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August 21, 2017

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: CMS-5522-P; Medicare Program; CY 2018 Updates to the Quality Payment Program

Dear Administrator Verma,

On behalf of the 7,200 members of The Society of Thoracic Surgeons, I am writing to provide comments on the Calendar Year 2018 Proposed Updates to the Quality Payment Program (QPP) as published in the *Federal Register* on June 30, 2017. STS appreciates the opportunity to comment on the implementation of Year 2 of QPP.

Founded in 1964, STS is an international not-for-profit organization representing more than 7,200 cardiothoracic surgeons, researchers, and allied health care professionals in 90 countries who are dedicated to ensuring the best surgical care for patients with diseases of the heart, lungs, and other organs in the chest. The mission of the Society is to enhance the ability of cardiothoracic surgeons to provide the highest quality patient care through education, research, and advocacy.

General Comments

The Medicare Access and CHIP Reauthorization Act (MACRA) was designed to promote value (quality / cost) rather than simply rewarding physicians for the volume of service they provide. This means CMS must be able to effectively measure quality. STS has been a pioneer in this space with 34 quality measures endorsed by the National Quality Forum (NQF), second only to CMS in number of NQF-endorsed quality measures.

As practices continue to consolidate, an increasing number of surgeons now practice under larger, multi-specialty and often facility-based groups. Since these groups often opt to participate in federal quality reporting programs at the group practice level (i.e., at the Taxpayer Identification Number level), the individual clinicians in these practices are increasingly losing autonomy over the selection of measures and reporting mechanisms that are most relevant to their specific specialty and patient population. This arrangement will mean that cardiothoracic surgeons will not have the ability to influence their own personal quality scores as the hospitals may elect to report on quality measures that are insignificant or irrelevant to cardiothoracic surgery. This will result in a number of problems for physicians, patients, and the Medicare program:

a. MACRA was founded on the principles of promoting and incentivizing quality care throughout health care. However, without utilizing cardiothoracic surgery specific quality measures, CMS will fail to incentivize quality in one of the specialties that has the largest impact on Medicare beneficiaries and is one of the largest cost centers in the Medicare program.

b. Without utilizing measures specific to cardiothoracic surgery, cardiothoracic surgeons will not be able to quantify their value to their employers and will have their contribution to the overall performance of the hospital diminished.

Therefore, STS urges CMS to ensure that specialists, including physicians employed by larger or multi-specialty group practices, have the option to report on quality metrics that are germane to their practice. For specialists that participate in a Qualified Clinical Data Registries (QCDR), such as the STS National Database, or other qualified registries, it is imperative that CMS recognize these contributions and compare them to other measurable scoring options, such as the facility-based measures option. Recognizing and reviewing multiple data points and scoring the clinicians on the most beneficial or "highest scoring" submission will allow CMS to gather data that will capture specialty-reporting metrics while providing CMS and hospitals/ health systems a better understanding of physicians' contributions to increasing value in healthcare without penalizing clinicians in the process.

MIPS Program Details
Performance Period

We are proposing at §414.1320(c) and (c)(1) that for purposes of the MIPS payment year 2021 and future years, for the quality and cost performance categories, the performance period under MIPS would be the full calendar year (January 1 through December 31) that occurs 2 years prior to the applicable payment year.

We are proposing at §414.1320(d) and (d)(1) that for purposes of the MIPS payment year 2021, the performance period for the improvement activities and advancing care information performance categories would be a minimum of a continuous 90-day period within the calendar year that occurs 2 years prior to the applicable payment year, up to and including the full CY 2019 (January 1, 2019 through December 31, 2019).

STS opposes the proposed change to require a 12-month performance period for quality and cost data, while at the same time maintaining a 90-day continuous reporting period for improvement activities and advancing care information. In Year 1, CMS required clinicians to report a minimum of a 90-day performance period for quality, advancing care, and improvement activities. Requiring two different performance periods in Year 2 is unnecessarily confusing for clinicians who are still becoming comfortable with the program. Therefore, STS urges CMS to keep the performance period for all categories at 90-days of continuous reporting to ensure a neutral payment adjustment. Should CMS wish to extend the performance period to a continuous 12-month period, we recommend that this extension be implemented gradually and across all reporting categories in future years to ensure that clinicians are able to understand and adhere to reporting requirements for all four categories.

Submission Mechanisms

We are proposing to revise §414.1325(d) for purposes of the 2020 MIPS payment year and future years, beginning with performance periods occurring in 2018, to allow individual MIPS-eligible clinicians and groups to submit data on measures and activities, as applicable, via multiple data submission mechanisms for a single performance category (specifically, the quality, improvement activities, or advancing care information performance category).

STS supports the proposal to allow individual MIPS-eligible clinicians and groups to submit data on measures and activities utilizing multiple data submission mechanisms for a single performance category. However, STS does not agree that MIPS-eligible clinicians and groups that have fewer than the required number of measures and activities applicable and available under one submission mechanism be required to evaluate all other available reporting mechanisms for additional potentially relevant measures and activities in order to earn the maximum score in a particular performance category. STS agrees that for some clinicians, use of multiple data submission mechanisms may increase complexity and additional costs when many are already struggling to understand the program and implement programs to comply. Eventually, this approach may make sense, but for the first few years of the program, minimizing the complexity and costs associated with the program and ensuring that CMS can provide as much real-time feedback as possible to facilitate successful participation is critical to helping clinicians successfully and meaningfully participate.

STS supports the recommendation that entities may choose to submit measures using different mechanisms. For the same measures that are submitted using different mechanisms, each submission should be calculated and scored separately and only the submission that gives the clinician the higher score is counted.

Data Completeness Criteria

We propose to revise the data completeness criteria for the quality performance category at §414.1340(a)(2) to provide that MIPS-eligible clinicians and groups submitting quality measures data using the QCDR, qualified registry, or EHR submission mechanism must submit data on at least 50 percent of the individual MIPS-eligible clinician's or group's patients that meet the measure's denominator criteria, regardless of payer, for MIPS payment year 2020. We also propose to revise the data completeness criteria for the quality performance category at §414.1340(b)(2) to provide that MIPS-eligible clinicians and groups submitting quality measures data using Medicare Part B claims, must submit data on at least 50 percent of the applicable Medicare Part B patients seen during the performance period to which the measure applies for MIPS payment year 2020. We further propose at §414.1340(a)(3), that MIPS-eligible clinicians and groups submitting quality measures data using the QCDR, qualified registry, or EHR submission mechanism must submit data on at least 60 percent of the individual MIPS-eligible clinician or group's patients that meet the measure's denominator criteria, regardless of payer for MIPS payment year 2021.

As MIPS-eligible clinicians gain experience with the MIPS, we would propose to steadily increase these thresholds for future years through rulemaking.

STS supports the proposal to maintain the 50 percent data completeness threshold for QCDRs, qualified registries, EHRs and claims-based data submissions for the 2020 payment year. We believe this proposal will allow MIPS-eligible clinicians to continue to adjust to the program and become more proficient in their reporting. We believe that increasing the data completeness threshold over time is appropriate and reasonable in order to meet the goals of the MIPS program. STS is encouraged by the CMS proposal to gradually increase the data completeness threshold over time in order to provide all clinicians time to better understand the data completeness requirements.

STS feels that it is important that clinicians who meet the data completeness thresholds be rewarded in the scoring process. We agree with the proposal to modify the number of points from 3 to 1 for the 2020 performance year for measures that fail data completeness for MIPS-eligible clinicians or groups, with the exception of small practices, will result in movement to more accurate and complete quality reporting.

Cost Performance Category

We are proposing at §414.1350(b)(2) to change the weight of the cost performance category from 10 percent to zero percent for the 2020 MIPS payment year. We continue to have concerns about the level of familiarity and understanding of cost measures among clinicians. We will use this 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 that clinicians will be more comfortable with their role in reducing costs for their patients.

STS supports the proposal to change the weight of the cost category from 10 percent to 0 percent for Year 2 of the Quality Payment Program. We agree with assertion that most MIPS-eligible clinicians and groups continue to have limited familiarity and understanding of cost performance category. Many clinicians do not understand how the Medicare Spending Per Beneficiary (MSPB) and Total Per Capita Costs for All Attributed Beneficiaries measures are calculated and attributed to their individual or group costs. This lack of understanding makes it difficult for clinicians to interpret and understand their cost reports.

While STS supports the proposal to reweight the cost category to 0%, we believe it is critical that CMS provide significant education and resources to MIPS-eligible clinicians and groups to ensure they have a clear understanding of the cost category and what targets they will be expected to meet in future years. This education *must* include: 1) the components considered within the cost category, 2) how scoring occurs within the cost category and 3) the overall affect this category will have on their overall score when the cost category weight is adjusted to 30% in 2020.

Additionally, STS supports the proposal to forfeit using the 10 episode-based measures that were approved for the 2017 performance year for the 2018 performance year. We agree that new measures developed with significant clinical input will be more accurate and will identify relevant cost and attribution issues associated with episodes of care. The forthcoming patient relationship code reporting requirement on a voluntary basis will also contribute to more accurate attribution.

Although CMS is required, by statute, to increase the cost category to 30% in 2019, STS urges CMS to consider excluding any clinicians for which there are no applicable episode-based cost measures or cost measures that do not result in a sufficient or valid sample of patients from the cost category.

Improvement Activity Criteria

We are proposing new, high-weighted activities in Table F in the Appendix of this proposed rule. As explained in the CY 2017 Quality Payment Program final rule (81 FR 77194), we believe that high weighting should be used for activities that directly address areas with the greatest impact on beneficiary care, safety, health, and wellbeing. We are not proposing changes to this approach in this proposed rule; however, we will take these suggested additional criteria into consideration for designating high-weighted activities in future rulemaking.

We are requesting comment on whether we should establish a minimum threshold (for example, 50 percent) of the clinicians (NPIs) that must complete an improvement activity in order for the entire group (TIN) to receive credit in the improvement activities performance category in future years. In addition, we are requesting comments on recommended minimum threshold percentages and whether we should establish different thresholds based on the size of the group.

We are requesting comments on how to set this threshold while maintaining the goal of promoting greater participation in an improvement activity.

STS supports the proposal to develop additional high-level activities. We encourage CMS to leverage activities that utilize QCDR, registry, and other data reporting and feedback mechanisms to facilitate improvement activities as high-level activities. Focusing on the development of improvement activities that are easily captured, documented and reported with specific criteria, outcomes and goals will allow CMS to measure performance and overall improvement and move away from attestation. In order to assess performance and improvement, some activities may require a multi-year commitment while others can be measured within in a performance period or year.

In future years, STS urges CMS to set a minimum threshold whereby 50% of the clinicians must complete an improvement activity for the entire group (TIN) to receive credit in the improvement activities performance category. Cardiothoracic surgeons should be meeting this threshold in their practices. Therefore, STS believes it is reasonable to develop a 50% participation threshold for a group in order to encourage these activities. For groups of 16 or more clinicians, STS believes that a minimum threshold where 50% of the clinicians must complete an improvement activity to get credit is reasonable and appropriate. For small groups of 15 or fewer clinicians, STS encourages CMS to determine if a minimum threshold imposes too large of a burden on the practice. If there is a negative effect, CMS should consider developing thresholds based on group size. We encourage CMS to consider increasing the minimum threshold gradually over a designated period.

Advancing Care Information (ACI) Performance Category

We are proposing not to include in the estimation physicians for whom the advancing care information performance category would be weighted at zero percent under our proposal in section II.C.6.f.(7) of this proposed rule to implement certain provisions of the 21st Century Cures Act (that is, physicians who are

determined hospital-based or ambulatory surgical center based, or who are granted an exception based on significant hardship or decertified EHR technology.

STS supports the proposal to continue to reweight the ACI performance category to 0 percent of the MIPS final score for Year 2 of QPP for clinicians who meet its definition of "hospital-based." We believe the proposed threshold of 75% outlined in the proposed rule to be arbitrary and fear it may exclude some hospital-based clinicians. To ensure that hospital-based clinicians are appropriately captured, we urge CMS to change the hospital-based threshold for a TIN that furnishes a lower percentage of professional services in sites of service identified by the place of service (POS) 21 for inpatient hospital services, POS code 23 for emergency room services, POS 22 for on-campus outpatient hospital and the addition of POS 19 for off-campus-outpatient hospital. This may be accomplished by considering services provided across the identified POS codes and lowering the percentage threshold. This approach will capture the clinicians, such as cardiothoracic surgeons, who provide most their services in the facility setting and do not have sufficient measures available to report on the category. STS welcomes the opportunity to work with CMS to ensure that this provision captures all clinicians who perform much of their services in a facility setting.

Like many other professions, cardiothoracic surgeons provide services in multiple settings. In order to ensure that these clinicians are not penalized for their multiple setting practices, we urge CMS to consider these clinicians when determining if the threshold is met.

Additionally, we appreciate the proposal to implement the 21st Century Cures provision to define exceptions for hospital-based MIPS-eligible clinicians under the ACI performance category. We agree and appreciates the assumption that hospital-based, MIPS-eligible clinicians do not have sufficient ACI measures applicable to them. In order to mitigate any confusion on the determination of whether a MIPS-eligible clinician is hospital-based, we encourage CMS to notify eligible clinicians as soon as possible prior to a beginning of the performance year. While providing this determination, we ask that CMS provide a reminder to those clinicians who have been deemed hospital-based that if they choose to report on ACI measures, the 0% score will be negated and their reporting will be scored like all other MIPS-eligible clinicians on how they perform within the ACI category. This reminder to all hospital-based clinicians will ensure that they are aware of their status and do not inadvertently report and be scored on the ACI measures, which could negatively affect their overall score if they are not able to successfully report due to the lack of measures available to them.

<u>Improvement Activities Bonus Score under the Advancing Care Information Performance Category</u>

In this proposed rule, we are proposing to expand this policy beginning with the CY 2018 performance period by identifying additional improvement activities in Table 6 that would be eligible for the advancing care information performance category bonus score if they are completed using CEHRT functionality.

STS appreciates the efforts of CMS to advance the use of certified electronic health record technology (CEHRT). Clinical data registries, including STS's National Database, are founded on the principles to promote and encourage a culture of performance improvement to ensure quality patient care. We urge CMS to recognize the value of these clinical registries by providing greater incentives through the ACI

scoring policies to give greater weight to clinicians who have invested in the meaningful use of QCDRs to improve patient care.

Quality Performance Category

Topped Out Measures

We propose a 3-year timeline for identifying and proposing to remove topped out measures. After a measure has been identified as topped out for three consecutive years, we may propose to remove the measure through comment and rulemaking for the 4th year. Therefore, in the 4th year, if finalized through rulemaking, the measure would be removed and would no longer be available for reporting during the performance period. This proposal provides a path toward removing topped out measures over time, and will apply to the MIPS quality measures. QCDR measures that consistently are identified as topped out according to the same timeline as proposed below, would not be approved for use in year 4 during the QCDR self-nomination review process, and would not go through the comment and rulemaking process described below.

STS is deeply concerned with the proposal to identify and remove measures they deem to be topped out. Without certain commonly used measures, we fear quality patient care will be undermined. Certain measures, including #21 Antibiotic Selection or #43 CABG IMA Use are important measures to identify patient outcomes. These measures are currently being met or exceeded across the cardiothoracic practice, yet are still crucial measures to ensure the maintenance of high quality care. Due to their importance, maintaining these measures will allow clinicians to accurately capture the care being provided to patients. Therefore, STS strongly believes that measures deemed as topped out should not automatically initiate removal from the program. Instead, measures that CMS deems to be topped out should, after notice and comment, be retained in the MIPS program but should be awarded a capped number of points minimum number of points. While providers who rely solely on the topped-out measures may not be eligible for a bonus payment, clinicians will be able to report on these useful measures and patients will continue to benefit from these important quality measures.

Additionally, we urge CMS to notify all measure owners through notice and comment in year 1 of the 3-year proposed timeline that a measure may be deemed as topped out. Doing so will allow the measure owner the opportunity to develop additional measures that will ensure the highest quality of care for our patients and be deemed appropriate within the QPP.

Scoring Improvement for MIPS Quality Category Percent Score

We propose at §414.1380(b)(1)(xvi)(E) to define an improvement percent score to mean the score that represents improvement for the purposes of calculating the quality performance category percent score. We also propose at §414.1380(b)(1)(xvi)(C) that an improvement percent score would be assessed at the quality performance category level and included in the calculation of the quality performance category percent score.

Consistent with bonuses available in the quality performance category, we propose at §414.1380(b)(1)(xvi)(B) that the improvement percent score may not total more than 10 percentage points.

STS supports the proposal to assess the improvement percent score based on the category level. Many of the measures that are used for reporting vary slightly year to year. Therefore, the CMS is reasonable and appropriate to ensure consistency.

We note that many QCDRs often report the same measures year-to-year. We ask that there be consistency in how the overall quality performance achievement score is calculated. The objective of the QPP is to reward improvement from year-to-year, we support requiring some level of year-to-year consistency.

Facility-Based Measures Scoring Option for the 2020 MIPS Payment Year for the Quality and Cost Performance Categories

We propose at §414.1380(e)(2)(i) that a MIPS-eligible clinician is considered facility-based as an individual if the MIPS-eligible clinician furnishes 75 percent or more of their covered professional services (as defined in section 1848(k)(3)(A) of the Act) in sites of service identified by the POS codes used in the HIPAA standard transaction as an inpatient hospital, as identified by POS code 21, or an emergency room, as identified by POS code 23, based on claims for a period prior to the performance period as specified by CMS.

STS supports the proposal to allow facility-based, MIPS-eligible clinicians to have their quality and cost performance category scores derived from a designated hospital's Value-Based Purchasing program score. Additionally, we support the alternative proposal where CMS will automatically apply facility-based measurement to MIPS-eligible clinicians and groups comparing that to any data submitted by the MIPS-eligible clinician through any available reporting mechanism and determine the quality and cost performance category scores based on the highest score. We appreciate the recognition that clinicians who perform much of their services in a facility-based setting are presented with unique challenges and opportunities within the Quality Payment Program.

We support the overall proposal to ensure that facility-based clinicians are appropriately recognized in the Quality Payment Program; however, **we believe the proposed 75% threshold outlined in the proposed rule to be arbitrary and fear it may exclude some hospital-based clinicians.** In order to capture those clinicians that provide the majority of their services in a facility setting, we urge CMS to change the threshold for a TIN that furnishes a lower percentage of professional services in sites of service identified by the place of service (POS) 21 for inpatient hospital services, POS code 23 for emergency room services and the addition of POS 22 for on-campus outpatient hospital. This may be accomplished by considering services provided across the identified POS codes and lowering the percentage threshold. This will capture the clinicians, such as cardiothoracic surgeons, who provide the majority of their services in the facility. STS welcomes the opportunity to work with CMS to ensure that this provision captures all clinicians who perform much of their services in a facility setting. We do not believe that this policy would place non-facility-based MIPS-eligible clinicians at a competitive disadvantage since there are so many variables that would impact the final MIPS measure scores for any given clinician.

Transparency is essential to ensuring that the facility-based provision is successful. It is imperative that all physicians fully understand all of their options under the MIPs program, including what their potential facility-based scores are in advance of the conclusion of the MIPS performance period.

Therefore, **STS supports the proposal to notify MIPS-eligible clinicians that they are eligible for facility-based measurement as early as possible prior to the submission period.** Early notification will allow clinicians to make the best decision for their practices. We do not believe that providing this vital information to facility-based MIPS-eligible clinicians will provide any advantage over MIPS-eligible clinicians who are not facility-based as there are a number of variables in the MIPS program that will affect a clinician's final score.

Election of Facility-Based Measurement

We propose that those clinicians or groups who are eligible for and wish to elect facility-based measurement would be required to submit their election during the data submission period as determined at §414.1325(f) through the attestation submission mechanism established for the improvement activities and advancing care information performance categories. If technically feasible, we would let the MIPS-eligible clinician know that they were eligible for facility-based measurement prior to the submission period, so that MIPS-eligible clinicians would be informed if this option is available to them.

We also considered an alternative approach of not requiring an election process but instead automatically applying facility-based measurement to MIPS-eligible clinicians and groups who are eligible for facility-based measurement, if technically feasible. Under this approach, we would calculate a MIPS-eligible clinician's facility-based measurement score based on the hospital's (as identified using the process described in section II.C.6.b. of this proposed rule) performance using the methodology described in section II.C.7.a.2.b. of this proposed rule, and automatically use that facility-based measurement score for the quality and cost performance category scores if the facility-based measurement score is higher than the quality and cost performance category scores as determined based on data submitted by the MIPS-eligible clinician through any available reporting mechanism.

STS supports the alternative proposal that, if technically feasible, CMS will automatically apply facility-based measurement to MIPS-eligible clinicians and groups based on the proposed methodology and scoring. We support the provision that will grant a clinician the highest score if the clinician utilizes other submission mechanisms, such as a QCDR. We support the CMS proposal to automatically use the facility-based measurement score for the quality and cost performance categories if this score is higher than the quality and cost performance category scores determined by data submitted by the MIPS-eligible clinician through any available reporting mechanism. This approach encourages clinicians to utilize specialty-specific reporting mechanisms when available and will provide CMS with additional data that can be utilized to promote and evaluate quality without penalizing the clinician. While the STS agrees that it is important that clinicians are aware of the various ways in which they participate, this process ensures that all clinicians who meet the criteria are participating at some level. STS maintains the position that this approach will not provide facility-based clinicians with an advantage, as there are other factors that may affect participation and scoring.

Establishing the Performance Threshold

Given our desire to provide a meaningful ramp between the transition year's 3- point performance threshold and the 2021 MIPS payment year performance threshold using the mean or median of the final

scores for all MIPS-eligible clinicians for a prior period, we are proposing to set the performance threshold at 15 points for the 2020 MIPS payment year.

We also considered an alternative of setting the performance threshold at 33 points, which would require full participation both in improvement activities and in the quality performance category (either for a small group or for a large group that meets data completeness standards) to meet the performance threshold. Such a threshold would make the step to the required mean or median performance threshold in MIPS payment year 2021 less steep, but could present further challenges to clinicians who have not previously participated in legacy quality reporting programs.

While we understand that CMS is required to adhere to MACRA-mandated performance thresholds in future years, **STS is deeply concerned with the proposal to increase the performance threshold from 3 points to 15 points for the 2020 payment year.** This drastic increase will create misunderstanding and panic during the second transition year. Therefore, we urge CMS to increase the performance threshold in a more gradual fashion. We believe a lower threshold of six points for the 2020 payment year is more reasonable to ensure that all clinicians are able to adjust to a higher threshold while being able to meet the performance threshold without sacrificing care or their final score.

CMS has asked for feedback on the use the mean and median of the final scores for all MIPS-eligible clinicians for a prior period. This approach will create significant confusion amongst all clinicians. **Therefore, we urge CMS to be more transparent in its calculations of the mean and medium performance threshold score.** We ask that CMS provide guidance as to how they will factor in those clinicians that choose to do the minimum in the 2017 reporting year. For example, it is unclear if these calculations will include bonus points awarded to clinicians, which could skew the mean or median. Until further guidance is issued, we urge CMS to use the lower score of either the mean or median.

<u>Feedback and Information to Improve Performance</u>

We are proposing to provide Quality Payment Program performance feedback to eligible clinicians and groups. Initially, we would provide performance feedback on an annual basis. In future years, we aim to provide performance feedback on a more frequent basis, which is in line with clinician requests for timely, actionable feedback that they can use to improve care.

STS appreciates the performance feedback provided by CMS to eligible clinicians. We support the proposal to provide performance feedback on a more frequent basis in future years. We urge CMS to provide these essential feedback reports in real-time if and when possible. This real-time feedback will allow clinicians to adjust their performance in order to be successful in the program in a given year. We believe CMS can achieve more timely feedback by collecting data by third party data submission vendors on a more frequent basis. CMS has provided data for the Durable Medical Equipment demonstration in a much more timely fashion (every three-six months) so that participants in the demo could react to the CMS measurement on which they were being evaluated. We urge CMS to adopt the same infrastructure reporting system that existed for this demo and currently exists under the Bundled Payments for Care Improvement (BPCI) program so that providers can understand their performance in a much more relevant timeframe.

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Qualified Clinical Data Registries
Self-Nomination Period

We are proposing, beginning with the 2019 performance period, a simplified process in which existing qualified registries in good standing may continue their participation in MIPS by attesting that the qualified registry's approved data validation plan, cost, approved MIPS quality measures, 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. Specifically, existing qualified registries in good standing may attest during the self-nomination period that they have no changes to their approved self-nomination application from the previous year of MIPS. In addition, the existing qualified registry may decide to make minimal changes to their self-nomination application from the previous year, which would be submitted by the qualified registry for CMS review and approval by the close of the self-nomination period.

We request comments on this proposal. In the development of this proposal, we had reviewed the possibility of offering a multi-year approval, where qualified registries would be approved for a 2-year increment of time.

STS appreciates the proposal to simplify the QCDR self-nomination process, as we believe this may be beneficial to reduce the administrative burden of the QCDR vendor. However, we urge CMS to establish a more effective and efficient process for the review and approval process for QCDR measures. To date, this process has been disorganized and lacks transparency. We believe that a two-year timeframe for measure approvals would be acceptable. However, we urge CMS to make exception to this proposal to allow a QCDR to replace a measure if deems necessary.

We seek comment for future rulemaking, on requiring QCDRs that develop and report on QCDR measures, must fully develop and test (that is, conduct reliability and validity testing) their QCDR measures, by the time of submission of the new measure during the self-nomination process.

STS is concerned with the proposal to require QCDRs to "fully develop and test" their measures. We fear this requirement will create significant burden on the QCDR vendor. We urge CMS to work with QCDRs to identify development and testing requirements that will not create increased burden but will satisfy the objective to ensure that the QCDR meets all requirements of the MIPS program. The QCDR mechanism was intended to serve a test-bed for new and innovative measures. Requiring QCDRs to adhere to testing standards prior to the adoption of measures would contradict the Congressional intent of this mechanism and stymie efforts to fill critical measure gaps.

Beginning with the 2018 performance period and for future program years, we propose 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 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 (QCDR vendor) would still own and maintain the QCDR measure, but would allow other approved QCDRs to utilize their QCDR measure with proper notification.

STS supports the proposal to allow QCDRs to seek permission to use another QCDR's measures. However, we believe CMS must detail how they will handle benchmarking two QCDRs using the same measure. In order to mitigate any unintended consequences, we encourage CMS to evaluate benchmark data separately.

QCDR Criteria for Data Submission

While CMS is not proposing any change in the data submission for QCDRs, **we urge** CMS to provide any required changes to how QCDRs submit clinician data to be detailed in writing to each QCDR with advance notice. This written communication from CMS should include all specifications and information about the submission process. We encourage CMS to provide this written communication to all QCDRs as early as possible to ensure the QCDR has time to reconfigure its systems, if required. For example, CMS has not made available support information for submitting risk-adjusted measures in QPP XML Format. Additionally, the estimated delivery date of this information for early September gives QCDRs submitting this way a shorter period to implement the updates.

Overview of the APM Incentive

In general, STS believes there is still great confusion around what is and is-not an Advanced APM. CMS has well documented its case for creating the "MIPS APM" designation, which was not included in the original MACRA statute. However, some discrepancies in its implementation remain. For example, CMS states on its QPP resources pages that, "most Advanced APMs are also MIPS APMs so that if an eligible clinician participating in the Advanced APM does not meet the threshold of having sufficient payments or patients through an Advanced APM in order to become a Qualifying APM Participant (QP), the eligible clinician will be scored under MIPS according to the APM scoring standard." However, not all Advanced APMs have been designated as MIPS APMs. Once such example is the Coronary Artery Bypass Graft (CABG) Episode Payment Model (EPM). While we understand CMS has proposed to cancel the CABG EPM, we are still concerned that CMS has created a precedent of approving an Advanced APM without creating a MIPS APM reporting corollary for those Advanced APM participants who fail to meet the QP or Partial QP thresholds.

Again, while we understand CMS may finalize the cancellation of EPMs, using the previously finalized policies as an example, STS has expressed concerns with the CABG EPM model approach to the assessment of a CABG EPM participant's status as a Qualifying Participant. We believe that CMS created siloed EPMs (separate CABG and Acute Myocardial Infarction (AMI) EPMs) which could be undermining the investments and efforts of Advanced APM participants by making it more difficult for them to achieve QP status. We request that CMS be mindful of this. Such an approach is also consistent with the highly-desirable and strongly-encouraged concept of the "heart team."

Advanced APM Criteria: Financial Risk

In the CY 2017 Quality Payment Program final rule (81 FR 77418), we divided the discussion of this criterion into two main elements: (1) What it means for an APM Entity to bear financial risk for monetary losses under an APM); and (2) what levels of risk we would consider to be in excess of a nominal amount. For each of these elements, we established a generally applicable standard and a Medical Home Model standard.

We propose to amend §§414.1415(c)(3)(i)(A) and (c)(4)(i)(A) through (D) 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. Under this proposed policy, when assessing whether an APM meets the generally applicable revenue-based nominal amount standard, where total risk under the model is not expressly defined in terms of revenue, we would calculate the estimated total Medicare Parts A and B revenue of providers and suppliers at risk for each APM Entity. We 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.

STS joins other medical societies in our appreciation of The proposalproposal to extend the 8% revenue-based nominal amount standard for Year 2 of the program. MACRA mandates significant financial risk for any participant of Advanced APMs. Eight percent represents a significant financial burden to participating clinicians. In fact, we believe that CMS should consider lowering the Revenue Based Standard below 8% in order to ensure an environment where participation in models can thrive. CMS could then base the future Revenue Based Standard risk percentage based on the data and experience of models rather than trying to formulate a policy without experiential information about Advanced APMs.". This will provide greater stability within the program and allow entities to develop an APM that will meet the requirements and will allow all clinicians the understanding of the APM to work toward satisfying the requirements for participation.

<u>Advanced APM Criteria- Remaining Other Payers</u>

We propose to allow remaining other payers, including commercial and other private payers, to request that we determine whether other payer arrangements are Other Payer Advanced APMs starting in 2019 prior to the 2020 All-Payer QP Performance Period and annually each year thereafter.

STS agrees with the proposal and believes that payer-initiated process is likely to be the least burdensome, more heavily utilized process for other payer APM recognition especially since physicians are likely to be overwhelmed with and/or acclimating to MIPS requirements in the near term. CMS should allow payers to initiate the Other-Payer Advanced APM determination process in time for the 2019 performance All-Payer QP Performance Period alongside the QP-initiated process.

The Society of Thoracic Surgeons appreciates the opportunity to provide our comments on proposed changes to the Calendar Year 2018 Quality Payment Program. We would welcome the opportunity to work with CMS as you continue to implement this program. Please contact Courtney Yohe, Director of Government Relations at 202-787-1230 should you need additional information or clarification.

Sincerely,

Richard Prager, MD
President