AMERICAN ACADEMY OF
OTOLARYNGOLOGY–
HEAD AND NECK SURGERY



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SUBMITTED VIA ELECTRONIC FILING

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–5517–FC
P.O. Box 8013
Baltimore, MD 21244-8016

Re: Medicare Program; CY 2018 Updates to the Quality Payment Program

Dear Administrator Verma:

On behalf of the American Academy of Otolaryngology—Head and Neck Surgery (AAO-HNS) I am pleased to submit the following comments on "Medicare Program; CY 2018 Updates to the Quality Payment Program (QPP)," published in the Federal Register on June 30, 2017.

The Academy appreciates that CMS has listened and worked to address many of the concerns raised by the Academy and other stakeholders as evidenced by the changes to the programs in this proposed rule. However, we stress the importance of the need to continue to work together to address remaining concerns with the Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) programs to allow the greatest number of Otolaryngologist – Head and Neck Surgeons to successfully participate in the programs. The following comments represent components of the MIPS and APM programs of highest priority to the AAO-HNS, our members, and the patients we serve.

We have outlined below our priority issues and then we continue with our more detailed comments on the proposed rule.

- The Academy thanks CMS for considering the impact MIPS reporting has on practices, particularly rural and small practices, and for further modifying the low-volume threshold.
- The Academy is concerned about the proposed change requiring a full calendar year of reporting rather than the "pick your pace" periods. CMS should consider requiring a 180-day reporting period for the quality performance category for CY 2018, increasing to a full year in CY 2019.
- We do not support CMS' proposed timeline for classifying measures as "topped out." CMS' three year vetting of QCDR measures could reduce the ability of subspecialties to develop and strengthen new measures.
- The Academy strongly disagrees with CMS's proposal to give full ACI credit to MIPS eligible clinicians for engaging with a specialized or clinical data registry **only** if the clinician is in "active engagement option

3: production." Many roadblocks delay reaching this stage. For example, Reg-ent registry sites have experienced lengthy delays caused by EHR vendors either due to prohibitive fees being charged; specific technology requirements, deadlines, and reluctance to change their requirements and apparent data blocking.

- Specialists, including Otolaryngologist – Head and Neck Surgeons, have historically had difficulty defining roles when developing previous quality-based pilots and programs, and the Academy believes that MACRA provides CMS with the vehicles necessary to develop APMs for specialists who would qualify for Advanced APM bonus payments. Given it may be difficult for surgical specialties to meet the APM revenue threshold, and unless it is adjusted to a lower threshold, there should be a sliding scale to get into an APM and then the threshold could be increased over time so that specialty providers may be able to participate in this program.

## I. The Merit-based Incentive Payment System (Fed. Reg. 30019)

### A. MIPS Exclusions and Virtual Groups (Fed. Reg. 30023)

#### i. MIPS Exclusions (Fed. Reg. 30023)

In comments submitted to CMS for the CY 2017 final rule, the Academy thanked CMS for developing exclusions to protect eligible clinicians (ECs), who may not meet appropriate thresholds to report under MIPS, specifically for modification of the low-volume threshold, which protected ECs and groups who may not meet appropriate thresholds to report under MIPS. The Academy cautioned CMS to consider the ramifications of a potential increase and urged CMS to maintain flexibility when calculating a low-volume threshold and determining levels based on data collected from the first few years of MIPS reporting. For CY 2018, CMS proposes further modifying the low-volume threshold in the proposed rule to state, "that increasing the low-volume threshold to exclude individual eligible clinicians or groups that have Medicare Part B allowed charges less than or equal to $90,000 or that provide care for 200 or fewer Part B-enrolled Medicare beneficiaries. The proposed increase in the low volume threshold will exclude approximately 134,000 additional clinicians from MIPS in CY 2018." **The Academy thanks CMS for considering the impact MIPS reporting has on practices, particularly rural and small practices, and for further modifying the low-volume threshold. Additionally, CMS should run and publish analyses that detail how selecting the mean versus median will affect the number of physicians who receive penalties and incentive payments as well as if choosing one over the other would disproportionately impact certain specialties, small practices, or sites of service.**

In the CY 2017 final rule, CMS developed a MIPS eligibility determination process for individual ECs and groups based on 12 months of data from two time periods in 2015 through 2017, with a 60-day claims run out. For CY 2018, CMS recommends modifying the low-volume threshold for the performance periods occurring in 2018 and future years by replacing the 60-day claims run out period with a 30-day period. CMS notes that reducing the run out period results in a one percent decrease in data completeness, and indicates that a 30-day claims run out period would still allow for timely determinations. **The Academy requests that CMS monitor the proposed change in the claims time period and report out the impact in the CY 2019 proposed rule.**

**ii.** Quality Data Submission Criteria (Fed. Reg. 30038)

In the CY 2018 proposed rule, CMS outlines the criteria for quality data submission. If fewer than six measures apply to the individual MIPS eligible clinician or group, then the individual MIPS eligible clinician or group would be required to report on each measure that is applicable. CMS has defined ''applicable'' to mean measures relevant to a particular MIPS eligible clinician's services or care rendered. CMS notes that the agency will only make determinations as to whether a sufficient number of measures are applicable for claims based and registry submission mechanisms and that CMS will not make this determination for EHR and QCDR submission mechanisms. **The Academy thanks CMS for excluding eligible clinicians unable to report 6 performance measures via a QCDR from the measures applicability determination process.**

**1. Virtual Group Criteria**

In the CY 2018 proposed rule, CMS outlines the criteria for virtual group participation. CMS defines a virtual group as a combination of two or more TINs composed of an individual EC or a group with 10 or fewer ECs under the TIN that elects to form a virtual group with at least one other such solo practitioner or group for a performance period for a year. CMS states the importance for virtual groups to have the flexibility to determine their own size and does not place a limit on virtual group size. Additionally, CMS does not place any restrictions on specialty designations for virtual groups.

CMS proposes a December 1 election deadline for individual ECs and groups wishing to form a virtual group. Additionally, CMS proposes a two-stage election process where individual ECs and groups can receive eligibility determinations before forming a virtual group and executing a formal written agreement. **The Academy appreciates CMS not limiting the size or specialty designation for virtual groups and setting a firm election deadline and process for virtual groups. However, as stated in our comments in the CY 2017 rule, we reiterate the December 1, 2017 deadline does not provide sufficient time for virtual group formation. If CMS cannot provide ECs and groups sufficient time to make the necessary decisions before forming a virtual group, CMS should consider delaying virtual group implementation for an additional year until sufficient guidance and time is afforded to practices, allowing them to make informed decisions for virtual group participation.**

Virtual groups will execute a formal written agreement as part of the virtual group election process. CMS indicates they will create a model written agreement for individual ECs and groups to use as a template. After forming a virtual group, CMS proposes to assign a virtual group ID, rather than create a new TIN for the virtual group entity. The Academy thanks CMS for providing model written agreements and not forcing virtual groups to form new TINs, which would add to the administrative burden for entities electing to become virtual groups. However, the Academy cautions CMS to consider the burden of such agreements and the use of a virtual group ID. CMS continues to add administrative complexity to the claims process through layered IDs and modifiers. CMS should strive to simplify the reporting process for ECs and groups rather than increase the administrative burden.

In the CY 2018 proposed rule, CMS proposes applying the same CY 2017 MIPS group reporting requirements to virtual group reporting, including the assessment and scoring across all performance categories, for virtual groups of 15 or under. **The Academy appreciates CMS aligning virtual group reporting and applying consistency across all reporting options and methods. However, when doing so, CMS needs to sufficiently address risk adjustment mechanisms for virtual groups and develop methodologies to**

**account for the unique nature of virtual groups. Appropriate risk adjustment is critical for virtual groups because of the heterogeneous make-up of these groups (e.g., geographic and specialty diversity).**

#### iii. Small Practice Provisions (Fed. Reg. 30019)

In CY 2018, CMS proposes introducing several provisions to specifically help small practices reduce the administrative burden of reporting under MIPS. CMS defines a small practice as an entity with 15 or fewer clinicians. Rather than requiring small practices to attest to the size of their group, CMS proposes to make these determinations using claims data based on a 12-month assessment period. **The Academy thanks CMS for utilizing claims data rather than adding the administrative burden of forcing small practices to attest to the size of their group.**

Additionally, as previously mentioned, CMS proposes increasing the low-volume threshold, which will exempt a larger number of small practices from MIPS reporting. For small practices, CMS plans to continue assigning 3 points for measures that do not meet the data completeness criteria (requiring that at least 50 percent of possible data are submitted), rather than reducing the measure to 1 point, as proposed for larger practices. CMS also proposes to add a small practice bonus of five points to the final score for ECs who participate in MIPS for the 2018 performance period. **The Academy thanks CMS for considering the burden of reporting placed on smaller practices and providing additional relief and bonus points for practices making good faith efforts to report under MIPS. The Academy also encourages CMS to continue to provide this relief to small practices beyond CY 2018, especially as the performance threshold for MIPS reporting will likely increase in future reporting years.**

### B. MIPS Performance Period (Fed. Reg. 30034)

#### i. MIPS Performance Period (Fed. Reg. 30034)

For CY 2018 and future years, CMS proposes increasing the performance periods of the quality and cost categories from the "pick your pace" reporting options to a full calendar year (January 1 through December 31). We appreciate that CMS does provide additional policies in the CY 2018 proposed rule to reduce the administrative burden on small and rural practices reporting under MIPS through the increased low-volume threshold, small practice and Health Professional Shortage Areas HPSA provisions, and proposed 15-point performance threshold. **However, the Academy is concerned that practices that chose to report under the "test" performance category will face sticker shock in reporting for a full year. Instead, CMS should consider requiring a 180-day reporting period for the quality performance category for CY 2018, increasing to a full year in CY 2019.** This gradual transition will allow practices to report a sufficient amount of data without being burdened by a steep increase in reporting requirements and allow for more time to alleviate some of the technical challenges in the change in reporting.

#### ii. Reporting Mechanisms (Fed. Reg. 30034)

For CY 2018 forward, CMS proposes to allow individual ECs and groups to submit data on measures and activities via multiple data submission mechanisms for a single performance category (specifically, the quality, improvement activities, and ACI performance categories). **The Academy thanks CMS for reversing the finalized 2017 policy and allowing multiple data submission mechanisms for each performance category.**

**This change will provide additional reporting flexibility for ECs and groups and increase the number of measures available for reporting.**

### iii. MIPS Composite Score Methodology (Fed. Reg. 30095)

CMS does not propose substantial changes to the calculation of an EC's or group's MIPS composite score. The Academy continues to believe that the overall scoring methodology for the MIPS program should be simplified. If physicians do not comprehend the scoring, they are likely to view the program as unfair and may be subject to financial penalties solely due to confusion rather than their actual performance. While we understand part of this complexity is due to statutory language and the requirement for a composite score, we believe that CMS can make some changes to improve the proposed scoring structure. The Academy supports CMS' proposal to adopt a new scoring option for the quality and cost performance categories that allows facility-based MIPS eligible clinicians to be scored based on their facility's performance.

### iv. Quality Measures Benchmarks (Fed. Reg. 30100)

In the CY 2018 proposed rule, CMS proposes to maintain the policy to assign 3 points to measures that are submitted but do not have a benchmark or do not meet the case minimum, which does not apply to the CMS Web Interface measures and administrative claims based measures. The Academy appreciates CMS' continued efforts to provide stability from CY 2017 to CY 2018 MIPS reporting by not altering the number of points for measures submitted without a benchmark or do not meet the case minimum.

In the proposed rule, CMS states "performance period benchmarks are created in the same manner as historical benchmarks using decile categories based on a percentile distribution and that each benchmark must have a minimum of 20 individual clinicians or groups who reported on the measure meeting the data completeness requirement and case minimum case size criteria and performance greater than zero**."** In previous comments, the Academy voiced concerns over CMS excluding measures with a zero-performance score from measure benchmarks. **While we understand CMS' apprehension about skewing the distribution with potentially inaccurate scores, we believe it would be feasible to isolate the inverse measures and potentially invert the scores to allow for their inclusion in benchmarking. Inverse measures have value, particularly in our specialty. Accordingly, the Academy again requests CMS' continued evaluation of the impact of inverse measure zero-performance scores, which should be considered an indication of high quality practice, on benchmarking through the inaugural years of MIPS.**

### v. Performance Threshold (Fed. Reg. 30147)

For the CY 2018 performance period, CMS proposes increasing the performance threshold to 15 points from 3 points. CMS proposes keeping the additional performance threshold for exceptional performers at 70 points for CY 2018. CMS states the 15-point performance threshold represents an increase from the 2017 level while maintaining flexibility for ECs and groups to meet the performance threshold in a number of ways. **The Academy appreciates CMS maintaining flexibility and limiting the increase in the performance threshold for the second year of MIPS reporting by setting the performance threshold at 15 points. This level will allow a large number of ECs and groups to successfully report under MIPS while allowing them to prepare for increases in reporting requirements in future years.**

## C. Quality Performance Category (Fed. Reg. 30036)

### i. Quality Data Submission Criteria (Fed. Reg. 30038)

In the CY 2018 proposed rule, CMS does not alter the reporting criteria for the quality performance category. ECs and groups will report on the same number of measures as required in CY 2017. **The Academy thanks CMS for providing ECs with clearly defined reporting targets and maintaining program stability, easing the transition from reporting under legacy quality programs to MIPS.** In the CY 2017 Quality Payment Program final rule, CMS removed the requirement for measures to span across multiple domains of the National Quality Strategy (NQS). In the CY 2018 proposed rule, CMS states they do not require ECs to select measures across multiple domains, but encourages ECs to do so. **The Academy appreciates CMS continuing to provide institutional flexibility by keeping reporting criteria consistent from CY 2017 to 2018. As previously mentioned, the Academy believes program and reporting stability is essential for the new programs.**

For CY 2018, CMS proposes to keep a majority of the measures and specialty sets available for reporting. However, CMS does propose several new measures available for reporting in 2018. Specifically, CMS proposes adding *NQF #657 Otitis Media with Effusion (OME): Systemic Antimicrobials- Avoidance of Inappropriate Use* for CY 2018. Additionally, following comments submitted by the Academy, CMS proposes adding the following measures to the Otolaryngology specialty set for reporting: *NQF# 0069 Appropriate Treatment for Children with Upper Respiratory Infection (URI); NQF #0041 Preventive Care and Screening: Influenza Immunization; NQF #0043 Pneumonia Vaccination Status for Older Adults; NQF #0101 Falls: Risk Assessment; NQF #0101 Falls: Plan of Care; Quality # 265 Biopsy Follow-Up; Quality # 277 Sleep Apnea: Severity Assessment at Initial Diagnosis; Quality # 278 Sleep Apnea: Positive Airway Pressure Therapy Prescribed; Quality # 279 Sleep Apnea: Assessment of Adherence to Positive Airway Pressure Therapy; Quality # 398 Optimal Asthma Control.* **The Academy thanks CMS for considering comments submitted following the CY 2017 final rule and including these measures in the Otolaryngology specialty measure set for 2018. The inclusion of these measures is not only appropriate for Otolaryngologist – Head and Neck Surgeons, but is essential for our diverse number of subspecialties to report.** In addition to these added measures, the Academy identified other measures that should be added to the Otolaryngology specialty measure set for 2018. They are: *NQF #0097 Medication Reconciliation Post-Discharge; NQF #1799 Medication Management for People with Asthma (MMA);* and *Quality #066 Appropriate Testing for Children with Pharyngitis.* **Additionally, the Academy plans on submitting new measures currently under development with the Academy's QCDR application for CY 2018 certification.**

Under the proposed rule, CMS seeks comment on expanding the patient experience data available for the CAHPS for MIPS survey. Currently, the CAHPS for MIPS survey is available for groups to report under the MIPS. In comments previously submitted to CMS, we strongly encouraged CMS to make the CAHPS for Physician Quality Reporting System (PQRS) optional, regardless of group or practice size. As CMS has noted, requiring CAHPS for PQRS reporting creates an administrative and financial burden for practices that must select and pay for a CMS-certified survey vendor to administer the PQRS survey on their behalf. **The Academy thanks CMS for continuing to not require groups to participate in the CAHPS for MIPS survey, and we thank CMS for allowing voluntary, incentivized reporting of CAHPS for MIPS.**

In addition, as we have outlined in previous comments, we agree with the concerns of the American College of Surgeons (ACS) regarding the limitations of CAHPS to surgical care 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. The Academy believes this would be in alignment with the recommendations of both the NQF and the Measure

Applications Partnership (MAP), and that reporting S-CAHPS through surgical registries, such as the Academy's Reg-ent registry, would provide Otolaryngologists with additional reporting means.

CMS proposes to revise the data completeness criteria for the quality performance category to require that ECs and groups submitting quality measures data using the qualified clinical data registry (QCDR), qualified registry, or Electronic Health Record (EHR) submission mechanism must submit data on at least 50 percent of the individual EC's or group's patients that meet the measure's denominator criteria, regardless of payer, for MIPS payment year 2020. CMS also proposes a 60 percent data completeness threshold for MIPS payment year 2021. **The Academy is pleased that CMS will not increase data completeness threshold for 2018 and will only increase the threshold 10 percent for 2019. We believe this gradual increase will allow ECs to fully transition to the MIPS program without disadvantaging certain ECs and groups.** CMS also proposes revising the floor for data completeness criteria for practices with more than 15 ECs, lowering from 3 points to 1 point for measures that fall below the data completeness criteria. The Academy thanks CMS for continued emphasis on the burdens placed on small practices by not revising the floor for data completeness for practices with 15 or fewer ECs.

For CY 2018, CMS proposes to remove cross-cutting measures from most of the specialty sets. The Academy agrees with CMS' assessment that cross-cutting measures may or may not be relevant to their practices, contingent on the ECs or groups. In previous comments, the Academy expressed concerns on the potential burden of the cross-cutting measure requirement on qualified clinical data registries (QCDRs). More specifically, we believed that the reduced number of available cross-cutting measures was too limiting. **The Academy thanks CMS for proposing to remove cross-cutting measures from most specialty sets and encourages CMS to finalize this proposal.**

### ii. Global and Population-Based Measures (Fed. Reg. 30042)

For CY 2018, CMS does not propose any changes for the global and population-based measures. **The Academy thanks CMS for not including the Acute Conditions Composite and Chronic Conditions Composite measures for CY 2018 and providing ECs and groups with necessary reporting criteria stability.**

### iii. Topped-out Measures (Fed. Reg. 30045)

In the CY 2018 proposed rule, CMS proposes for QCDR measures, that a measure be removed after it has been identified as topped out for 3 consecutive years, but without going through the comment and rulemaking process. CMS' three year vetting of QCDR measures **could reduce the ability of subspecialties to develop and strengthen new measures.** In addition, Congress created the QCDR mechanism to fill critical gaps in the traditional quality measure sets and to ensure that clinicians have access to measures that are more meaningful and relevant to their specialty. We strongly suggest that QCDR measures that have been identified as topped out only be removed after going through the notice and comment rulemaking process. **The Academy also believes CMS should consider the breadth of applicable measures by clinician type and only remove topped-out measures in scenarios where sufficient numbers of applicable measures remain for specialist providers to successfully report. We also strongly recommend that a formal review process and timeline be created for QCDR measures identified as topped out as part of the QCDR measures approval process.**

The Academy requests increased flexibility for review of topped-out measures, a delay in the timeline for removing non-outcome and outcome measures without a benchmark, and an expansion of the non-MIPS or QCDR measures cap to 30 non-MIPS per subspecialty for all QCDRs. Given that many QCDRs represent multiple subspecialties, this will ensure that all clinicians have meaningful measures within the QCDR for reporting and quality improvement purposes.

#### iv. Topped-out Measures Special Scoring (Fed. Reg. 30105)

In CY 2018 CMS identified measures they believe should be scored with the special topped out scoring for the 2018 performance period by using a set of criteria, which are intended as a way to phase in CMS' topped-out measure policy for selected measures. CMS selected two process measures applicable to Otolaryngology Head and Neck Surgery because CMS wants to continue to encourage reporting on high priority outcome measures, and the small subset of structure measures was confined to only three specialties. **The Academy does not support special topped out measures scoring for Perioperative Care measures 21 and 23 because there are so few surgical measures available for use by Otolaryngology Head and Neck Surgeons. This particularly highlights the need for surgeons to have measures that evaluate surgical quality. It will take time to develop the full spectrum of measures, i.e. those which evaluate both the medical and surgical management of care.**

### D. QCDR Components (Fed. Reg. 30159)

For the 2019 performance period, CMS proposes a simplified process in which existing QCDRs in good standing may continue their participation in MIPS by attesting that the QCDR's approved data validation plan, cost, measures, activities, services, and performance categories offered in the previous year's performance period of MIPS have minimal or no changes and will be used for the upcoming performance period. In addition, existing QCDRs may decide to make minimal changes to their approved self-nomination application from the previous year. Minimal changes may include limited changes to their performance categories, adding or removing MIPS quality measures, and adding or updating existing services and/or cost information. Existing QCDRs in good standing may also submit for CMS review and approval, substantive changes to measure specifications for existing QCDR measures that were approved the previous year, or submit new QCDR measures for CMS review and approval without having to complete the entire self-nomination application. In past comments, the Academy expressed concerns to CMS regarding the administrate burden and complexity placed upon QCDR entities through the annual application process. **The Academy thanks CMS for understanding this burden and for proposing to develop a simplified attestation process for QCDRs in good standing. The reduced time and resources spent on the application process will allow QCDRs to invest in the creation of new measures, which will add to the current inventory of quality measures overall and lead to an enhanced MIPS program.**

Beginning in the 2020 MIPS payment year, CMS proposes allowing individual MIPS ECs and groups to submit data on measures and activities, as applicable, via multiple data submission mechanisms for a single performance category. The Academy thanks CMS for listening to concerns raised by the Academy in comments submitted for the CY 2017 final rule. By proposing to allow ECs and groups to report via multiple data submission mechanisms, CMS will offer maximum flexibility to ECs and groups, allowing them to choose measures that accurately reflect their specialty and patient population, rather than the data reporting mechanism for each performance category.

For CY 2018, CMS does not propose any changes to the process of probation and disqualification of a third-party intermediary, including QCDRs. In comments submitted for the CY 2017 final rule, the Academy cautioned CMS on placing QCDRs on probation and posting low-quality data on QCDR's qualified postings when error rates exceed 3% particularly in 2017, which is a transition year. The Academy reiterates these comments and hopes CMS will provide leniency, as necessary, to entities that have made good faith efforts to report data for the new program.

Finally, CMS does not propose any changes to the criteria to qualify as a QCDR for CY 2018 and refers readers to the CY 2017 Quality Payment Program final rule. **While the Academy is appreciative of the stability CMS affords to ECs, groups, and QCDR entities in the proposed rule, the Academy remains concerned regarding CMS' intent to expand the EHR vendors' capabilities, given the enormous investment made by specialty societies in the development of QCDRs, specifically to provide centralized locations for clinicians to report on the quality, improvement activity, and ACI performance categories, and to track their progress in these categories over the performance period. Many societies have made some of the highest expenditure of funds in their histories toward the resources required to develop QCDRs and have expended considerable effort to follow the verbal and written guidance provided by CMS to meet QCDR requirements. The Academy believes CMS' actions in this regard, i.e. opening up these capabilities to EHR vendors who, in many instances have not been forthcoming, and in some cases have been actively obstructive, in sharing provider data with QCDRs, undermines both the financial investment and intellectual property contribution that the societies have made for QCDR development**. We reiterate comments submitted last year and agree with the Physician Clinical Registry Coalition's request that CMS clarify that QCDRs involving multiple organizations must be led and controlled by clinician-led professional organizations or similar entities that are focused on quality improvement relating to types of medical procedures, conditions, or diseases.

The proposed rule does not propose any changes to the criteria required to become a QCDR. The current regulations at 42 C.F.R. § 414.1400(d) allows entities that do not meet the QCDR requirements on their own to collaborate with external organizations to qualify as a QCDR. In its comments on the proposed and final rules on the implementation of MACRA provisions related to MIPS and APMs, the Academy shared its concerns about health information technology (HIT) vendors and other commercial entities qualifying as QCDRs without participation of clinician-led professional organizations focused on quality improvement.

The Academy agrees that small specialty groups should be able to partner with outside entities to form a QCDR. However, the Academy has seen the creation of "registries" by commercial entities for their clients to receive credit for improvement activities and bonus points under ACI. These vendor-led registries do not have a primary purpose of improving quality or supporting population health management, do not have clinical expertise or in-depth understanding about quality measurement, and are created for commercial purposes. **We ask CMS to specify that QCDRs and other registries that qualify for the improvement activities and specialized and clinical data registries under ACI should be limited to those developed and led by clinician-led organizations and medical societies. Without this clarification, the Academy is concerned that the development of specialty-wide or procedure/disease-based registries will be impeded as commercial entities increasingly become involved in and control the priorities of registries.**

**i. QCDR Criteria for Data Submission (Fed. Reg. 30160)**

Beginning with the 2018 performance period and for future program years, CMS proposes that QCDR vendors may seek permission from another QCDR to use an existing measure that is owned by the other QCDR. If a QCDR would like to report on an existing QCDR measure that is owned by another QCDR, they must have permission from the QCDR that owns the measure that they can use the measure for the performance period. Permission must be granted at the time of self-nomination, so that the QCDR that is using the measure can include the proof of permission for CMS review and approval for the measure to be used in the performance period. The QCDR measure owner would still own and maintain the QCDR measure, but would allow other approved QCDRs to utilize their QCDR measure with proper notification. This proposal will help to harmonize clinically similar measures and limit the use of measures that only slightly differ from another.

**The Academy generally supports the harmonization of measures across QCDRs if appropriate copyright procedures are in place to protect intellectual property and given the significant resources that measures developers are investing in the development of evidence-based QCDR measures.** The Academy does appreciate the steps being taken thus far to protect the intellectual property rights of QCDR measure developers. However, the Academy believes further improvement could be made to record and track QCDR measures ownership rights**.** CMS should clarify what form of proof must be submitted to show permission to use another QCDR's measure. **Absent such permissions from the measure owners, CMS approval to use measures should not be granted.** In addition, to ensure the smooth sharing of non-MIPS measures, CMS needs to properly record ownership of <u>all</u> approved QCDR measures to protect the intellectual property rights of the owner of the measure. It should make the ownership information it collects generally available to QCDRs to facilitate sharing of non-MIPS measures between these entities. Overall, the licensing of measures incentivizes organizations to invest in developing new and improved measures, and it is crucial for CMS to create a process to ensure other users respect the intellectual property rights of the measure developers.

The Academy also requests that CMS further simplify the QCDR self-nomination process by increasing the length of QCDR approval to two years; the creation of two separate benchmarks for reporting QCDR measures electronically and manually; and allow QCDRs and other clinical outcomes data registries to support virtual groups in aggregating measures and activities for reporting.

Finally, we disagree with requiring QCDRs to submit provisionally-approved measures for MIPS inclusion. MIPS reporting is only one aspect of Reg-ent, and as such, we are encouraging our members to utilize the QCDR because of the full range of potential quality improvement benefits that it provides. Given all of the time and resources our members have devoted to the development of our QCDR measures, we have concerns about how our QCDR measures could be implemented by other entities, so we want assurance that our intellectual property rights in our measures are protected.

### E. Improvement Activities Performance Category (Fed. Reg. 30051)

#### i. Improvement Activities Data Submission Criteria - Submission Mechanisms (Fed. Reg. 30053)

The Academy thanks CMS for continuing to allow multiple reporting mechanisms for submitting data for improvement activities including qualified registry, EHR, QCDR, CMS Web Interface, and attestation methods. We also appreciate that, during the transition year of MIPS and future years, all individual ECs or groups must designate a "yes" response for applicable activities to their practice on the Improvement Activities Inventory. **The Academy appreciates CMS continuing to utilize attestation for improvement activities**

**in order to reduce the burden to practicing physicians especially during the initial years of the MIPS program when the learning curve is high.**

As previously mentioned, in the CY 2018 proposed rule, CMS revises the provision that ECs and groups may only use one submission mechanism per performance category to allow, for purposes of the 2020 MIPS payment year moving forward, individual ECs and groups to submit measures and activities via as many submission mechanisms as necessary to meet the requirements of the quality, improvement activities, or ACI performance categories. **The Academy thanks CMS for reversing the finalized 2017 policy and allowing multiple data submission mechanisms for each performance category. This change will provide additional reporting flexibility for ECs and groups and increase the number of measures available for reporting.**

In the CY 2018 proposed rule, CMS proposes adding new, high-weighted activities and notes that suggested additional criteria will be taken into consideration for designating high-weighted activities in future rulemaking. CMS reaffirms that high-weighting should be used for activities that directly address areas with the greatest impact on beneficiary care, safety, health, and wellbeing. In comments submitted for the CY 2017 proposed rule, the Academy requested that CMS assign high weights for registry-related improvement activities, and the Academy strongly believes that participation in a QCDR and other clinical outcome data registries encourages performance of multiple improvement activities. In addition, assigning a high weight to registry-related improvement activities will create increased participation in QCDRs, which helps achieve the basic premise of MIPS to tie physician payment to quality through the increased reporting of measures. **The Academy reiterates the request that CMS apply a high weight to registry-related improvement activities.**

### ii. Required Period of Time for Performing an Activity (Fed. Reg. 30055)

In the CY 2017 Quality Payment Program final rule, CMS specified that ECs or groups must perform improvement activities for at least 90 consecutive days during the performance period to receive credit for the improvement activities category. Additionally, if one member of a group completes an improvement activity, the entire group will receive credit for that activity, and all ECs reporting as a group will receive the same score for the improvement activities performance category if at least one clinician within the group is performing the activity for a continuous 90 days. In the 2018 proposed rule, CMS reaffirms this performance period, and plans to apply these finalized policies to virtual groups. **In comments submitted for the CY 2017 final rule, the Academy identified some activities where a 90-day timeframe is not applicable, and again requests that CMS reevaluate reporting periods for improvement activities in future rulemaking to account for improvement activities for which a 90-day continuous reporting period may not be applicable.** For example, for the activity titled "Use of a QCDR to generate regular feedback reports that summarize local practice patterns and treatment outcomes, including for vulnerable populations," would the surgeon have to access feedback reports for 90 days to count as an activity?

CMS also seeks comment on implementing a minimum threshold for groups reporting improvement activities, such as requiring 50 percent of the clinicians to complete an improvement activity in order for the entire group (TIN) to receive credit. CMS should review data submitted by clinicians from the first few years of MIPS before implementing additional reporting requirements for improvement activities. **The Academy cautions CMS in making decisions that could adversely affect clinician participation in MIPS without first reviewing requisite data.**

### iii. Special Consideration for Small, Rural, or Health Professional Shortage Areas (HPSA) Practices (Fed. Reg. 30055)

The Academy thanks CMS for not proposing to change the policies concerning regarding small, rural, or HPSA practices, and for maintaining higher weights and reducing the required number of activities required for participants in these practices to achieve full participation in the improvement activities performance category.

### iv. Improvement Activities Policies for Future Years of the MIPS Program - (a) Proposed Approach for Identifying New Subcategories and New Activities (Fed. Reg. 30056)

CMS proposes to continue to utilize previously finalized improvement activities for CY 2018, unless specifically noted in the proposed rule. The Academy thanks CMS for promoting continuity among possible improvement activities and encourages CMS to continue as many improvement activities with minimal changes as possible on an annual basis. It often takes practices substantial time and resources to implement new activities, such as making changes to practice patterns, and substantial changes to activities on an annual basis will only serve to disrupt practices.

The Academy is pleased that CMS reaffirms their support for alignment among improvement activities, quality measures, and the ACI performance categories, as well as the potential inclusion of emerging certified health IT capabilities in improvement activities in future reporting years. **The Academy supports CMS' stated focus on incentivizing the use of health IT, telehealth, and connection of patients to community-based services in the CY 2018 proposed rule**.

Finally, in the CY 2018 proposed rule, CMS proposes to formalize an Annual Call for Activities process for adding possible new activities to the Improvement Activities Inventory. The Academy agrees with CMS' position that this will allow EC organizations and other stakeholders to take part in the identification and submission of improvement activities for consideration. **We thank CMS for providing this opportunity for collaboration, including determining criteria for stakeholders to identify activities, and finalizing an Annual Call for Activities timeline.**

## F. Advancing Care Information (ACI) Performance Category (Fed. Reg. 30057)

In the CY 2017 final rule, CMS noted plans to adopt more stringent measures of Meaningful Use and additional benchmarks, including using the benchmarks as a baseline or threshold for future reporting. In comments submitted to CMS for the CY 2017 proposed rule, the Academy stated our support for increased flexibility and EHR adoption to allow for increased participation in MIPS, but was concerned with CMS' intent to adopt unknown more stringent measures of Meaningful Use and benchmarks in the future. The Academy requested further clarification from CMS to share, as soon as possible, which stringent measures of Meaningful Use they may consider, along with timely notification of how the benchmarks will be developed and put into place. In response to concerns raised by the Academy and other stakeholders, in the CY 2018 proposed rule, CMS provides ECs and groups with advanced notice and flexible processes that will help ECs and their support staff to better prepare for adherence to category requirements and lead to increased successful participation and reporting. **The Academy thanks CMS for taking the Academy's and other stakeholder's concerns into consideration when developing policies for CY 2018 and beyond.**

### i. Scoring Considerations (Fed. Reg. 30058)

In the CY 2018 proposed rule, CMS does not propose any changes to the base score methodology as established in the CY 2017 Quality Payment Program final rule. CMS reaffirms the policy that ECs must report a numerator of at least one for the numerator/denominator measures, or a "yes" response for the yes/no measure, in order to earn the 50 percentage points in the base score. In addition, if the base score requirements are not met, an EC will receive a score of zero for the ACI performance category. **The Academy thanks CMS for retaining scoring considerations from 2017 for the ACI performance category. Further, the Academy encourages CMS to continue to implement policies that promote stability in the program through the first few years of reporting. This will allow all ECs and groups to gain familiarity with reporting requirements.**

### ii. Performance Period Definition for ACI Performance Category (Fed. Reg. 30063)

CMS proposes maintain the minimum of 90 consecutive days of data for CY 2018 and CY 2019. This proposal runs parallel to the proposed increased reporting periods for the quality and cost performance categories. **The Academy applauds CMS for recognizing each performance category is unique and should be treated as such. CMS should continue to implement policies that promote stability in the program through the first few years of reporting by keeping reporting requirements and periods relatively stable. This will allow all ECs and groups to gain familiarity with reporting requirements, increasing buy-in and reporting for future years.**

### iii. ACI Performance Category Data Submission and Collection (Fed. Reg. 30063)

In comments submitted for the CY 2017 final rule, the Academy thanked CMS for the flexibility to utilize 2014 or 2015 Edition Certified Electronic Health Record Technology (CEHRT). This flexibility helps ECs as they transition to MIPS. The Academy also believes utilization of both technology editions are a step towards gradually addressing interoperability concerns. For CY 2018, CMS proposes that ECs may use EHR technology certified to either the 2014 or 2015 Edition certification criteria, or a combination of the two, for the CY 2018 performance period. CMS also proposes to encourage new participants to adopt certified health IT and to incentivize participants to upgrade their technology to 2015 Edition products by offering a bonus of 10 percentage points under the ACI performance category for ECs who report the Advancing Care Information Objectives and Measures for the performance period in CY 2018 using only 2015 Edition CEHRT. **The Academy praises CMS for understanding the effort and cost required for practices to transition to 2015 Edition CEHRT and allowing the flexibility in reporting under MIPS for CY 2018. We believe the utilization of both technology editions are a step towards gradually addressing interoperability concerns. The Academy also thanks CMS for providing incentives through bonus points for the ACI category for using 2015 Edition CEHRT. Finally, we encourage CMS to leverage their relationships with health IT vendors and work to achieve both operational and technical interoperability through every available mechanism.**

### iv. Objectives and Measures Specification (Fed. Reg. 30066)

#### 1. Coordination of Care Through Patient Engagement (Fed. Reg. 30068)

Under the Coordination of Care Through Patient Engagement Objective, CMS proposes clarifying the View, Download, Transmit (VDT) Measure by making it clear the action must be taken by the patient or the patient-authorized representatives. The Academy supports granting patient access to VDT information and encourages

patient engagement. However, it is unfair to score clinicians solely on the action of patients. Clinicians can encourage patients to interact and engage in their care, however, they do not have the ability to force patients to take any actions. CMS should consider this when designing ACI objectives and reframe the measure to require the ability for patients to view, download, or transmit data. As such, providers should not be penalized if a patient does not use a patient portal. Additionally, providers should not receive a bonus for those patients who do utilize this mechanism of communication.

The Academy strongly disagrees with CMS's proposal to give full ACI credit to MIPS eligible clinicians for engaging with a specialized or clinical data registry **only** if the clinician is in "active engagement option 3: production." Option 3 requires eligible clinicians to have completed testing and validation of the electronic submission and to electronically submit production level data to the registry. It is important to note that there are often roadblocks that delay reaching this stage. **Reg-ent registry sites have experienced lengthy delays caused by EHR vendors either due to prohibitive fees being charged; specific technology requirements, deadlines, and reluctance to change their requirements and apparent data blocking.**

The Academy also requests clarification from CMS on how it distinguishes "test" data from "production" data. The Academy requests that CMS continue to allow active engagement of options 1 and 2 to qualify for full ACI credit for the registry measure. While a registry may not be in full production, a clinician in options 1 and 2 has made a significant effort to move towards full production, including registering with a registry and/or testing data submissions. By moving forward with its proposal as currently written, CMS will be denying eligible clinicians that have registered and/or tested with registries ACI credit because of delays with the EHR vendor or registry that are likely beyond their control. Clinicians must invest significant time and financial resources to use electronic reporting and registries, and are therefore are much more likely to pursue these means when there are more significant benefits to making the investment throughout the process.

### 2. Health Information Exchange Including Electronic Prescribing (Fed. Reg. 30068)

In comments submitted for the CY 2017 final rule, the Academy supported the use of electronic prescribing (e-prescribing) and expressed our concerns that many prescriptions still cannot be electronically transmitted, due to technical barriers and specific patient considerations. For surgeons, this requirement depends on the interoperability of EHR systems; as noted previously, this is something that has not yet been realized, except within health systems sharing the same software. **The Academy once again asks CMS to leverage their relationships with health IT vendors to achieve technical and operational interoperability to ensure all ECs can meet MIPS reporting requirements, including e-prescribing. In addition, the Secretary has been given the authority to waive application of Meaningful Use e-prescribing requirements as deemed appropriate. The other statutory requirements for Meaningful Use, including health information exchange and quality reporting, can be achieved by electronically participating in a QCDR. While CMS has the flexibility to waive this requirement, QCDRs could easily support an attestation for their participants to report that they used e-prescribing.** In the CY 2018 proposed rule, CMS clarifies the action needed to claim the proposed exclusion for the E-Prescribing Objective and Measure. The Academy thanks CMS for providing this clarification for clinicians.

### v. MIPS Eligible Clinicians Facing a Significant Hardship (Fed. Reg. 30075)

In the CY 2017 final rule, CMS established hardship exemptions for clinicians who meet specific criteria. CMS proposes to use the same categories of significant hardship and application process for CY 2018. If an EC or

group is granted a significant hardship, CMS will assign a zero percent weight to the ACI performance category in the MIPS final score for the year the hardship was granted. CMS also states they are proposing not to apply the 5-year limitation for hardship exemptions to ECs and groups. CMS proposes a new significant hardship exception for ECs who are in small practices, and proposes reweighting the ACI performance category for ECs who are ASC-based or whose CEHRT systems have been decertified under the Office of the National Coordinator (ONC) certification program. CMS proposes allowing ECs and groups to apply for these significant hardships by December 31 of the performance period year, and will accept applications on a rolling basis. **The Academy thanks CMS for building flexibility into the methodology for ECs and groups who face hardships, as well as expanding these exemptions based on stakeholder input.**

### G. Cost Performance Category (Fed. Reg. 30047)

For the 2017 MIPS reporting period, CMS used their statutory authority to reweight the cost performance category to zero, but stated they would still provide cost reports to clinicians for 2017. The Academy thanked CMS for ensuring clinicians will not be scored per the cost performance category in 2017, and encouraged CMS to utilize the wealth of data that will be collected in 2017 to further refine the cost performance category. **We stated CMS should work to ensure that attribution methodologies are sound and provide ample protections to ensure clinicians are only scored on the cost of care for which they are directly responsible. CMS should continue to test and seek input on all components of the cost performance category before applying cost considerations to a clinician's CPS.**

For CY 2018, CMS proposes to change the weight of the cost performance category from the 10 percent weight finalized in the 2017 final rule to zero percent. CMS has expressed concerns about the level of familiarity and understanding of cost measures among clinicians, and will use the additional year in which the score in the cost performance category does not count towards the final score for outreach to increase understanding of the measures so clinicians will be more comfortable with their role in reducing costs for their patients. **The Academy applauds CMS' reluctance to implement a cost performance category that remains complex and misunderstood by clinicians and thanks CMS for proposing to retain the zero percent weight for 2018. The Academy agrees that CMS should continue to perform outreach to increase understanding of measures the cost category will use for performance measurement.** As the MIPS program continues, providers and specialty societies should be provided the time to review and comment through the rule making process any proposed mechanism for reporting the cost category. The Academy also understands CMS' trepidation for continuing a zero percent weight and no incentives for clinicians to review and understand cost scores before the mandated increase in weight takes place. Due to this, CMS should consider using statutory authority to create a cost bonus score for ECs who perform well. CMS is already sending out reports on cost and can simply reweight the cost category for ECs who perform well, while holding those who need improvement harmless, for 2018 reporting. This will incentivize ECs to pay attention to cost measurement in 2018 without unfairly punishing them.

In the CY 2018 proposed rule, CMS proposes not including in the cost performance category the 10 episode-based measures adopted for the 2017 MIPS performance period in the CY 2017 Quality Payment Program final rule. Instead, CMS will work to develop new episode-based measures, with significant clinician input, for future performance periods. The Academy thanks CMS for not utilizing these episode-based measures and pledging to seek significant clinician input for the development of episode-based measures. Under the cost performance category in 2017, CMS did not finalize a substantial number of episode-based measures, including several relevant to Otolaryngologist – Head and Neck Surgeons. The Academy remains concerned that

specialists, such as Otolaryngologist – Head and Neck Surgeons, will be scored based on episode-based measures that are not applicable to the patients they treat daily or to their specialties.

We remain committed to working with CMS to develop episode-based measures that are accurate and helpful to clinicians, including our members. In 2017, Academy representatives participated in the clinical committee for the MACRA cost performance category and provided input on thyroidectomy, laryngectomy, tracheal repair, and tracheotomy episode groupers. However, there is much work to be done in the cost performance category and the Academy continues to offer our clinical expertise in the development of relevant episode-based measures.

For the 2018 MIPS performance period and future performance periods, CMS proposes to include in the cost performance category the total per capita cost measure and the Medicare Spending Per Beneficiary (MSPB) measure as finalized for the 2017 MIPS performance period. In comments submitted to CMS for the proposed and final rules for CY 2017, the Academy expressed apprehension regarding the cost performance category, specifically stating we were concerned that CMS was rolling over a flawed value-based modifier (VM) program for MIPS performance purposes by using the total per capital cost measure and MSPB measure used under the VM program. CMS states that the application of the VM is familiar to clinicians and justifies utilizing methodology from the program in the cost performance category. Clinicians may be familiar with the methodology for the VM, but this does not mean it is accurate. In the CY 2017 Medicare Physician Fee Schedule (MPFS) proposed and final rules, CMS provided detail on how they would correct VM calculations that are incorrect due to third party vendor or CMS errors. As stated in our comments on the MPFS, the Academy continues believes if CMS does not have the ability to ensure VM calculations and the subsequent payment modifications are correct with a high degree of certainty, clinicians should be held harmless until CMS can ensure all issues with VM calculations are corrected.

Finally, before instituting category in future reporting periods, the Academy remains concerned that the cost of care will be incorrectly attributed to clinicians. The Academy once again asks CMS to develop risk-adjustment and attribution methodologies that ensure ECs are only scored for the cost of care for which they are directly responsible.

### H. Public Reporting on Physician Compare (Fed. Reg. 30163)

In the CY 2018 proposed rule, CMS intends to continue publishing individual and group periodic aggregate and final MIPS scores and performance under each MIPS category, as well as Advanced APM participant names and performance, to Physician Compare. Additionally, CMS proposes including benchmarking information to allow for physician comparison, data that had been voluntarily submitted, social risk factor stratification for complex patients, and provider Board Certification information on Physician Compare.

In comments submitted for the CY 2017 proposed rule, the Academy expressed concern that consumers utilizing Physician Compare may have difficulty understanding and interpreting the data, and urged CMS to develop language clearly explaining that an EC failing to meet MIPS reporting criteria does not necessarily constitute poor quality of care. In response to concerns raised by the Academy and other stakeholders, CMS echoes the concern that consumers who misunderstand and improperly interpret data will be unable to use Physician Compare information in a meaningful way to make informed decisions, and indicates that individual EC and group performance information must be published in an easily understandable format. Further, CMS affirms that published language must indicate that information may not be representative of the EC's entire

patient population, the variety of services furnished by the EC, or the health conditions of individuals treated. **The Academy thanks CMS for acknowledging the need for disclaimer language and specifically urges CMS to develop language clearly explaining that failing to meet MIPS reporting criteria does not necessarily constitute poor quality of care so patients can appropriately make decisions regarding their choice of clinician.**

In the CY 2018 proposed rule, CMS finalizes a policy to extend the current Physician Compare 30-day preview period for ECs, starting with data from the 2017 MIPS performance period, which is available for public reporting in late 2018. CMS plans to coordinate data review and any relevant data resubmission or correction between Physician Compare and the four performance categories of MIPS. All data available for public reporting are available for review and correction during the targeted review process, which will begin at least 30 days in advance of the publication of new data. Data under review is not publicly reported until the review is complete. **The Academy thanks CMS for finalizing a 30-day preview period in advance of the publication of data on Physician Compare, which will allow providers to review and submit corrections.**

## I. Technical Assistance to Small Practices and Practices in Health Professional Shortage Areas (HPSAs)

### i. Small Practices (Fed. Reg. 30013)

In the CY 2018 proposed rule, CMS indicates that, during a period of 5 years, $100 million in funding was provided to make technical assistance (TA) available to provide guidance to ECs in small practices through contracts with regional health collaboratives, and others. CMS also notes that assistance with the MIPS performance categories or the transition to APM participation will be available to ECs in practices of 15 or fewer clinicians, with priority given to practices located in rural areas or medically underserved areas (MUAs), and practices with low MIPS final scores. **While the Academy is appreciative of CMS' efforts to develop TA and utilize the dedicated funding streams allocated through MACRA, it is nearly impossible for smaller associations like the Academy to access this funding through traditional contract bidding processes. Small medical associations often do not employ the specialists to apply for government contracts and grants. Instead, CMS should implement an option to provide funding to smaller organizations, such as specialty societies, for education and create realistic opportunities for specialty societies to receive funding. This funding will help develop an adequate portfolio of appropriate quality measures and provide members with valuable assistance, considering specialty societies are the trusted and recognized source of education for physicians, particularly those in small or rural practices.**

### ii. Virtual Groups (Fed. Reg. 30030)

Additionally, CMS proposes providing TA for 2018 and 2019 reporting years to support ECs who join virtual groups. TA will include the TA infrastructure that groups may already be using, as available on the Quality Payment Program (QPP) website, as well as model agreements and access to the Quality Payment Program Service Center. CMS also intends to provide an electronic election process, if technically feasible, beginning in CY 2019, for ECs to form virtual groups. **While the Academy appreciates CMS' understanding that TA will be vital for individual ECs and groups seeking to form virtual groups, it only serves to highlight that virtual group participation may not be ready for CY 2018. The Academy once again reiterates our request to delay implementation of virtual groups until sufficient guidance and time is afforded to practices, allowing them to make informed decisions for virtual group participation.**

## II. Alternative Payment Models (APMs) (Fed. Reg. 30170)

Throughout the development of MACRA-related regulations, including in comments submitted for the request for information (RFI), the CY 2017 proposed and final rules, and in meetings with CMS officials, the Academy has consistently stressed the importance of flexibility as one of the major characteristics necessary for the APM program to succeed. **Specialists, including Otolaryngologist – Head and Neck Surgeons, have historically had difficulty defining roles when developing previous quality-based pilots and programs, and the Academy believes that MACRA provides CMS with the vehicles necessary to develop APMs for specialists who would qualify for Advanced APM bonus payments.** Last year, the Academy participated in a partnership with the American College of Surgeons (ACS) and Brandeis University to develop an episode grouper model for surgical care that would involve the clustering of multiple episodes into one APM from a menu of episodes for surgeons. This model was presented in front of the Patient-Focused Payment Model (PTAC) in 2017, and the Academy believes this offers CMS the ability to review and test APMs for historically disenfranchised specialties like Otolaryngology.

In the CY 2018 proposed rule, CMS provides proposals that offer clarity and stability for clinicians considering attempting to participate in Advanced APMs and MIPS APMs. The Academy appreciates CMS' efforts to listen to the concerns for clinicians, specifically surgical specialists. As CMS continues to work towards the development of additional Advanced and MIPS APMs, along with other payers, **the Academy continues to encourage CMS to leverage their relationships with health IT vendors and work to achieve both operational and technical interoperability through every available mechanism. Clinicians too often still run into data blocking issues with health IT vendors between hospital systems and in data submission for quality programs such as QRs and QCDRs. This limits access to vital information, which can inform development of the innovative ideas that transform the healthcare system.**

### i. Nominal Amount of Risk (Fed. Reg. 30173)

In comments submitted to CMS for the CY 2017 final rule, the Academy expressed concerns for the finalized definition of nominal financial risk. Specifically, we stated the definition was defined in an "incredibly complex and restrictive manner; the proposed 'nominal financial risk' calculation was difficult for many experts, let alone practices and clinicians, to understand, and even more difficult for specialty societies, such as the Academy, to explain to members." In response to comments submitted by a multitude of stakeholders, including the Academy, CMS acknowledged the complexity of the definition of nominal financial risk, stating they "agree with commenters that, all else equal, less complex criteria are preferable, regardless of the underlying difficulty for APMs to meet the criteria."

For CY 2018, CMS proposes to more clearly define the generally applicable revenue-based nominal amount standard and the Medical Home Model revenue-based nominal amount standard as a percentage of the average estimated total Medicare Parts A and B revenue of providers and suppliers in participating APM Entities. Specifically, CMS states they would calculate the estimated total Medicare Parts A and B revenue of providers and suppliers at risk for each APM Entity. CMS would then calculate an average of all the estimated total Medicare Parts A and B revenue of providers and suppliers at risk for each APM Entity, and if that average estimated total Medicare Parts A and B revenue at risk for all APM Entities was equal to or greater than 8 percent, the APM would satisfy the generally applicable revenue-based nominal amount standard. **The Academy appreciates CMS simplifying the definition for the applicable revenue-based nominal amount**

**standards in a more understandable format. This clear explanation will make it easier for the Academy to explain the standard to clinicians, and for practices to understand.**

In the CY 2017 final rule, the Academy joined the AMA in calling on CMS to maintain nominal amount standards beyond 2018, providing necessary stability as practices make important business decisions as to whether they should join an Advanced APM. CMS proposes to maintain the current revenue-based nominal amount standard at 8 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities for the 2019 and 2020 Medicare QP Performance Periods. **The Academy thanks CMS for providing clear targets for practices considering participating in an Advanced APM in the next few years by maintaining these nominal amount standards through 2020.**

CMS also seeks comment on whether they should consider a different, potentially lower, revenue-based nominal amount standard only for small practices and those in rural areas that are not participating in a Medical Home Model for the 2019 and 2020 Medicare QP Performance Periods. **The Academy encourages CMS to develop a lower revenue-based nominal standard for small and rural practices through at least the 2019 and 2020 performance periods. By establishing a lower standard, CMS could encourage practices to adopt payment models that will not only improve care for their patients, but encourage better coordination of care and help to lower the cost of care.**

### ii. All-Payer Combination Option (Fed. Reg. 30177)

Beginning in 2019, in addition to the Medicare Option, ECs may become Qualifying APM Participants (QPs) through the Combination All-Payer and Medicare Payment Threshold Option, which CMS refers to as the All-Payer Combination Option. The All-Payer Combination Option does not replace or supersede the Medicare Option; instead, it would allow eligible clinicians to become QPs by meeting the QP thresholds through a pair of calculations that assess Medicare Part B covered professional services furnished through Advanced APMs, and a combination of both Medicare Part B covered professional services furnished through Advanced APMs and services furnished through Other Payer Advanced APMs.

According to the CY 2018 proposed rule, CMS will conduct QP determinations sequentially so the Medicare Option is applied before the All-Payer Combination Option. CMS states an EC only needs to be a QP under either the Medicare Option or the All-Payer Combination Option to be a QP for the payment year. The All-Payer Combination Option encourages ECs to participate in payment arrangements with payers other than Medicare that have payment designs that satisfy the Other Payer Advanced APM criteria. It also encourages sustained participation in Advanced APMs across multiple payers.

CMS also outlines the criteria for determining whether Other Payer APMs meet the Other Payer Advanced APM criteria. To seek a QP determination under the All-Payer Combination Option:
- The eligible clinician submits to CMS sufficient information on all relevant payment arrangements with other payers;
- Based upon that information CMS determines that at least one of those payment arrangements is an Other Payer Advanced APM; and
- The eligible clinician meets the relevant QP thresholds by having sufficient payments or patients attributed to a combination of participation in Other Payer Advanced APMs and Advanced APMs.

As currently described, CMS places the onus on practices to gather the necessary information to seek an All-Payer Combination determination. While the Academy appreciates that CMS cannot identify whether an other-payer arrangement meets the criteria to be an Other Payer Advanced APM without receiving the required information from an external source, CMS places an undue burden on practices trying to determine if they meet the All-Payer Combination Option by forcing practices to submit a substantial amount of paperwork. **CMS should streamline the All-Payer Combination Option by working with payers to ensure the administrative burden placed on practices is simplified. The All-Payer Combination Option was developed to encourage increased Advanced APM participation, and increasing the administrative burden for participation threatens to stifle participation.** Additionally, CMS needs to clearly articulate what is "sufficient information on all relevant payment arrangements" before making any All-Payer Combination Option determinations. As currently defined, arbitrary and subjective definitions for "sufficient information" will make it hard for practices to know what should be submitted to CMS. Instead, CMS should work with payers to define and standardize required paperwork, reducing the burden placed on practices seeking a determination. Given it may be difficult for surgical specialties to meet the APM revenue threshold, and unless it is adjusted to a lower threshold, there should be a sliding scale to get into an APM and then the threshold could be increased over time so that specialty providers may be able to participate in this program.

### iii. Patient-Focused Payment Models (PFPMs) (Fed. Reg. 30207)

In 2017, ACS and Brandeis University presented a physician focused payment model proposal in front of the PTAC. Specifically, this model is designed to allow providers and entities to find their own way toward high-quality, high-value care. Under the ACS-Brandeis model, the patient-focused philosophy of both the grouper and APM recognizes that surgical care is team-based, and that coordination with medical specialists, primary care, and the other segments of the delivery system involved, plays an important role in improving outcomes. The ACS-Brandeis model is broad in scope and therefore intentionally flexible in design, as an episode in this model does not require a hospitalization, therefore the framework is applicable to multiple care settings. This flexibility is important because many specialties currently lack opportunities to meaningfully participate in voluntary Advanced APMs due to their geography, practice patterns, or a lack of models covering their specialties or the specific type of care they provide. The ACS-Brandeis model specifically will provide Otolaryngologists with the opportunity to participate by including several episodes for Otolaryngologists.

In comments submitted to CMS, the PTAC said the ACS-Brandeis model does not meet the value over volume criteria. The Academy disagrees with this analysis. The model ties quality measurement closely to the episode of care being measured for resource use, galvanizing the model with respect to shared accountability in team-based care. The highest rewards (associated with the Excellent quality tier) are reserved for those participating in episode-based quality measurement. Despite this concern, the PTAC recommended that CMS test the ACS-Brandeis APM. The Academy praises the PTAC's advisors and staff for their diligent work reviewing the ACS-Brandeis APM and other proposals. **The Academy encourages CMS to proceed with the PTAC recommendation to test the ACS-Brandeis APM. If CMS chooses to scale down the procedure and condition episodes in the model, CMS should ensure there is a diverse sampling of procedures and conditions representing several specialties, including Otolaryngologists – Head and Neck Surgeons.** When choosing procedure and condition episodes for the model, the Academy reminds CMS to be cognizant of specialties that have not had the chance to participate in a CMMI demonstration project or APM in the past. To that end, the Academy recommends CMS consider inclusion of Endoscopic Sinus Surgery, Parathyroidectomy, and Thyroidectomy measures in testing, which will allow many Otolaryngologists to participate in an APM for the first time.

## III. Conclusion

The American Academy of Otolaryngology—Head and Neck Surgery appreciates the opportunity to provide comment and recommendations regarding these important policies on behalf of our members. As we have indicated above, we appreciate the administration's outreach to the physician community during the comment period on this inaugural rule, including the listening sessions, briefings, and meeting with us individually. We are committed to working collaboratively with CMS and others as regulations in future years are prepared and the agency continues to work to implement these MACRA reforms. If you have any questions or require further information, please contact Jenna Kappel, Director, Health Policy at jkappel@entnet.org or 703-535-3724. Thank you.

Sincerely,

James C Denneny III

James C. Denneny III, MD, FACS
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