AMERICAN SOCIETY OF PLASTIC SURGEONS®
THE PLASTIC SURGERY FOUNDATION™

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

December 30, 2018

The Honorable Seema Verma,
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1693-IFC
Mail Stop C4-26-05
7500 Security Blvd,
Baltimore, MD 21244-1850

Via Electronic Submission: http://www.regulations.gov

Re: File Code-CMS-1693-IFC; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Saving Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program

Dear Administrator Verma:

The American Society of Plastic Surgeons (ASPS) appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services (CMS) Final Rule for the Physician Fee Schedule for CY 2019, published in the 42 CFR Parts 405, 410, 411, 414, 415, 425, 496, 2018 *Federal Register*.

ASPS is the largest association of plastic surgeons in the world, representing more than 7,000 members and 93 percent of all American Board of Plastic Surgery board-certified plastic surgeons in the United States. Plastic surgeons provide highly skilled surgical services that improve both the functional capacity and quality of life of patients. These services include the treatment of congenital deformities, burn injuries, traumatic injuries, hand conditions, and cancer reconstruction. ASPS promotes the highest quality patient care, professional and ethical standards, and supports education, research, and public service activities of plastic surgeons.

Outlined below are several key areas of concern in relation to this final rule.

Updates to the Quality Payment Program

ASPS appreciates the work CMS has done to address concerns previously raised about the functionality of the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models. The Agency has finalized many new policies in this rule, and we respectfully offer the following observations.

Low Volume Threshold Opt-In Policy

The ASPS appreciates concessions to small and rural practices such as the expansion of the Low-Volume Threshold (LVT) to include covered services and by offering certain low-volume providers the choice to opt-in to the program and potentially qualify for positive payment adjustments. However, ***ASPS would like to seek clarification on the 24-month eligibility period for a clinician choosing to opt-in***. If a clinician meets at least one of the criteria in the first eligibility determination period, but then falls below the threshold for all three determination categories, will they still be able to opt-in to the program? We believe physicians that may find themselves in this situation should be able to continue to participate, especially given that they likely will have spent the first three quarters of the program year dutifully reporting data only to find out they are no longer eligible with 90 days left in the program year. This seems to be directly in conflict with the goals of value-based medicine and the Agency's initiative to remove clinician reporting burden.

Quality Component of MIPS

QCDR Measure Selection

New QCDR quality measures require the establishment of benchmarks which assumes adequate physician participation to create the data range. Unfortunately, when new QCDR measures are launched, many members are not familiar or comfortable with selecting these measures, or are reluctant to use them because of the risk that they might lack a benchmark and put the clinician at a scoring disadvantage. In addition, it takes excessive time and resources to develop QCDR measures tailored for the clinical work of plastic surgeons. ***ASPS requests that CMS allow up to 24 months for new QCDR measures to be placed on provisional status to establish benchmarks before they are considered for removal from the program***.

ASPS also requests that CMS reconsider data from non-MIPS eligible clinicians in the determination of benchmarks when QCDRs can provide such data. It has become abundantly clear during the first two program years that only small, often solo, plastic surgery practices are eligible for MIPS. As CMS already has indicated its willingness to rely on historical benchmarks even despite major overhauls to measure denominators, quality actions, and the captured patient populations (original proposal for how to benchmark measure 226 in 2018), we believe a precedent may now exist for including non-MIPS eligible clinicians' data when creating benchmarks for new QCDR measures.

Case Minimum Requirements

The case minimums of 20 cases per quality measure are often difficult for many plastic surgeons in small office-based practices in which many of their cases are elective procedures without associated quality measures. While we recognize that CMS uses case minimums to ensure minimum standards of reliability, we do not believe that a clinician should be denied the opportunity to earn the maximum number of achievement points on a measure simply because they are unable to meet the case minimum.

Topped Out Measures

While the ASPS agrees with the spirit of removing measures in which performance is consistently high and in which improvements are minimal, surgeons have very few quality measures that can be attributed to their clinical work. Surgeons report that familiar PQRS/MIPS measures have allowed them to meet the six-measure minimum. Beginning with the 2019 performance period, CMS finalized the incremental removal of process measures from the program. ASPS has looked at the list of Measures Under Consideration (MUC) for the 2020 MIPS reporting year and note with frustration that only one measure applies to our specialty (MUC18-47). If more plastic surgery applicable measures are removed than are replaced, our physicians will be constrained to fewer options than other specialties for reporting measures. This directly impedes their ability to fully participate in the program. We also remind the Agency that there are data to show that when we stop measuring something, performance decreases, and suggest the Agency investigate creation of a "legacy" measure set - akin to the surgical checklist, where there could be a composite set of formerly topped out measures (e.g. VTE prophylaxis, prophylactic antibiotics-- administering and discontinuing). ASPS would like to point out that QCDRs have previously been told by CMS that any QCDR measures developed to fill the gap left by removal of a similar MIPS measure would not receive approval. We also note that MIPS measures such as QPP 21 (*Perioperative Care: Selection of Prophylactic Antibiotic - First OR Second Generation Cephalosporin*) and 23 (*Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients*), which are both stewarded by the ASPS, may have disproportionate achievement across specialties. ***ASPS requests that in future rulemaking, CMS create a procedure for stratifying performance rates by specialty and allow those that still show a large gap in care to continue reporting the measures***. ***We also request that CMS consider composites or another alternative that could involve a scoring cap that would allow for the ongoing reporting of topped out measures.*** We believe these proposals balance the goals of CMS' Meaningful Measures initiative by creating flexibility for low performers to strive for improvement, while challenging high performers to continue to demonstrate improvement in other areas.

Promoting Interoperability (PI)

ASPS appreciates the provision in the 2019 final rule to reweight this category to 0% for small and rural practices that apply for exclusion. As we have previously commented, costs associated with upgrading to the 2015 edition of CEHRT can be prohibitive for many small and solo practices, even though the administrative burdens associated with an upgrade may be lessened. During the previous reporting year, nearly all our MIPS eligible plastic surgeons were in practices of 15 or fewer clinicians, exempting them from PI reporting. We believe these providers will continue to be MIPS eligible in subsequent program years and encourage CMS to continue to reweight this category to 0% for small practices.

Scoring Methodology

We appreciate the flexibility CMS has extended to program participants by allowing different collection types to submit quality performance including electronic formats (and claims format for small practices), the ability to report 90-days of improvement activities, reweighting of the

PI category, and taking advantage of flexibility authorized under the Bipartisan Budget Act of 2018 to gradually transition to a MIPS performance threshold based on the national mean or median. However, we would argue that the performance threshold is too high for surgeons trying to avoid an ever-increasing negative payment adjustment. ***ASPS requests lowering the performance threshold to 15 points for the next year to ensure a more meaningful and positive experience for surgeons***, especially because of the uncertainty surrounding the Cost component of their scores. CMS has finalized a policy of reweighting the Cost category to 0% if there are not sufficient measures applicable to a MIPS eligible clinician (81 FR 77322 through 77325). Although CMS has finalized the policy in 2019, we implore CMS to reconsider for the 2020 program year. Given that every program year we seem to have fewer meaningful quality measures for our specialty to report, we suggest CMS reweight Cost into Improvement Activites if the Promoting Interoperability category has already been reweighted into Quality to ensure one category does not count towards the overwhelming majority of the score. We further request the Agency communicate this information in advance of submission to physicians as they do for PI exemption and hardship exemption status, so that the physician and QCDR have as accurate as possible a picture of their final score.

Bonus Point Reweighing

Due to the 45% weighting of the Quality category in 2019, the finalized change in how the small practice bonus is applied inside of the category instead of to the overall score only adds 2.7 points to the final score instead of 3 points, a 10% reduction in hardship exemption relief. This means small practices will be burdened with more time spent manually reporting Quality data than their peers, who do use electronic health systems, to make up for their inability to achieve points through PI. This undermines the Agency's good intention to promote "Patients over Paperwork." If left the same, this bonus will only continue to diminish proportional to the overall weighting of the Quality category. ***ASPS requests bonus points are added to the overall category score rather than the Quality category to reduce the risk of fluctuation for score reweighting between categories.***

PI Scoring Complexity

For our physicians that can and do report data in the PI category, we also note with frustration the increasing complexity of the scoring methodology with seemingly infinite if-then scenarios for claiming exclusions. This is particularly important given that failure to claim an exclusion for a required measure will automatically result in an overall PI category score of 0, even if all other measures have been accurately reported. ***ASPS asks the Agency to streamline scoring for this category in future program years.***

CMS Licensing Agreements and Duplicative Measures

ASPS appreciates that the requirement to mandate licensing of QCDR measures as part of the QCDR nomination process was removed this year. ***ASPS strongly opposes any future attempts at forced licensing due to the risk of intellectual property violation and its failure to recognize the magnitude of resources required from physician membership organizations to develop QCDR measures representing surgical practice***. ASPS does not see mandatory licensing as a solution to the reduction of duplicative measures. Instead, we encourage CMS to build questions into the self-nomination process around the rigor of a QCDR's measure development process and the good faith efforts made to invite stakeholder participation. We worry that mandatory measure licensing will allow stakeholders that were invited to the measure development panel, but declined, to unduly benefit at the expense of the measure steward's resources.

CMS also appears to be focused on reducing the number of measures as part of burden reduction under the Meaningful Measures Initiative. This may be helpful for primary care clinicians or even for CMS, but for specialists, reducing the number of available measures *adds* burden rather than reduces it, makes the program even less relevant than it already is, and discourages meaningful engagement. The QCDR process was developed to allow specialties to develop more meaningful measures for their members to report for accountability purposes and the Meaningful Measures Initiatives seems to undermine that effort for specialists. CMS' focus on reducing duplicative measures requires combining measures that have different patient populations and expected outcomes and that does not make sense. Recently, we were told to harmonize a new post-operative pain management measure with a post-operative multimodal pain management measure on the Measures Under Consideration (MUC) list. While we were given until the 2021 reporting year to perform this harmonization, we note that the proposed measure on the MUC list does not even come with an accompanying specification. This means we cannot check which procedures from our fully developed measure are included in this proposed measure's denominator eligible population. Further, the measurement period of interest is the peri-operative period ending at discharge from the post anesthesia care unit (PACU). Our measure looks at the time after patient discharge and aims to decrease the number of opioid pills in circulation, an entirely different period and expected outcome. The goal isn't always to have as many cases as possible within one measure. Sometimes there are very important nuances and outcomes that are important to one specialty but not to another. At the very least the Agency needs to take a hard look at how and why they are asking QCDRs to harmonize, how that might impact the participation of specific specialties, and determine transparent standard operating procedures to ensure the bar is applied fairly across all QCDRs.

Quality Reporting Deadline Changes

The QCDR nomination deadline was moved forward 60 days this year from November 1 to September 1, 2019. ASPS is aggressively creating QCDR measures specifically for plastic surgeons. This shortened development runway will result in some measures slated for completion by a November 1st application deadline being delayed until the next program year, adversely affecting our surgeons in a program year where many of their reportable measures

have been targeted for removal or fewer points. ***ASPS strongly advises that as CMS proposes future operational changes to the program which necessitate a retooling of a QCDR's resources, they delay implementation until the following program year***. We have also noticed in the Agency's response to comments received on the proposed rule that CMS intends to propose a requirement for measure testing in the 2020 rule. Again, we strongly suggest CMS heed our advice as this would constitute a significant change from the current language of "measures past the conceptual stage" during the self-nomination period and require major operational changes to a QCDR's measure development process as well as creating a significant added resource burden for measure developers.

Conclusion

ASPS appreciates the opportunity to offer these comments, and we look forward to working with CMS to ensure quality reporting that that supports the participation of plastic surgeons. Should you have any questions about our comments, please Carol Sieck, ASPS Director of Quality & Performance Measurement at csieck@plasticsurgery.org or at (847) 228-3389.

Sincerely,

Alan Matarasso, MD
President, American Society of Plastic Surgeons

cc: Greg Greco, MD – ASPS Board Vice President of Health Policy & Advocacy
Gayle Gordillo, MD – ASPS Board Vice President of Research
Steve Bonawitz, MD – Chair, ASPS Healthcare Delivery Subcommittee
Aamir Siddiqui, MD – Chair, ASPS Quality and Performance Measurement Committee
Peter Ray, MD- Vice Chair, ASPS Quality and Performance Measurement Committee
Paul Weiss, MD – Chair, ASPS Coding and Payment Policy Subcommittee
Jeffrey Kozlow, MD-Vice-Chair, ASPS Coding and Payment Policy Subcommittee
C. Bob Basu, MD- ASPS LAC Federal Chair
Greg Swank, MD- ASPS LAC Federal Vice Chair
Devinder Singh, MD- ASPS LAC Regulatory Chair