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December 29, 2017

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Room 445-G, Huber H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

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:

The American Urological Association (AUA) appreciates the opportunity to comment on the final rule for the second year of the Quality Payment Program. The AUA is a globally-engaged organization with more than 22,000 members practicing in more than 100 countries. Our members represent the world's largest collection of expertise and insight into the treatment of urologic disease. Of the total AUA membership, more than 15,000 are based in the United States and provide invaluable support to the urologic community by fostering the highest standards of urologic care through education, research and the formulation of health policy.

We appreciate the many accommodations that CMS has made for the second year of the Quality Payment Program, particularly the additional options to support individual and small group practices. Nonetheless, we are concerned that the cumulative Merit-based Incentive Payment System (MIPS) quality and activity data collection and reporting requirements will create an unbearable administrative burden for clinicians. We believe that the MIPS program, with some enhancement, has the potential to improve health care services; however, we feel that the final regulations are not broad enough to minimize the time consuming data requirements that interfere with patient care. The excessive and misaligned reporting metrics required for the MIPS program are a leading contributor to physician burnout, and have led some policy experts to believe that MIPS should be eliminated and replaced in its entirety. Based on the above concerns, the AUA would like to offer the following comments and alternative recommendations for consideration.

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Submission Mechanisms
The AUA commends CMS for maintaining the current submission mechanism policies that permit individual and group clinicians to elect to submit MIPS program data via multiple submission mechanisms, but not for the same performance category. CMS acknowledges that it currently does not have the ability to aggregate data on the same measure across multiple submission mechanisms and is aiming to implement multiple submission mechanisms for a single performance category as a future option. As stated in our prior comments on the proposed rule, we believe the use of multiple mechanisms for a single performance category will make it difficult to discuss MIPS performance, estimate best scoring strategies, and assess year-to-year performance category improvements for participants in the AUA's qualified clinical data registry (QCDR), referred to as AQUA. **Thus, we encourage CMS to focus on ensuring the appropriate corrective actions are taken to enable use of multiple submission mechanisms for a single performance category and not rush implementation before operationally feasible.**

Topped Out Measures
In the final rule, CMS adopted a timeline to identify topped out measures that will discontinue measure use after 4 years, if measure performance is so high and unvarying that meaningful distinctions and improvement in performance can no longer be made. Therefore, after a measure has been considered topped out for 3 consecutive years, in the 4th year, if finalized through rulemaking, the measure would be removed and would no longer be available for reporting. Similarly, CMS has decided that QCDR measures that are identified as topped out according to the same timeline would not be approved for use in the 4th year during the QCDR self-nomination review process. However, the identified QCDR measures would not undergo the comment and rulemaking process because the measures are not approved in this manner. While that may be true, a growing number of AUA members report quality data via QCDR, and using different methodologies to identify and discontinue topped out measures is inconsistent.

The AUA, in partnership with the Physician Clinical Registry Coalition expressed concern about the process for identifying topped out non-MIPS measures. Specifically, we are concerned that it may not be possible for medical specialties to maintain a QCDR if CMS determines that many of the measures are topped out and not approved for reporting. We would like to echo the sentiments expressed by the Physician Clinical Registry Coalition as a reminder that 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. The combination of topped-out measures and slow approval of QCDR measures creates an effect that is counter to the statutory purpose of QCDRs of being innovative and targeted to the needs of different specialties. **If the expectation is for clinicians to report on measures significant to their practice, we urge CMS to develop a methodology for vetting QCDR topped out measures that is comparable to the comment and rulemaking process for non-MIPS measures.**

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Establishing the Performance Threshold

In the final rule, CMS discusses its rationale for establishing a 15-point performance threshold for the second year of the MIPS program. The AUA remains opposed to the performance threshold increase from 3-points to 15-points for the 2018 performance period. We understand it is CMS' intention to provide a meaningful on-ramp between the threshold at the onset of the program and the 3rd year of the program that requires the performance threshold to be set based on the mean or median of the final scores for all MIPS eligible clinicians for a prior period, according to statute. However, we disagree that a 9-point difference in the performance threshold one year later will motivate clinicians to strive towards more complete reporting in preparation for the 2019 performance period. Instead, we are concerned that the increase is too steep and will create a margin for failure in the MIPS program. We believe a 6-point threshold is a more reasonable increase from the current 3-point threshold.

Although value-based reporting is not entirely new to clinicians; MIPS however, consolidates several programs with new performance activities and a different scoring methodology that makes the reporting requirements unreasonably complex and time-consuming, thereby placing an increased burden on clinicians, many of whom are still adapting to reporting for the different MIPS performance categories. Like many clinicians, AUA members are at various levels of MIPS readiness and need additional time to understand program requirements for the various performance categories, decide which measures and activities are best to report for their practice, and then map their EHR systems for satisfactory participation.

As written, CMS is setting a performance threshold that may result in a negative payment adjustment for those clinicians who are making a diligent and honest effort to meet program requirements, but have not had adequate time to prepare for success under MIPS. We strongly encourage CMS to be responsive to health care stakeholder's ongoing concerns by acknowledging stakeholder recommendations for a lower performance threshold for Year 2 of the MIPS program. We are aware CMS' Office of Clinician Engagement is committed to reducing regulatory burdens for clinicians. **As such we urge CMS to allow for more time to spend with patients rather than spending an inordinate amount of time completing regulatory reporting requirements. We also urge CMS to retract the 15-point performance threshold and assign a 6-point threshold to encourage successful participation for the 2018 MIPS performance period.**

MIPS Performance Periods

As stated in our prior comments on the proposed rule, the AUA supports a continuous 90-day performance period for the MIPS Improvement Activities and Advancing Care Information performance categories for 2018. However, we believe that the reporting periods should be consistent across-the-board, particularly during the early years of the program. If it is possible to earn the maximum number of points by reporting data for a

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consecutive 90-day period, then why stipulate a full year reporting period for the Quality performance category? We are concerned that the lack of standardization across the Quality, Improvement Activities and Advancing Care Information performance categories will lead to further misalignment in the MIPS program. Consistency is needed during the initial stages of adjustment. A full year reporting period for the Quality performance category should be optional for those clinicians who are unable to meet data submission requirements within a 90-day period. **Again, we urge CMS to allow clinicians the option to submit data for the Quality performance category for a continuous 90-day period.**

Improvement Activity Criteria

The AUA would like to thank CMS for encompassing the AUA Score Index (AUA-SI), also known as the International Prostate Symptom Score (IPSS), under Improvement Activity_ Patient Safety & Practice Assessment 8_Use of Patient Safety Tools (IA_PSPA_8) as a medium weight for the 2018 performance period. The AUA-SI is used to quantify lower urinary tract symptoms (LUTS) associated with benign prostatic hyperplasia (BPH), and will serve as validation that the patient completed the symptom score and discussed it with the clinician to determine together appropriate treatment based on patient preferences.

Advancing Care Information Performance Category

The AUA commends CMS for adopting the proposal to allow use of 2014 or 2015 Edition of certified electronic health record technology (CEHRT), or a combination of the two Editions, for the 2018 performance period. We also would like to thank CMS for extending the continuous 90-day reporting period for the 2018 and 2019 performance periods, and for offering a bonus of 10 percentage points for those clinicians that use the 2015 Edition CEHRT for end-to-end data submission. **Again, we recommend that CMS continue to offer the bonus points as long as use of the 2015 Edition CEHRT remains an option to incentivize increased use of the latest software.**

Conclusion

In closing, we would like to thank CMS for the many flexibilities included for the second year of the Quality Payment Program and for the opportunity to offer our comments and recommendations. If you have any questions or wish to discuss our comments, please contact Lisa Miller-Jones at (202) 403-8501 or lmiller@auanet.org.

Sincerely,

Christopher M. Gonzalez, MD, MBA
Chair, Public Policy Council

J. Stuart Wolf, Jr., MD
Chair, Science & Quality Council