AMERICAN ACADEMY OF
OTOLARYNGOLOGY–
HEAD AND NECK SURGERY

December 29, 2017

SUBMITTED VIA ELECTRONIC FILING

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–5522–FC and IFC
P.O. Box 8013
Baltimore, MD 21244-8016

RE: Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year

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; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year," published in the Federal Register on November 16, 2017. We believe CMS has listened and worked to address many of the concerns raised by the AAO-HNS and other stakeholders as evidenced by the finalized changes to the programs. However, we emphasize the importance of the need to continue to work together to address remaining concerns with the MIPS and APM programs. Specifically, we look forward to future collaborative efforts to minimize the complexity of the programs and the additional burdens placed on our members who must understand and meet the many shifting requirements to ensure the greatest number of Otolaryngologist–Head and Neck Surgeons have the opportunity to successfully participate in the programs.

I. Merit-based Incentive Payment System (Fed. Reg. 53578)

A. MIPS Exclusions and Virtual Groups (Fed. Reg. 53586)

1. MIPS Exclusions (Fed. Reg. 53586)

The AAO-HNS thanks CMS for finalizing changes to the low-volume threshold to exclude individual eligible clinicians (ECs) 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 AAO-HNS also thanks CMS for finalizing the small practice bonus of five points for ECs in groups, virtual groups, or APM Entities that have 15 or fewer clinicians and that submit data on at least one performance category in the 2018 performance period. We also applaud CMS for finalizing a complex patient bonus, capped at five points (increased from three points as proposed). We believe these changes take into consideration the additional difficulties for small practices or practices that treat complex patients.

2. Virtual Group Criteria (Fed. Reg. 53593)

The AAO-HNS thanks CMS for moving forward with developing model written agreements for ECs to use as a template for virtual groups, and for not forcing virtual groups to form new TINs, which would add to the administrative burden for ECs and groups electing to become virtual groups. In addition, the AAO-HNS further appreciates CMS modifying regulation text to clearly explain the required elements for the formal written agreements for members within each virtual group. The AAO-HNS also thanks CMS for allowing ECs an additional 30 days (December 31 versus December 1) for virtual group election. Additionally, the AAO-HNS appreciates CMS responding to our comment regarding the need to address risk adjustment mechanisms for virtual groups and develop methodologies to account for the unique nature of virtual groups, noting that appropriate risk adjustment is critical for virtual groups due to their heterogenous nature (for example, geographic and specialty diversity).

3. Small Practice Provisions (Fed. Reg. 53571)

The AAO-HNS appreciates CMS finalizing the following provisions to specifically help small practices, defined as an entity with 15 or fewer clinicians, reduce the administrative burden of reporting under MIPS:

- CMS using data to attest to their size rather than requiring the small practice to attest;
- Exemption from the All-Cause Readmission measure; and
- Allowing small practices to submit applications for hardship exemption from the advancing care information (ACI) reporting category.

The AAO-HNS encourages CMS to continue to provide relief to small practices beyond CY 2018, especially if the performance threshold for MIPS reporting continues to increase in future reporting years.

4. MIPS Performance Period, Reporting Mechanisms, Composite Score Methodology, and Performance Threshold (Fed. Reg. 53617)

As stated in our proposed rule comments, **the AAO-HNS is concerned about the change from** "**pick your pace" reporting options to a full calendar year (January 1 through December 31), and that practices reporting under the "test" performance category will face "sticker shock" in reporting for a full year. In addition, if in fact participation is low because of the drastic change in the reporting timeframe, the AAO-HNS requests that CMS consider reverting back to the 180-day reporting period for the quality performance category for CY 2018, with an increase to a full year in CY 2019.**

Further, the AAO-HNS thanks CMS for allowing multiple submission mechanisms for a single performance category (specifically, the quality improvement activities and ACI performance categories), beginning in the 2019 performance period, which will reduce reporting burdens on participating ECs.

As noted in our previous comments, the AAO-HNS continues to believe that the overall scoring methodology for the MIPS program can and 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. **We appreciate that CMS noted that beginning in 2018, it will implement improvement scoring for the quality and cost performance categories to determine how the policies affect MIPS ECs. Further, we thank CMS for reaffirming that a facility-based MIPS EC can be scored based on their facility's performance.**

The AAO-HNS 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 and the additional performance threshold for exceptional performers at 70 points. This level will allow a large number of ECs and groups to successfully report under MIPS while enabling them to prepare for increases in reporting requirements in future years.

B. Quality Performance Category (Fed. Reg. 53635)

1. Quality Performance Period (Fed. Reg. 53628)

The AAO-HNS again thanks CMS for maintaining the policy to assign three points to measures that are submitted but do not have a benchmark or do not meet the case minimum, such as the CMS Web Interface measures and administrative claims based measures. We believe that maintaining this policy will provide ECs with stability from CY 2017 to CY 2018 MIPS reporting.

In the CY 2018 final rule, CMS restated that "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 AAO-HNS 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. **The AAO-HNS again requests CMS' re-institution of the 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.**

2. Quality Data Submission Criteria (Fed. Reg. 53628)

The AAO-HNS appreciates CMS continuing to provide institutional flexibility by keeping reporting criteria consistent from CY 2017 to 2018. In addition, **we thank CMS for finalizing new measures and including the new 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.

We also thank CMS for continuing to not require groups to participate in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS survey, and we thank CMS for allowing voluntary, incentivized reporting of CAHPS for MIPS. 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. We appreciate that CMS is not changing the requirement for the percent of the individual EC's or group's patients that meet the measure's denominator criteria and is maintaining the 60 percent requirement. We believe this gradual increase will allow ECs to fully transition to the MIPS program without disadvantaging certain ECs and groups. We also believe that not revising the floor for data completeness for practices with 15 or fewer ECs will minimize burdens placed on small practices. Finally, the AAO-HNS thanks CMS for making the policy final to remove cross-cutting measures from most specialty sets. The AAO-HNS agrees with CMS' assessment that cross-cutting measures may or may not be relevant to their practices, contingent on the ECs or groups.

3. Topped-out Measures (Fed. Reg. 53638) and Special Scoring (Fed. Reg. 53721)

In the CY 2018 final rule, CMS clarifies that the proposed timeline for topped-out measures is more accurately described as a four-year timeline. After a measure has been identified as topped out for three consecutive years, CMS may propose to remove the measure through notice-and-comment rulemaking for the fourth year. Therefore, in the fourth year, if finalized through rulemaking, the measure would be removed and would no longer be available for reporting during the performance period. This proposal would provide a path toward removing topped-out measures over time and will apply to the MIPS quality measures. Qualified Clinical Data Registry (QCDR) measures that consistently are identified as topped out, according to the same timeline as proposed above, would not be approved

for use in year four during the QCDR self-nomination review process. These identified QCDR measures would not be removed through the notice-and-comment and rulemaking process. CMS is finalizing the phase in of this policy starting with a select set of six highly topped-out measures, including two process measures in the Otolaryngology Specialty Set: (21) Perioperative Care: Selection of Prophylactic Antibiotic - First OR Second Generation Cephalospor and (23) Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients).

We appreciate the clarification that the MIPS topped-out measures would go through the comment and rulemaking process. However, the AAO-HNS is disappointed that CMS has chosen to move forward with the decision to remove these topped-out measures. We strongly believe this is why the measures noted previously (NQF #0097 and NQF #1799) should be approved. In addition, **while we appreciate that CMS has finalized a timeline for topped-out quality measures for MIPS reporting, 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.**

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. In the final rule, CMS finalized a scoring cap of seven points, rather than the proposed six points. **While we appreciate the change to the scoring cap, the AAO-HNS once again notes disappointment and disagreement with the special topped-out measures scoring for Perioperative Care Measures 21 and 23 because there are so few surgical measures available for use by Otolaryngologist-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.

a. Expansion of QCDR Measures Cap to 30 for Each Subspecialty

The AAO-HNS again requests an expansion of the QCDR measures cap so that each subspecialty within otolaryngology is allotted 30 measures. As stated in our previous comments, and supported by the Physician Clinical Registry Coalition, 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. During past meetings including one with CMS and the Academy leadership, CMS agreed that it would be reasonable to increase the 30 limit rule for specialties that are highly subspecialized, e.g. Otolaryngology which encompasses general otolaryngology, pediatrics, laryngology, broncho-esophagology, sleep medicine, otology, neurotology, rhinology, allergy, geriatrics, and facial plastics so that meaningful measures are available to all of our members.

C. QCDR Components (Fed. Reg. 53807)

For the 2019 performance period, CMS finalized the proposal that allows an existing QCDR in good standing to continue its 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, QCDRs in good standing with minimal changes or substantial changes to a specific aspect of the application can have these specified changes reviewed while attesting that the remainder of their application remains the same from the previous year. A QCDR that has any changes will still be required to submit changes under the normal self-nomination process.

We are disappointed that CMS considered the two-year QCDR approval period, but did not decide to finalize the extension due to concerns that it would result in restricting QCDRs by having them support the same fixed services they had the first year and would not provide flexibility for QCDRs to add or remove services, measures, and activities. Additional concerns included the fact that QCDRs would not be able to make changes to their organizational

structure, would create complications to place poorly performing QCDRs on probation or disqualifying them, and would not take into consideration potential changes in the MIPS program.

While the AAO-HNS understands the concerns raised by CMS, the "simplified" process that was finalized as noted above, is not helpful for specialty society QCDRs given that, at this point in the process, new measures are still being developed. Further, the AAO-HNS echoes comments submitted by the Physician Clinical Registry Coalition urging CMS to make broad changes to its QCDR measure review process, including an organized, transparent, and consistent process to incentivize registries to develop new QCDR measures and continue to self-nominate as QCDRs. Therefore, **the AAO-HNS requests that CMS develop a plan that would allow the measures submission process to change each year without requiring full re-submission of the QCDR requirements**. **In addition, we look forward to the simplified application process promised by CMS.** 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.

The AAO-HNS thanks CMS for listening to concerns raised by the AAO-HNS in comments submitted for the CY 2017 final rule allowing individual ECs and groups to submit data and measures and activities via multiple data submission categories for a single performance category. 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.

While the AAO-HNS is appreciative that CMS made no changes to the criteria to qualify as a QCDR, the AAO-HNS remains concerned regarding CMS' intent to expand the EHR vendors' capabilities. This is especially true 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 AAO-HNS 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. **Most commercial vendors do not have the clinical expertise that the physician-led registries have to ensure the clinical integrity of quality measures.** Further, 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.

1. QCDR Criteria for Data Submission (Fed. Reg. 53812)

In our comments to CMS on the proposed rule, we noted our **general support of 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 AAO-HNS noted we appreciate the steps being taken thus far to protect the intellectual property rights of QCDR measure developers. However, the AAO-HNS commented that we believed further improvement could be made to record and track QCDR measures ownership rights**.** We were pleased to see that in the final rule, CMS made changes to the proposal to include that QCDRs may report on QCDR measures owned by another QCDR with the appropriate permissions and that QCDRs must publicly post QCDR measure specifications no later than 15 calendar days following our approval of the measures specifications.

In addition, in comments to CMS on the proposed rule, we urged CMS to properly record ownership of all approved QCDR measures to protect the intellectual property rights of the owner of the measure. The AAO-HNS is pleased to see that in the final rule, CMS is modifying their proposal to also include that CMS will assign QCDR measure IDs after the QCDR measure has been approved, and the same measure ID must be used by other QCDRs that have received permission to also report the measure. Furthermore, CMS also clarified that the borrowing QCDR must use the exact measure specification provided by the QCDR measure owner.

D. Improvement Activities Performance Category (Fed. Reg. 53650)

1. Improvement Activities Data Submission Criteria – Submission Mechanisms

The AAO-HNS appreciates that CMS allowed reporting flexibility for improvement activities, including use of many different methods to submit data, and requiring only a "yes" response for activities within the inventory. We believe that this flexibility will be helpful during the initial implementation years of the Quality Payment Program. Further, the AAO-HNS would like to thank CMS for finalizing 21 new improvement activities and changes to 27 previously adopted improvement activities. **Among the changes, the AAO-HNS appreciates activities that were changed from a medium-weighted to a high-weighted activity, especially those related to QCDR participation (e.g., Appendix Table G, IA_AHE_3).** The new and updated activities will allow for increased participation, achievement of specific organizational goals, and a more seamless transition into the QPP. **However, we are disappointed that CMS did not assign high weights for registry-related improvement activities.** Given this, the AAO-HNS reiterates the request for CMS to change its approach for weighting improvement activities and believes assigning high weight for registry-related improvement activities will help achieve the basic premise of MIPS to tie physician payment to quality through the increased reporting of measures.

2. Required Period of Time for Performing an Activity

As with previously submitted comments, the AAO-HNS is concerned that CMS finalized the policy requiring ECs or groups to perform improvement activities for at least 90 consecutive days during the performance period to receive credit for the improvement activities category. **We believe there are some activities where a 90-day timeframe is not applicable, and again request 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 possible.** Although the generally accepted time frame for quality improvement is 90 days, improvement activities cover a spectrum of time to complete, from short cycles in a private practice setting to system focused change requiring more lengthy improvement cycles. For example, improvement activities focused on patient outcomes and reducing morbidity and mortality may take much longer than 90 days to complete. However, enhancements/regular updates to practice websites/tools that also include considerations for patients with cognitive disabilities may not require 90 consecutive days to complete.

3. Improvement Activities Policies for Future years of the MIPS Program – Approach for Identifying New Subcategories and New Activities

The AAO-HNS agrees with CMS' position that the Annual Call for Activities process for adding new activities 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 to submit feedback via an online nomination form and appreciate the feedback loop that is being created for future program years.**

E. Advancing Care Information (ACI) Performance Category (Fed. Reg. 53574)

1. Scoring Consideration and Performance Period Definition

The AAO-HNS thanks CMS for retaining scoring considerations from 2017 for the ACI performance category (25 percent of the final score) and encourages CMS to continue to implement policies that promote stability in the program through the first few years of reporting. By finalizing the minimum of 90 consecutive days requirement of data for CY 2018 and CY 2019, this will allow ECs and groups to gain familiarity with reporting requirements, increasing buy-in and reporting for future years.

2. ACI Performance Category Data Submission and Collection

For the 2018 performance period, MIPS ECs will have the option to report the ACI Transition Objectives and Measures using 2014 Edition CEHRT, 2015 Edition CEHRT, or a combination of 2014 and 2015 Edition CEHRT, as long as the EHR technology they possess can support the objectives and measures to which they plan to attest. MIPS ECs will also have the option to attest to the ACI Objectives and Measures using 2015 Edition CEHRT or a combination of 2014 and 2015 Edition CEHRT, as long as their EHR technology can support the objectives and measures to which they plan to attest. **The AAO-HNS appreciates that CMS will not mandate that physicians update their EHRs in 2018, and values CMS recognition of the challenges physicians face in adopting new certified health IT. Further, we ask CMS to maintain flexibility in CY 2019 for physicians to use 2014 or 2015 Edition CEHRT or a combination of the two systems.**

3. Objectives and Measures Specification - MIPS Eligible Clinicians Facing a Significant Hardship (Fed. Reg. 53681)

The AAO-HNS appreciates that CMS did not impose a limitation on the total number of MIPS payment years for which the ACI performance category could be weighted at zero percent. CMS will automatically reweight, without requiring an application, the ACI performance category to zero percent for a MIPS EC who lacks face-to-face patient interaction. We request further clarification and a definition for "face-to-face patient interaction" to help physicians better understand the implementation of the hardship requirements (i.e., as physicians increasingly rely on telemedicine, would Skype sessions with a physician be considered "face-to-face" or not?).

F. Cost Performance Category (Fed. Reg. 53574)

For the 2020 MIPS payment year, CMS is finalizing a 10 percent weight for the cost performance category in the final score in order to ease the transition to a 30 percent weight for the cost performance category in the 2021 MIPS payment year. For the 2018 MIPS performance period, CMS is adopting the total per capita costs for all attributed beneficiaries measure and the Medicare Spending per Beneficiary (MSPB) measure that were adopted for the 2017 MIPS performance period, and will not use the 10 episode-based measures that were adopted for the 2017 MIPS performance period. Although data on the episode-based measures has been made available to clinicians in the past, CMS is in the process of developing new episode-based measures with significant clinician input and believes it would be more prudent to introduce these new measures over time.

The AAO-HNS appreciates the <u>gradual</u> adoption of measures overtime and urges CMS to adopt episode-based measures that are applicable to physicians' patients and specialties before increasing the weight of this category. Additionally, as stated in previous comment letters, **CMS should consider using statutory authority to create a cost bonus score for ECs who perform well.** CMS is currently 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. Finally, before instituting more stringent performance requirements in future reporting periods, **AAO-HNS 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. Further, as CMS develops these methodologies, the**

AAO-HNS requests that CMS allow for ample time to collect stakeholder input on the implementation of cost performance category requirements.

G. Public Reporting on Physician Compare (Fed. Reg. 53819)

The AAO-HNS 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. The Academy also appreciates CMS for engaging in ongoing analyses and user testing of the final Physician Compare score and aggregate information, and **we again urge CMS to develop language clearly explaining that failing to meet MIPS reporting criteria does not necessarily constitute poor quality of care.**

II. Alternative Payment Models (APMs) – (Fed. Reg. 53832)

The AAO-HNS commends CMS for its continued efforts to create policies which allow for flexibility in future innovative Advanced APMs, including the finalized policy that gives MIPS ECs participating in a MIPS APM 30-75 percent of the final score, depending on the availability of the APM quality data for reporting (e.g., this offers more flexibility for the participating physician). However, **the AAO-HNS remains concerned that the final rule does not provide the flexibility to allow for the broadest scope of innovative models to ensure the greatest number of physicians can not only participate, but succeed, in APMs.** Specialists, including Otolaryngologist–Head and Neck Surgeons, have historically had difficulty defining roles when developing previous quality-based pilots and programs. However, the AAO-HNS believes that MACRA provides CMS with the vehicles necessary to develop APMs for specialists who would qualify for Advanced APM bonus payments.

A. Nominal Amount of Risk (Fed. Reg. 53836)

The AAO-HNS thanks CMS for providing clear targets for practices considering participation in an Advanced APM in the next few years by maintaining the nominal amount standards at eight 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. **However, the AAO-HNS is disappointed that CMS did not set a lower revenue-based nominal standard for small practices and those in rural areas, either for 2018 or future reporting years.** We urge CMS to consider the unique needs of practitioners working in small and rural practices, and the impact this has on their ability to meaningfully participate in Advanced APMs. We look forward to working with the agency in future rulemaking to address this important area of concern for our members.

B. All-Payer Combination Option (Fed. Reg. 53844)

The AAO-HNS remains concerned about the significant burden placed on practices to gather the necessary information to seek an All-Payer Combination determination by 2019. While we appreciate 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 reduced.** The All-Payer Combination Option was developed to encourage broader participation in Advanced APMs, and increasing the administrative burden for participation threatens to stifle participation.

C. Patient-Focused Payment Models (PFPMs) (Fed. Reg. 53891)

The AAO-HNS continues to seek development of meaningful Advanced APMs, including Patient-Focused Payment Models (PFPMs), for Otolaryngologist-Head and Neck Surgeon participation. Unfortunately, **there is not one episodic model that could be developed for a disease condition that would be applicable to more than 50 percent of all Otolaryngologists. As such, the AAO-HNS, along with several other surgical specialties, partnered with the 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.**

The ACS-Brandeis model was presented to the Patient-Focused Payment Model Technical Advisory Committee (PTAC) in April of 2017. The AAO-HNS agrees with testimony recently delivered by the PTAC at a November 2017 Congressional hearing on MACRA. Specifically, as stated in the PTAC testimony, we believe that "closer coordination between PTAC and CMS and CMMI will enable greater efficiency, greater capacity to implement more innovative models, and greater clarity for applicants seeking to understand the process of submission and approval…".

The AAO-HNS was pleased to learn the ACS-Brandeis model recently received approval from HHS to move forward with additional development in anticipation of testing. Given that our specialty has not had the opportunity to meaningfully participate in a CMMI demonstration project or an APM in the past, we recommend inclusion of Endoscopic Sinus Surgery, Parathyroidectomy, and Thyroidectomy measures in testing of the ACS-Brandeis model, which will allow many Otolaryngologists to participate in an Advanced APM for the first time. **While we understand that section 1868(c) of the Act does not require CMS to test proposals that are recommended by the PTAC, the AAO-HNS strongly encourages CMS to review and test innovative Advanced APMs, such as the ACS-Brandeis model, which seek to engage historically disenfranchised specialties like Otolaryngology.**

III. Automatic Extreme and Uncontrollable Circumstance Policy with Interim Final Rule (Fed. Reg. 53897)

The AAO-HNS thanks CMS for recognizing the existing hardships for MIPS ECs recently impacted by extreme weather conditions. CMS has reduced clinician burden by not requiring a MIPS submission, and instead scoring the categories at zero.

IV. 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. If you have any questions or require further information, please contact Claudia Vasquez, MS, Senior Manager of Health Policy, at cvasquez@entnet.org or 703-535-3725.

Sincerely,

James C Denneny III

James C. Denneny III, MD, FACS
Executive Vice President and CEO