on which benchmark decile range the MIPS eligible clinician's performance on the measure is between. **ACS believes that using percentiles or deciles or any other "Rank Based Statistics" for performance ranking that then gets translated into payment policy is inherently unstable for multiple reasons. For one, it results in no information on statistically significant differences at the ends of performance spectrum. It also shrinks every performance difference into the same indistinguishable difference (e.g., rank 23rd, rank 24th, rank 25th). As a result, it hides what real differences are, fails to drive effective quality improvement, and demoralizes participants by always penalizing a certain proportion of providers. Therefore, ACS opposes this proposal. Instead, we would support a methodology which uses some basis of statistical significance or classification based on underlying spread of the distribution.**

To ensure that CMS has robust benchmarks, CMS proposes that each benchmark must have a minimum of 20 MIPS eligible clinicians. ACS seeks clarity on the reliability and validity of a 20 patient sample. While we appreciate that CMS is aiming for a benchmark sample size that minimizes cliffs between deciles, **we do not agree with CMS' rationale for not increasing the benchmark sample size due to concerns that an increase could limit the number of measures with benchmarks.** CMS should set the benchmark at a place that produces the most reliable and accurate data. If that results in a limited number of measures with benchmarks, then that is a signal that the measure is not yet suitable for accountability and that CMS should continue to collect and track it, but not use it to penalize clinicians.

CMS also proposes that MIPS eligible clinicians who report measures with a performance rate of 0% would not be included in the benchmarks. CMS identified some measures that had a large cluster of eligible clinicians with a 0% performance rate and is concerned that this represents clinicians who are not actively engaging in that measurement activity. For example, it could be clinicians reporting the measures that are programmed into their EHR and that are submitted unintentionally, rather than measures the clinician has actively selected for quality improvement. **ACS supports not including a performance rate of 0% measures in the benchmarks since they could inappropriately skew distribution.**

Finally, CMS proposes that clinicians, regardless of whether they report as an individual or group, and regardless of specialty, that submit data using the same submission mechanism would be included in the same benchmark. ACS does not believe that CMS should combine benchmarks for individuals and groups until it has more information on group versus individual performance.

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This proposal ignores the fact that groups that elect to report as such are typically larger, more sophisticated, and have more resources than individual reporters. Specialty adjustments (similar to what CMS currently applies to the MSPB measure) might even be appropriate for select quality measures, and we ask CMS to consider evaluating the feasibility of doing this in the near future. CMS also proposes to create separate benchmarks for submission mechanisms that do not have comparable measure specifications. In general, we support efforts to ensure more equitable and accurate comparisons.

Overall, we strongly urge CMS to provide more specific information on benchmarks, cutoffs and other performance parameters in future rules so that the public has an opportunity to understand and comment on them. While CMS provides an example of how the benchmarks would be established and the deciles constructed, it does not provide specific examples of how measures proposed for inclusion in MIPS would be benchmarked according to the proposed methodology. Alternatively, we request that CMS hold a listening session to seek comment on the benchmarks it will establish for each measure.

Topped Out Measures

CMS proposes to identify “topped out” measures by using a definition similar to the Hospital Value-based Purchasing Program (HVBP): Truncated Coefficient of Variation¹³ is less than 0.10 and the 75th and 90th percentiles are within 2 standard errors; 14 or median value for a process measure that is 95% or greater (80 FR 49550). CMS would maintain most topped out measures, but proposes to limit the maximum number of points a topped out measure can achieve based on how clustered the scores are.

Using 2014 PQRS quality reported data measures, CMS modeled the proposed benchmark methodology and found that approximately half of the measures proposed under the quality performance category are topped out. As such, the ACS appreciates CMS’ decision to not remove most topped out measures at this time since removing such a large volume of measures would make it even more difficult for surgeons to identify a sufficient number of applicable measures to report. Removal of these measures also limits CMS’ ability to track performance over time and to determine if a measure is truly topped out or if only high performers are choosing to report it.

To keep things administratively simple in the initial years of MIPS, we recommend that CMS not score topped out and non-topped out measures differently since this would add another level of complexity to what is an already complex program. CMS should only consider policies for differentiating between topped out and non-topped out measures in the future,

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once it has established a reliable foundation of data under MIPS. We also encourage CMS to adopt a broader policy of maintaining measures in MIPS for a minimum number of years (e.g. at least five years) to limit scenarios where CMS does not have historical data on the same exact measure to set a benchmark or otherwise evaluate performance. **ACS supports a gradual process for identifying and phasing out topped out measures with opportunity for stakeholder engagement and the ability to replace topped out measures so that all specialties continuously have applicable and meaningful measures to report.**

Finally, ACS requests that CMS identify in proposed rulemaking measures that it considers topped out so that the public has an opportunity to provide meaningful feedback on why performance might appear that way. In the current rule, CMS does not indicate which measures on the MIPS list are topped out. However, CMS also proposes to remove some measures because they are topped out (e.g., PQRS #22: Perioperative Care: Discontinuation of Prophylactic Parenteral Antibiotics (Non-Cardiac Procedures), which seems to contradict its proposal to maintain such measures. We request that CMS explain its rationale for preserving some topped out measures while proposing to remove others.

Incentives to Report High Priority Measures

CMS proposes scoring adjustments to create incentives for clinicians to submit certain high priority measures (i.e., outcome, appropriate use, patient safety, efficiency, patient experience and care coordination measures) and to allow these measures to have more impact on the total quality performance category score. Specifically, CMS proposes to provide two bonus points for each outcome and patient experience measure and one bonus point for other high priority measures reported in addition to the one outcome/high priority measure that would already be required under the proposed quality reporting criteria. Bonus points would also be available for measures that are not scored (i.e., not included in the top six measures for the quality performance category score). However, bonus points for high priority measures would be capped at 5% of the denominator of the quality performance category score. These policies would apply to MIPS quality measures, as well as non-MIPS measures reported through QCDRs. CMS proposes to determine which measures are high priority during the QCDR measure review process.

ACS supports the concept of rewarding clinicians who select more robust measures that are more challenging to capture and result in more impactful data. However, it is difficult to comment on this proposal without knowing how CMS will classify measures submitted by QCDRs. We request that CMS provide clearer guidance on what specific criteria must be met for a measure to

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fall into each specific high priority category. **We also strongly believe that QCDRs should be allowed to determine the most appropriate classification for each of its measures, including whether a measure falls into a high priority category, subject to the QCDR measure approval process.**

Although we support the goal of moving toward more “high value” measures, we oppose CMS’ proposal to increase requirements for outcome and other high priority measures in the future. Measures that have the greatest value in driving results differ by specialty, patient, and setting. For example, process measures that are evidence-based can be integral to improving outcomes and patient safety. These measures should be preserved as an option for specialties or areas of measurement that are not yet capable of tracking outcomes. There are also many remaining methodological issues related to risk adjustment and attribution that need to be resolved before CMS should consider increasing requirements related to outcome measures. Finally, we urge CMS to use caution when requiring clinicians to report on certain types of measures since clinicians do not have influence over which measures are developed and available to meet their needs.

In the initial years of MIPS and over the longer term, we request that CMS closely track to what extent surgeons versus non-surgeons are earning points based on high priority measures to ensure all clinicians have an equal opportunity to maximize their score. If CMS identifies an imbalance, it should adopt policies to correct it.

Incentives to Use CEHRT

CMS also proposes to allow one bonus point under the quality performance category score for each reported measure up to the cap described, if a clinician meets the requirements for “end-to-end electronic reporting.” This would be accomplished when:

- The clinician uses CEHRT to record the measure’s demographic and clinical data elements in conformance to the standards relevant for the measure and submission pathway, including but not necessarily limited to the standards included in the CEHRT definition;
- The clinician exports and transmits measure data electronically to a third party using relevant standards or directly to CMS using a federally defined submission method; and
- The third party intermediary (for example, a QCDR) uses automated software to aggregate measure data, calculate measures, perform any filtering of measurement data, and submit the data electronically to CMS using a submission method.

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ACS reminds CMS that not all QCDRs have the capability to exchange data with CEHRT in a format specified by federal standards. Additionally, we do not believe the bonus points for CEHRT align with MACRA's goal of incentivizing registry reporting. **To truly increase the use of registry reporting, we believe all clinicians utilizing a QCDR should be eligible for a bonus point in the quality performance category, regardless of whether data is exchanged with CEHRT.**

Seeking Comment on Measuring Improvement

Section 1848(q)(3)(B) of the Act requires the Secretary, in establishing performance standards for measures and activities for the four MIPS performance categories, to consider historical performance standards, improvement, and the opportunity for continued improvement. Section 1848(q)(5)(D) of the Act lays out the requirements for incorporating performance improvement into the MIPS scoring methodology beginning with the second MIPS performance period, if data sufficient to measure improvement is available. Section 1848(q)(5)(D)(ii) of the Act also provides that achievement may be weighted higher than improvement. CMS seeks feedback on three specific options for measuring improvement in the future:

Option 1 – Approach similar to HVBP: CMS would assign from 1-10 points for achievement (i.e., compared to benchmark performance scores for each applicable measures) and from 1-9 points for improvement (i.e., compared to the clinician's own previous performance during a baseline period for each measure). CMS would then compare the achievement and improvement scores for each measure and only use whichever is greater, but only those clinicians with the top achievement would be able to receive the maximum number of points. If a clinician's practice was not open during the baseline period, but was open during the performance period, points would be awarded based on achievement only for that performance period.

Option 2 – Approach similar to Shared Savings Program: Clinicians would receive a certain number of bonus points for the quality performance category for improvement, although the total points received for the performance may not exceed the maximum total points for the performance category in the absence of the quality improvement points. CMS would score individual measures and determine the corresponding number of points that may be earned based on the clinician's performance. Bonus points would be awarded based on a clinician's net improvement in measures within the quality performance category, which would be calculated by determining the total number of significantly improved measures and subtracting the total number of significantly declined measures. Up to four bonus points would be awarded based on a comparison of the clinician's net improvement in performance on

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the measures to the total number of individual measures in the quality performance category. When bonus points are added to points earned for the quality measures in the quality performance category, the total points received for the quality performance category may not exceed the maximum total points for the performance category in the absence of the quality improvement points.

Option 3 – Approach similar to Medicare Advantage 5-star rating methodology: CMS would identify an overall “improvement measure score” by comparing the underlying numeric data for measures from the prior year with the data from measures for the performance period. To obtain an “improvement measure score” clinicians would need to have data for both years in at least half of the required measures for the quality performance category. The numerator for the overall “improvement measure” would be the net improvement, which is a sum of the number of significantly improved measures minus the number of significantly declined measures. The denominator is the number of measures eligible for improvement. CMS recognizes that high performing clinicians may have less room for improvement and consequently may have lower scores on the overall “improvement measure”. Therefore, similar to CMS’ 5-star rating methodology for health plans, CMS would calculate a clinician’s score with the “improvement measure” and without, and use the best score.

ACS supports the general concept of evaluating both achievement and improvement since it incentivizes advancements in quality, but also rewards those who are able to maintain high performance. For example, recognizing improvement could be important for a clinician with historically low performance or with a particularly complex patient population, but recognizing achievement is a way to incentivize historically high performers to maintain that level of performance without holding them to an endlessly high standard. **While certain aspects of each of CMS’ proposed alternatives might have merit, we generally favor Option 1, an approach that is similar to the HVBP, where CMS evaluates both achievement and improvement and recognizes whichever resulted in a higher score.** We urge CMS to continue to evaluate the feasibility of each proposed approach and factors that might impede application of each strategy, such as the dynamic nature of practices. For example, if a particular group improves one year but the payment adjustment is applied two years later, the clinicians or groups responsible for positive results may no longer be part of the group and may never see any reward for their achievements.

Targeted Review of MIPS Adjustments

CMS proposes to adopt a targeted review process under MIPS wherein a MIPS eligible clinician may request that CMS review the calculation of the MIPS

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adjustment factor and, as applicable, the calculation of the additional MIPS adjustment factor applicable to a MIPS eligible clinician for a year. With respect to the process for submitting a request for targeted review, CMS proposes the following:

- A MIPS eligible clinician electing to request a targeted review may submit their request within 60 days (or a longer period specified by CMS) after the close of the data submission period. All requests for targeted review must be submitted by July 31 after the close of the data submission period or by a later date that CMS specifies in guidance.
- CMS will provide a response with its decision on whether or not a targeted review is warranted. If a targeted review is warranted, the timeline for completing that review may be dependent on the number of reviews requested (for example, multiple reviews versus a single review by one MIPS eligible clinician) and general nature of the review.
- As this process is informal and the statute does not require a formal appeals process, CMS will not include a hearing process. The MIPS eligible clinician may submit additional information to assist in their targeted review at the time of request. If CMS or its contractors request additional information from the MIPS eligible clinician, the supporting information must be received within 10 calendar days of the request. Non-responsiveness to the request for additional information will result in the closure of that targeted review request, although another review request may be submitted if the targeted review submission deadline has not passed. Since this is an informal review process and given the limitations on review under MACRA, decisions based on the targeted review will be final, and there will be no further review or appeal.

ACS opposes the proposed deadline for submitting a request for targeted review. We do not believe that 60 days following the close of the data submission period is an adequate amount of time to allow for providers to submit a request for targeted review. Eligible clinicians and groups will be faced with the daunting task of reviewing four performance categories then determining overall performance on these categories to determine whether a targeted review is warranted—prior to MACRA, providers only needed to address data submitted on one program. We urge CMS to provide additional time, given the added complexity of the review. **Furthermore, this proposed deadline to submit a targeted review occurs close to the time providers are expected to receive their complete feedback reports, as CMS anticipates releasing feedback reports in July following the data submission deadline.** In the past, eligible clinicians have experienced delays in accessing their feedback reports because they were required to establish accounts in order to view these reports. For example, PQRS participants and their staff currently

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need an Enterprise Identity Management (EIDM) account to access feedback reports. Therefore, **ACS disagrees with the proposed approach, as eligible clinicians may not have the data necessary to determine whether a targeted review is needed until feedback reports are received, accessed, and analyzed.**

ACS also opposes the requirement that, should additional supporting documentation be needed to review the request, an eligible clinician or group would be required to receive such documentation within 10 calendar days of the request. We do not believe 10 days is enough time to gather additional evidence and respond to CMS. Depending on the complexity of the issue, the request for additional information may require collaboration with multiple stakeholders within a practice or group, between an eligible clinician and his/her vendor, etc. Therefore, CMS should provide flexibility in situations where it may not be feasible to respond within 10 days. We request that CMS provide the following caveat to this proposal: if an eligible clinician or group believes more time is needed, then the eligible clinician or group must respond to the request for supporting documentation or with a request for an extension within 10 calendar day of the request.

Third Party Data Submission

QCDR Standards

CMS proposes to maintain The Office of the National Coordinator for Health Information Technology standards and require EHR-based data submission (whether transmitted directly from the EHR or from a data intermediary) to be certified EHR technology (CEHRT) to submit quality measures, ACI, and CPIA data for MIPS. In addition, health IT vendors would be required to comply with the QRDA Implementation Guides (specified in sub-regulation guidance) if submitting data from a certified EHR technology. With respect to the proposed requirement to comply with QRDA Implementation Guides, health IT vendors, such as QCDRs, have historically experienced issues submitting data using the uniform standards set forth in the QRDA Implementation Guide. Due to the clinical nature of many variables present in ACS registries, the data are not easily mapped to EHR variables in all institutions. **We request that CMS provide greater flexibility in the submission standards set forth for health IT vendors, particularly in the first year of implementation of the MIPS, including the ability to submit data via QCDR XML.**

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Proposed QCDR Requirements for Data Submission

CMS proposes to require QCDRs submitting MIPS quality measures that are risk-adjusted (and have the risk-adjusted variables and methodology listed in the measure specifications) to submit the risk-adjusted measure results to CMS when submitting the data for these measures.

QCDR Risk Adjustment Requirements

ACS supports the requirement to have QCDRs submit risk-adjusted measure results. ACS applauds CMS for the requirement that QCDRs submit risk-adjusted measure results, and that the risk adjustment methodology and risk variables are included in the measure specifications. These requirements are also critical for purposes of transparency. Without appropriate risk adjustment, surgeons are at a risk of misclassification. As an example, ACS ran a comparison of the Surgeon Specific Registry (SSR) 2015 raw data vs 2015 risk adjusted data for the surgical site infection (SSI) measure in the PQRS General Surgery Measures Group. The results of our analysis indicate that 50% of the poor performers were misclassified when risk adjustment is not applied.

However, we request that the data submission deadline be extended from March 31st following the performance year to April 31st. There are several reasons why this extension is critical for QCDR participation:

1. ACS registries that would be used as QCDRs generally have a lock date of 90 days past the date of surgery. This means that following the procedure, cases are open for 90 days to allow data collectors ample time to track surgical outcomes; data cannot be submitted until after the 90 days following surgery. Without a one-month extension, data cannot be submitted for October, November, and December. Additionally, due to seasonal variation of surgery, we have seen that there is an increase in surgeries during November and December because patients want to schedule their surgeries before January, when they would have to meet their full insurance deductible. Therefore, if CMS chooses to shorten the performance period for CY 2017 (based on our request earlier in the letter), then the months of October, November, and December will be critical for the attainment of sufficient sample size for the MIPS performance period. Without the inclusion of these months, many measures may have an insufficient case volume.
2. Following the 90-day lock date, additional time is needed for data analysis and risk adjustment. Analysis of risk adjusted measures is complex and requires more time to prepare for submission compared to

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measures which are not risk adjusted. For example, a case on December 31, 2017 case will not lock until April 1, 2018. Given the time needed for analytics, we would not be able to submit 2017 QCDR data through December until April 31, 2018.

For these reasons, we request that CMS extend the QCDR data submission deadline to April 31st, for risk adjusted measures. Additionally, QCDR should not be required to submit raw data, unadjusted data. Raw data should only be available for audit purposes to prevent the possibility of misclassification of care.

QCDR Feedback Reports

CMS proposes to require QCDRs to provide timely feedback, at least six times a year, on all of the MIPS performance categories that the QCDR will report to CMS. **ACS does not support this proposal, and encourages CMS to continue to require four feedback reports because the additional two feedback reports will not add any additional meaning for surgeons tracking their performance.** To start, surgeons will likely have very small sample sizes per report if produced every two months, deeming the reports unreliable. Additionally, due to the time needed to risk-adjust measures, it may not be feasible to provide data on risk-adjusted measures at least six times a year. If CMS chooses to require six feedback reports at year, they should not require that the results be risk-adjusted for all reports.

CMS proposes that QCDRs be required to agree that data inaccuracies including (but not limited to) TIN/NPI mismatches, formatting issues, calculation errors, data audit discrepancies affecting in excess of 3% of the total number of MIPS eligible clinicians submitted by the QCDR may result in notations on our qualified QCDR posting of low data quality and would place the QCDR on probation (if they decide to self-nominate for the next program year).

QCDR Error Rate

ACS opposes the 3% error rate proposed by CMS. QCDRs should not be fully responsible for data quality discrepancies, as the data is coming directly from physicians, the EHR, or clinical abstractors for the QCDR that are hired by physicians or hospitals. The QCDR itself should not be punished for data entered by individual program participants, as this would unnecessarily punish all participants in the program instead of just those that submitted incorrect data. Instead, we encourage CMS to require that QCDRS already have in place protocols for addressing inaccuracies. For example, ACS NSQIP currently

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requires participating institutions to have less than a 5% disagreement rate at the time of audit. If there is a disagreement rate higher than 5%, the individual participating hospital, the NSQIP data abstractors, and program management personnel at the site are removed from being included in NSQIP reports, required to go through retraining, and required to pass another audit before being allowed full participation into the program again.

Self-Nomination

ACS opposes the dates proposed by CMS for QCDR self-nomination. CMS proposes a self-nomination period from November 15, 2016 until January 15, 2017. At self-nomination, QCDRs would be required to provide descriptions and narrative specifications for each measure activity or objective for which it will submit to CMS by no later than January 15 of the applicable performance period for which the QCDR wishes to submit quality measures or other performance category (CPIA and advancing care information) data. For future years of the program, starting with the 2018 performance period, CMS proposes to establish the self-nomination period from September 1 of the prior year until November 1 of the prior year.

This proposal will be nearly impossible for QCDRs to meet given the timing of finalized regulations. Particularly during the start of the MIPS, we believe it is important to provide QCDRs with ample time to make adjustments before submitting information for self-nomination—if regulations are finalized in November, it is infeasible for QCDRs to submit for the following performance period. Even more, it is critical that QCDRs have the opportunity to learn from the previous performance period and make necessary updates to measures, etc., which would only give QCDRs 15 days to identify issues, resolve them, then submit to CMS all while preparing the data submission from the previous performance year. **We request that CMS extend the deadline for self-nomination to 3 months following the start of the performance period for the 2019 MIPS payment adjustment.**

Physician Compare

MACRA facilitates the continuation of the phased approach to public reporting by requiring the Secretary to make available on the Physician Compare website, in an easily understandable format, individual MIPS eligible clinician and groups performance information. CMS proposes that the following information be included on Physician Compare for each MIPS eligible clinician or group, either on the profile pages or in the downloadable database, depending on what is technically feasible for CMS:

- composite score for each MIPS eligible clinician,

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- performance of each MIPS eligible clinician for each performance category (CPIA, quality, ACI and resource use), and
- a periodic posting of aggregated information on MIPS, including the range of composite scores for all MIPS eligible clinician's and the range of the performance of all MIPS eligible clinician's with respect to each performance category.

CMS also proposes that all measures in the quality performance category that meet the public reporting standards would be included in the downloadable database, and that a subset of these measures would be publicly reported on the website's profile pages. In addition, CMS proposes to include a sub-set of resource use measures that meet the public reporting standards. **ACS believes that until eligible clinicians and groups have had ample experience with the MIPS, and until the measures have been appropriately risk adjusted and tested on consumers, CMS should delay posting this information.** In addition, for the same concerns we expressed above regarding the reliability of the measures proposed under the resource use performance category, we oppose CMS' proposal to display information on all resource use measures on Physician Compare. **We also believe eligible clinicians and groups should be given a grace period of at least two years until we understand the scoring of the MIPS program to ensure that the information posted does not result in the misclassification of care.**

With respect to non-MIPS QCDR measures in the quality performance category, ACS requests clarification as to how these measures would be publicly displayed, if at all? For example, would CMS provide QCDRs the option of posting measures information on its website? Or, would CMS post all measures information, including measures information on non-MIPS QCDR measures, on the Physician Compare website?

CMS proposes to make all activities under the MIPS CPIA performance category available for public reporting on Physician Compare. CPIAs that have been in use for less than one year would be excluded from public reporting. ACS seeks clarity on how CMS proposes to post CPIA information in a way that will be helpful and understandable to patients and caregivers.

CMS proposes to include information on eligible clinician's performance on the objectives and measures under the ACI performance category on Physician Compare. Specifically, CMS proposes to include an indicator for any eligible clinician or group for successful participation in the ACI performance category. CMS also proposes to include additional indicators, including but not limited to, identifying if the eligible clinician or group scores high performance

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in patient access, care coordination and patient engagement, or health information exchange.

Similar to our concerns for all MIPS components, ACS urges CMS to delay the display of MIPS information on Physician Compare. In addition, for the same concerns we expressed above regarding the proposed requirements for the ACI performance category, which remain largely similar to the requirements under the EHR Incentive Program, we oppose CMS' proposal to display information on performance in the ACI performance category.

OVERVIEW OF INCENTIVES FOR PARTICIPATION IN ADVANCED ALTERNATIVE PAYMENT MODELS

Overarching comments on Alternative Payment Models

MACRA includes many specific provisions about APMs for CMS to translate into policy and regulation. We appreciate areas in which CMS has been reasonable and flexible in using its discretion to interpret the law such as the Advanced APM quality measures criteria and the QP Threshold Score calculation options. Unfortunately, other CMS proposals create substantial difficulties for surgeon participation in APMs such as failing to identify any episode-based Advanced APMs or MIPS APMs for surgery. We are quite disappointed because we now anticipate that very few of our members will be able to meet the current criteria to reach Advanced APM QP status, and thereby will be excluded from receiving QP incentives, namely the 5% lump sum bonus, the higher annual update starting in 2026, and exclusion from MIPS. We therefore ask CMS to take steps promptly to expand current APM options and to create new opportunities for surgeons to participate in APMs including:

- (1) **Modify current models to meet Advanced APM requirements so surgeons can participate.** The BPCI and the CJR models should be adapted to make them both MIPS APMs and Advanced APMs.
- (2) **Create pathways for new APMs for surgeons.** In addition to expanding existing episode-based models, we request that CMS allocate substantial resources to expediently review new models as soon as the Physician-Focused Payment Model Technical Advisory Committee (PTAC) makes its recommendations. Such new models are likely to help fill the gap for specialists in the current CMS Advanced APM portfolio. We note that a new model is already under development by the ACS. This model, based upon episodes of care, is

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designed to enhance opportunities for surgeons and other specialists to participate in Advanced APMs.

We believe our requests above are in keeping with several of the core policy principles set forth by CMS as drivers of the agency's decisions about APMs, including:

- To the greatest extent possible, to continue to build a portfolio of APMs that collectively allows participation for a broad range of physicians and other practitioners.
- Maximize participation in both Advanced APMs and other APMs.
- Create policies that allow for flexibility in future innovative Advanced APMs.

Terms and Definitions

Medical Home Model

In this section of the proposed rule, CMS defines a number of APM-specific terms, including the definition of the “Medical Home Model” APM, which is an instrumental piece of MACRA, but not defined in law. CMS proposes that a Medical Home Model must, in addition to other elements, include model participants that are primary care practices or multispecialty practices that include primary care physicians and practitioners and offer primary care services. CMS further states that an APM cannot be a Medical Home Model unless it has a primary care focus, evidenced by specific design elements related to eligible clinicians practicing under the following list of Physician Specialty Codes: 01 General Practice; 08 Family Medicine; 11 Internal Medicine; 37 Pediatric Medicine; 38 Geriatric Medicine; 50 Nurse Practitioner; 89 Clinical Nurse Specialists; and 97 Physician Assistant. Although we acknowledge that CMS considers Medical Home Models to have a primary care focus, there are cases, especially in rural areas, where general surgeons also serve as primary care physicians and are the main care coordinator for their patients. As such, **we ask that CMS not limit the physicians required for a Medical Home Model to the list of Physician Specialty Codes enumerated above if the Medical Home Model meets four of the seven elements set forth in the proposed rule including “coordination of care across the medical neighborhood.”**

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Advanced APMs

An “Advanced APM” is a health care payment and/or delivery model that includes payment arrangements and other design elements as part of a particular approach to care improvement. CMS will administer an APM incentive payment based on whether an eligible clinician is a QP, which is a clinician who participates in an Advanced APM and meets the proposed Medicare revenue or patient count thresholds. CMS will calculate the lump sum incentive payment as 5% of the QP’s prior year payments for Part B covered professional services for years 2019-2024, and the QP will receive a higher update under the physician fee schedule compared to non-QPs starting in 2026.

CMS proposes that in cases where APMs offer multiple options or tracks with variations in the levels of financial risk, or multiple tracks designed for different types of organizations, the agency will assess its eligibility as an Advanced APM or MIPS APM by each such track or option within the APM independently. **We support this proposal because it will increase opportunities for APM development.** For example, if stakeholders submit a proposal for an APM model to CMS with multiple tracks, some of which meet the requirements for Advanced or MIPS APMs, while other tracks do not, it will still be of benefit to clinicians to have the option of participating in the Advanced or MIPS tracks.

Criteria

MACRA requires three criteria as necessary for an APM to be considered what CMS proposes to now call an “Advanced APM”: (1) the APM must require participants to use CEHRT; (2) the APM must provide for payment for covered professional services based on quality measures comparable to those in the quality performance category under MIPS; and (3) the APM must either require that participating APM Entities bear risk for monetary losses of more than a nominal amount under the APM or be a Medical Home Model expanded under section 1115A(c).

Use of Certified EHR Technology

CMS proposes that an Advanced APM must require at least 50% of eligible clinicians who are enrolled in Medicare to use CEHRT functions to “document and communicate clinical care with patients and other health care professionals” starting in 2017 and that the threshold would rise to 75% starting in 2018. **Overall, we support this proposal for use of CEHRT, and we appreciate CMS’ flexibility in proposing this requirement.** We are

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concerned, however, that the ramp up to 75% of eligible clinicians enrolled in Medicare to use CEHRT functions in 2018 could be too rapid. The ability of physicians to communicate clinical care with patients and other health care professionals is based on a level of interoperability that is not currently available to all clinicians using CEHRT. Clinicians may not be able to meet the 75% mark by 2018, so we urge CMS to proceed more slowly with the implementation of this requirement as the program progresses. In addition, when CMS assesses APM models for adherence to this criteria, we urge CMS to ensure that clinicians who would have had their MIPS ACI component otherwise weighted to zero be excluded from the model review. Examples of such clinicians include those who have insufficient internet connectivity.

Comparable Quality Measures

For the quality measures criterion of Advanced APMs, CMS proposes that Advanced APMs base payment on quality measures that have at least one (1) of the following types of measures:

- Any of the quality measures included on the proposed annual list of MIPS quality measures;
- Quality measures that are endorsed by a consensus-based entity;
- Quality measures developed as part of the Secretary's Quality Measure Development Plan;
- Quality measures submitted in response to the MIPS Call for Quality Measures; or
- Any other quality measures that CMS determines to have an evidence-based focus and be reliable and valid.

In addition, CMS proposes that an Advanced APM must include at least one outcome measure if an appropriate measure is available on the MIPS list of specific measures for that specific QP Performance Period. If there is no such measure at the time the APM is established, then CMS would not require that an outcome measure be included after APM implementation. **We support CMS' proposal for Advanced APM quality measures.** We are appreciative that CMS has proposed this approach that will give APMs flexibility in measuring quality. CMS has also proposed that MIPS-comparable measures may include measures that are fully developed after being tested in an APM and found reliable and valid. **We are supportive of this proposal as well because it could allow the development of model-specific and episode-specific measures that ideally would result in more meaningful measurement and data collection.**

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Financial Risk for Monetary Losses

CMS makes several proposals regarding financial risk. CMS states that the financial risk definitions set forth in the proposed rule would not impose any additional performance criteria on individual clinicians. For example, eligible clinicians themselves would not need to bear financial risk so long as the APM Entity bears that risk. **We support the proposal to require the APM Entity to bear risk** rather than the individual clinician given that understanding and assessing risk is complicated and ultimately the APM Entity as a whole should decide how much risk it is willing to take on as a body. We believe that this proposal is also important for continuing to promote APM participation in advance of having access to better attribution mechanisms. As CMS is fully aware, attribution of patients to individual clinicians is complicated and not yet fully developed. By requiring the APM entity to carry the financial risk associated with these models, CMS creates the flexibility for APM Entities to best define their risk structure while stakeholders continue to pursue more reliable and actionable attribution mechanisms when it is applied to individual clinicians. However, although we support entity-level risk, we urge CMS to provide regular and timely feedback to clinicians. Feedback to groups should also include sufficient data at the individual clinician level to be actionable.

CMS also states that financial risk for monetary losses under an APM must be tied to performance under the model as opposed to indirect losses related to financial investments APM Entities might make. **We urge CMS to allow certain aspects of business risk to count toward financial risk and not just limit risk to performance.** This is important because the costs of starting and running an APM will be significant and could be a hurdle to clinicians moving toward these models. For example, an American Hospital Association (AHA) analysis estimated start-up costs of \$11.6 million for a small ACO and \$26.1 million for a medium ACO.¹¹ A substantial upfront investment combined with the requirement to assume significant downside risk will be prohibitive given that the choice to invest in the infrastructure to support an APM will be a gamble for many potential APM Entities. Excluding business risk and upfront investments in an APM will make participation in APMs especially difficult and discouraging for small practices and clinicians in rural areas.

Often when CMS implements a new program or policy there is a “ramp up” period where there are either lower or no penalties, up-side rather than two-sided risk, or lower thresholds or targets. For example, within the Medicare Shared Savings Program (MSSP), CMS established a track 1 (shared savings only) as an “on-ramp” for ACOs while they gain experience and become ready

¹¹ Statement of the American Hospital Association before the Subcommittee on Health of the Committee on Ways and Means of the U.S. House of Representatives, 114th Cong. (2016) (testimony of American Hospital Association). Print.

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to accept risk via track 2. CMS stated its belief that offering the two tracks (one-sided and two-sided risk models), but requiring a transition to Track 2 in subsequent agreement periods, would increase interest in the MSSP by providing a gentler on ramp while maintaining the flexibility for more advanced ACOs to take on greater performance-based risk in return for a greater share of savings immediately upon entering the program.¹² In other words, ACOs are allowed more time to mature and develop the necessary infrastructure to meet the program goals, but there is also a reasonable balance between permitting ACOs additional time under track 1 and maintaining a clear timeframe for when ACOs must transition to performance-based risk. **As such, we ask that CMS consider, at the very least, accounting for the start-up costs of a new APM and the operational costs in the initial years of APM implementation.**

CMS also states that the amount of financial investment made by APM Entities might vary widely and could be difficult to quantify, resulting in uncertainty regarding whether an APM Entity had exceeded the nominal amount required by statute. We do not agree that it would be too difficult to assess these costs. **CMS could ascertain certain qualified expenses such as hiring additional employees including a care coordinator, the costs for complex data analytics, IT infrastructure, financial and legal consultation, and costs of addressing contractual issues within systems.** These costs should be taken into account at least for the first two years that an APM qualifies as an Advanced APM. This would provide some latitude to APM Entities participating in Advanced APMs as the APM Entities identify and iron out the initial operational issues associated with participating in a new model. We are concerned that CMS overestimates organizations' ability to accurately project potential losses under a new model, as shown by the limited success of the ACO program, so we urge CMS to take business and start up risk into account in order to encourage clinicians to move toward APM models.¹³ In the event that CMS declines to incorporate our recommendations regarding risk, we ask that CMS implement an alternate recommendation to account for this level of financial investment: **we believe CMS should then lower the percentage thresholds associated with marginal risk and total risk, and increase the minimum loss rate to take into account the upfront costs institutions must invest to become an APM Entity.**

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¹² Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations; Final Rule, 80 § 32759 (2015). Print.

¹³ Introcaso D, Berger G. MSSP Year Two: Medicare ACOs show muted success. Health Affairs Blog. September 24, 2015. Available at: <http://healthaffairs.org/blog/2015/09/24/mssp-year-two-medicare-acos-show-muted-success/>.



Nominal Amount of Financial Risk

MACRA also requires that Advanced APM Entities bear risk for monetary losses in excess of a nominal amount, which CMS calls the Nominal Risk Standard. CMS proposes to measure three dimensions of risk to determine whether an APM meets the Nominal Risk Standard:

- (1) **Minimum loss rate (MLR)** of no greater than 4% of expected expenditures. MLR is the percentage by which actual expenditures may exceed expected expenditures without triggering financial risk.
- (2) **Marginal risk** of at least 30%. Marginal risk is the percentage of the amount by which actual expenditures exceed expected expenditures for which an APM Entity would be liable under the APM.
- (3) **Total Potential risk** of at least 4% of expected expenditures. Total Potential Risk is the maximum potential payment for which an APM Entity could be liable under an APM.

ACS generally appreciates CMS' proposal to define Nominal Risk via these three dimensions of risk and we also believe the percentages associated with each of the three dimensions of risk will be reasonable for most APMs. In particular, we appreciate that CMS included a 4% MLR, which will allow for a margin of error in the risk adjustment and for unanticipated variation in expected expenditures. With respect to total risk, however, **we urge CMS to start with a lower requirement and increase the total risk requirement to the full 4% over the course of multiple years.** For example, the first year of participation could require a 2% total risk, and then the full 4% of total risk could be required in the second year of participation. In addition, as described above, if CMS is unable to incorporate start up risk in its calculation of risk, we ask that CMS lower the percentage thresholds associated with marginal risk, total risk, and the minimum loss rate to take into account the upfront costs institutions must invest to become an APM Entity. Also, while the concept of a minimum trigger, a cap, and the amount of risk in between that must be shared is on its face is relatively straightforward, this standard is challenging to explain. **We urge that CMS provide in depth education**, with examples of how to calculate risk with the three dimensions, including dollar amounts, to make this policy more clear.

With respect to the services/payments included in the risk calculation, **we believe that the assessment regarding risk to qualify as an Advanced APM should capture all payments for services being addressed as part of the model.** In essence, we appreciate that CMS is conducting its risk assessment based on the expenditures that are targeted by the model itself. Which services or spending this exactly entails will vary by the APM under assessment. The

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services could include a combination of Part A and Part B services, if both are included in the APM, or even Part D drugs when appropriate episode grouper model databases become available. While we believe the current CMS proposal would consider those costs, we request that CMS be explicit that it is assessing risk for purposes of Advanced APM eligibility based on the risk arrangement of the APM model under consideration.

We provide more detailed information on the scope of services and providers that we consider to be appropriately included in the risk requirements using the example of the ACS APM project. The ACS is developing an APM model using a CMS episode grouper. The model is currently being vetted with a number of surgical specialty societies and includes over 50 procedural episodes, approximately 50 condition episodes, and several supporting episodes for a total of 200 episodes. This model would welcome all physician specialties. The major areas where we have identified variation in this model include overuse of diagnostics, overuse of consultants, and overuse of post-acute care services, in addition to preventable complications. As such, we are planning to include these services in the model and we believe they should be allowed to be included in the risk requirements for Advanced APMs as well. If risk is defined too narrowly there will be little scope to improve value. The APM model we will propose plans to attribute risk to providers based on five Patient Relationship Categories: Primary Provider, Principle Provider, Episodic Provider, Supporting Provider, and Ancillary Provider. Each provider within each episode will have a different percentage of risk allocation, to be decided by the APM Entity. This will allow the APM Entity to allocate the risk appropriately thereby avoiding any individual clinician bearing a disproportionately high percentage of the risk.

Application of Criteria to current and recently announced APMs

Using the Advanced APM criteria that CMS proposed, CMS has identified the currently existing APMs that it anticipates would be Advanced APMs starting January 1, 2017. These models include: Comprehensive ESRD Care Large Dialysis Organization Arrangement, Comprehensive Primary Care Plus, Medicare Shared Savings Program Tracks 2 and 3, the Next Generation ACO Model, and the Oncology Care Model two-sided risk arrangement. We again note that no existing CMS episode-based models such as the BPCI models and the CJR qualify as either MIPS APMs or Advanced APMs. Currently, episode-based payment is one of the most appropriate APM models in which surgeons and other procedure-performing specialists could participate. It is therefore disappointing that such participation options are not available for these specialists to participate in APMs starting in January 2017, the first APM performance period.

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We urge CMS to dedicate resources to make both MIPS and Advanced APMs available to specialists as soon as possible. One important step toward this goal is for CMS to modify currently existing APMs to expand opportunities for specialists, including both the CJR and the BPCI models. It seems within CMS’ discretion to revise the agreements between existing episode-based APM entities and for CMS to address items such as model participant definition and CEHRT usage requirements in ways that would enable the CJR to reach Advanced APM status. Consideration of whether the risk under the BPCI could be interpreted as equivalent to that of the generally applicable standard seems also within the purview of CMS. We specifically request that CMS describe in the final rule the mechanism and timeline for attempting to remedy the APM characteristics that excluded the CJR program and the BPCI from the proposed Advanced APM list. A more detailed description of the flaws prohibiting the remaining CMS APM models from reaching Advanced APM status (beyond the abbreviated information in Table 32 of the Proposed Rule) should also be provided in the final rule.

In addition, in some instances, we envision an ACO or larger-risk bearing entity compensated on a capitated basis seeking to have predictable costs but not wanting to capitalize a high-infrastructure service. We request that CMS develop a policy that allows a group of surgeons to partner with a “parent model” Advanced APM to sell the specialized surgical services to the Advanced APM (such as an ACO or a Medical Home risk-bearing entity) and be considered part of the participant list of that anchor ACO. We believe this arrangement should be allowed as long as the group of surgeons is taking on two-sided risk. This would allow our members to limit their risk to that disease process, while the ACO limits its risk for poor outcomes/operational risk for high-cost diseases. It would also continue to provide access to the MACRA incentives enacted to encourage further participation in APMs by allowing surgeons to obtain Advanced APM credit for offering this type of bundled APM to a larger risk-bearing entity.

Qualifying APM Participant (QP) and Partial QP Determination

QP Performance Period

CMS proposes that the QP Performance Period is the full calendar year that aligns with the MIPS performance period (for instance, 2017 would be the QP Performance Period for the 2019 payment year). **We agree with CMS that it is ideal to align a QP Performance Period with the MIPS performance period** to reduce operational complexity. We are concerned, however, about the commencement of the performance period. The start date for APM

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performance of January 1, 2017 is too soon, given that it is unclear when the final regulations will be published setting forth the criteria as to whether an APM qualifies as an Advanced APM. With respect to APMs, given that the identification of APM participating physicians will be based on participant lists as of December 31, 2017, there is no justification for requiring that eligible APMs be implemented and physicians be participating in them on January 1, 2017. If the rules are finalized in the fall, physicians will need to understand the criteria, learn whether an APM is determined to be an Advanced APM, and then begin participation by January 1, 2017. This timeframe is unrealistic and **CMS should change both the APM and MIPS 2017 Performance Period to July 1, 2017-December 31.**

Because of the limited 2017 participation options for surgeons, **we also request that CMS offer an additional 2019 payment year QP qualification period for models approved to be Advanced APMs during 2018.** While we understand that eligible clinicians in these 2018 Advanced APMs would likely have already reported into the MIPS system in 2017, we believe that the limited participation options available for surgeons and the clear priority that MACRA places on APM participation both emphasize a need for CMS to create this flexibility to provide the opportunity for surgeons to qualify for the Advanced APM incentive payment.

Group Determination and Lists

CMS proposes that, in most instances, QP determination would be made at the group level and that the QP determination would apply to all the individual eligible clinicians who are identified as participants of the Advanced APM Entity. In other words, if an eligible clinician group's collective Threshold Score meets the relevant QP threshold, all eligible clinicians in that group would receive the same QP determination for the relevant year. **We support this proposal to make QP determination at the group level.** We agree that this approach would promote administrative simplicity, collaboration among group members, and positive change when an entire organization commits to participating in an Advanced APM. In addition, group level QP determination will likely make it easier for clinicians to participate and easier for APMs to get up and running.

CMS proposes that the group of eligible clinicians would consist of all the eligible clinicians identified as participants in an Advanced APM Entity during the QP Performance Period on a Participation List provided to CMS. CMS proposes that the Participation List for each Advanced APM would be compiled from CMS-maintained lists that will be used to identify each eligible clinician by a unique TIN/NPI combination attached to the identifier of the

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Advanced APM entity. **We request that CMS provide more clarity as to CMS’ definition of “Participant List” and what exactly qualifies as meeting this requirement.** One suggestion would be for CMS to consider any signed legal document describing the risk that a clinician in an APM agrees to take on as sufficient to show that the clinician is a participant. We also ask that CMS create a new term, other than “Participant List” for the group of eligible clinicians identified as participants in an Advanced APM Entity because “Participant List” is the term that defines participants under the Medicare Shared Savings Program.

CMS also proposes that in the case where an eligible clinician participates in multiple Advanced APM Entities, if one or more of the Advanced APM Entities meets the QP threshold, then the eligible clinician becomes a QP. If none of the Advanced APM Entities meet the QP threshold, then CMS proposes to assess the clinician individually. **We support this policy as it allows for the most opportunity for eligible clinicians to meet the QP threshold.** We appreciate that CMS is taking this flexible approach with clinicians who are participants in multiple Advanced APM Entities. Although we are concerned that at this time there are extremely limited options for surgeons to participate in APMs, in the future we hope that specialists will have the choice of participating in multiple APMs.

Qualifying APM Participant Determination: Medicare Option

Under the Medicare Option, CMS will determine an eligible clinician’s QP status for a payment year by calculating the Threshold Score and comparing it (either based on payment amounts or patient counts) to the relevant QP Threshold or Partial QP Threshold. The Threshold Score is expressed in terms of the percentage of the number of attributed beneficiaries (attributed to the APM) divided by the number of attribution-eligible beneficiaries (beneficiaries that could have been attributed to the APM). For example, for 2019-2021 the payment amount threshold that an eligible clinician must meet to be a QP is at least 25%. Also, as discussed above, CMS proposes that QP determination would be made in most instances at the group level. In other words, if an eligible clinician group’s collective Threshold Score meets the relevant QP threshold for that year, all eligible clinicians in that group would receive the same QP determination for the relevant year.

CMS proposes that it would calculate Threshold Scores of eligible clinicians in an Advanced APM Entity under both the *payment amount* and *patient count* methods for each QP Performance Period. CMS proposes that it would assign QP status using the more advantageous of the Advanced APM Entity’s two

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scores. **We support this proposal, and we appreciate that CMS is taking both payments and patients into consideration.**

Generally speaking for both the payment amount and the patient count methods, CMS uses these definitions for the numerator and the denominator:

- Numerator or “attributed beneficiary”: the beneficiary attributed to the Advanced APM Entity on the latest available list of attributed beneficiaries during the QP Performance Period based on each APM’s respective attribution rules. CMS proposes to use the attributed beneficiaries on Advanced APM attribution lists generated by each Advanced APM in making QP determination.
- Denominator or “attribution-eligible beneficiary”: a beneficiary who:
 - Is not enrolled in Medicare Advantage or a Medicare cost plan;
 - Does not have Medicare as a secondary payer;
 - Is enrolled in both Medicare Parts A and B;
 - Is at least 18 years of age;
 - Is a United States resident; and
 - Has a minimum of one claim for evaluation and management services by an eligible clinician or group of eligible clinicians within an APM Entity for any period during the QP Performance Period.

CMS also highlighted that specialty-focused or disease-specific APMs may have attribution methodologies that are not based on E/M services and could require targeted exceptions in these cases for such APMs so that the attributed beneficiary population is truly a subset of the attribution-eligible population.

We agree that it is necessary for CMS to consider exceptions/adjustments as needed to support disease and specialty focused models.

CMS also proposes that if the same Advanced APM Entity participates in multiple Advanced APMs and if at least one of those Advanced APMs is an episode payment model, that CMS would add the number of unique beneficiaries in the numerator of the episode payment model Advanced APM Entity to the numerators for non-episode payment models in which the Advanced APM Entity participates. CMS proposes that Advanced APM Entities would be considered the same if CMS determines that the eligible clinician participant lists are the same or substantially similar, or if the Advanced APM Entity participating in one Advanced APM is the same as or is a subset of the other. **We support this proposal.**

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Combination All-Payer and Medicare Payment Threshold Option

Beginning in 2021, in addition to the Medicare Option, eligible clinicians may also become QPs through the All-Payer Combination Option. This option allows eligible clinicians with lower levels of participation in Medicare Advanced APMs to become QPs through sufficient participation in Other Payer Advanced APMs with payers such as State Medicaid programs and commercial payers, including Medicare Advantage plans. CMS sets forth definitions, criteria, the Threshold Score calculation, and other details that closely mirror the Advanced APM Medicare Option proposals. CMS indicates that there is still time to refine the All-Payer Combination Option, given that this option does not start until 2021. **We support the fact that CMS has patterned this policy closely to the Advanced APM Medicare Option.** We stress that it is essential to establish consistent models, measures, and reporting mechanisms across payers as much as possible. We agree that there will be more time to further adjust the All-Payer Combination Option as we gain more experience with the Advanced APM Medicare Option, and we look forward to providing more feedback on both options in upcoming rulemaking cycles.

APM Incentive Payment

We are concerned that, as proposed, CMS is undermining one of its own stated goals of maximizing participation in Advanced APMs. CMS proposes that for eligible clinicians that are QPs, CMS would make the APM Incentive Payment to the TIN that is affiliated with the Advanced APM Entity through which the eligible clinician met the threshold during the QP performance period. From an administrative standpoint, we understand that CMS needs a streamlined incentive payment distribution mechanism. We also appreciate that CMS plans to send notification to both Advanced APM Entities as well as to the individual participating QPs of their APM Incentive Payment amount as soon as CMS has calculated the amount of the APM Incentive Payment. However, whether it was during the legislative discussions surrounding the passage of MACRA or as part of CMS' direct comments in this proposed rule, the APM incentive payment has always been intended to be an incentive for eligible clinicians to move into APMs and away from fee-for-service. We are extremely concerned that if the payments do not make their way to the eligible clinicians, it will be no incentive at all and could potentially undermine the entire structure that was intended under MACRA.

We continue to believe that one of the strongest steps that CMS made in this proposed rule was to attempt to develop generalizable criteria that could be applicable to all APMs without interfering with the APM development pathways that are already in existence. While we do not wish for CMS to get

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overly involved in the individual decisions that must be made at the Advanced APM Entity level regarding distribution of revenues, we also do not wish for these proposals to undermine the express intent of MACRA. **Therefore, at the very least, ACS requests that CMS direct all Advanced APMs to issue notifications to its eligible clinician participants regarding how it intends to handle the receipt of an Advanced APM incentive payment under this program.** While we understand this does not guarantee distribution of the incentive payments to eligible clinicians, it at least provides information to surgeons about the intent of the APM Entity with which they are affiliated so that the surgeon can make an informed decision about whether to continue participation and whether there is actually an individual incentive to participate in an APM at all.

PFPM Criteria

With respect to the proposed Physician-Focused Payment Model (PFPM) criteria, CMS proposes that they be organized into three categories: payment incentives; care delivery; and information availability. We are generally comfortable with most of these policies. However, CMS' proposal to include in the first category a criterion that the PFPM must either aim to solve an issue in payment policy not addressed in the CMS APM portfolio at the time it is proposed or include in its design APM Entities who have had limited opportunities to participate in APMs should be revised. **We urge CMS to clarify that the availability of current APMs addressing a disease, condition, or episode(s) should not preclude PFPM proposals that might address the same disease, condition, or episode(s) with a different payment or delivery model.** Instead, CMS should make multiple APMs available to physicians.

After the PTAC submits comments and recommendations to CMS on PFPMs, CMS will determine whether to evaluate and test the models. CMS states that the decision to test a model recommended by the PTAC would not require a second application process to CMS. CMS does not describe a time frame, process, or method by which it will review PTAC-recommended PFPMs. We appreciate CMS' clarification that a second application would not be required for those models recommended by the PTAC to CMS. But we are concerned that there are still many unknowns as to how CMS will handle PTAC recommendations. While we understand that CMS cannot predict the volume, quantity, or appropriateness of the PFPMs that the PTAC would recommend, **we urge CMS to provide more details on how it will review the models, including the time frame and the areas of priority.** At the very least, we ask that CMS release a plan for review as soon as feasible after the PTAC has clarified its processes and timelines and once CMS has gotten a sense of the

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volume of the proposals. In any event, **we urge CMS to devote resources necessary to specifically focus on APMs for specialists** in order to create more opportunities for surgeons to utilize these models as a way to improve quality and reduce costs.

ACS APM Project

An example of a model in development that could eventually be made available to both surgeons and non-surgeons who participate in both Medicare and with third party payers is the model that ACS is currently designing. The ACS has entered into a contract with Brandeis University and the Center for Surgery and Public Health at the Brigham and Women's Hospital to develop APM options for surgeons. The goal of the project is to develop a flexible episode-based APM framework that would allow surgeons to be Advanced APM participants or receive APM credit within MIPS. The model under development uses Episode Grouper software already familiar to CMS to group services together and attribute financial risk to the participating providers involved in a patient's care. This model would incorporate dozens of individual episodes and "cluster" them so that they are incorporated into one model for a number of physician specialties. To meet the proposed Advanced APM requirement contained in the NPRM, ACS has developed a robust set of measures based on the 5 phases of surgical care, and plans to build in appropriate financial risk at the APM entity level. It is our intent to work with our project team and partners to have a proposal ready for review by the end of 2016.

In our work we have identified a number of barriers to success for surgeons with respect to participating in APMs. First, APMs built on episodes of care are new business models that offer more team-based care tied to team based payment models. But this shared risk concept is new to surgeons and will take time to explain and implement. Second, APMs that address just one procedure or condition could be too limited. Instead, APM models should consist of multiple episodes that link multiple care providers into a bundle of episodes clustering around each provider who contributes to that episode. Moving from FFS in the direction of full capitation is a complication process fraught with challenges. The pathway is to transition from FFS, to procedural episodes, to condition episodes, to stacks of episodes in a cluster, and eventually to full capitation. If part of CMS' goal is to move away from FFS and in the direction of full capitation, the concept of clusters of episodes is an important step in the process. Third, intelligent software is required to run a grouper across a claims database that provides inputs for the episodes. CMS' grouper is well-tested and built on specialty inputs. As such, ACS seeks an APM framework that

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addresses these barriers and we believe that our model is a step toward closing the gap in availability of APMs for surgeons.

We appreciate the opportunity to comment on this proposed rule. The ACS looks forward to continuing dialogue with CMS on these important issues. If you have any questions about our comments, please contact Vinita Ollapally, Regulatory Affairs Manager at vollapally@facs.org or Jill Sage, Quality Affairs Manager at jsage@facs.org, both in our Division of Advocacy and Health Policy.

Sincerely,

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