

OFFICERS

President

Mark S. Soberman, MD, MBA, FACS
Monocacy Health Partners
Frederick Regional Health System
Frederick, Maryland

President-Elect

Thomas A. Gallo, MS
Virginia Cancer Institute
Richmond, Virginia

Treasurer

Randall A. Oyer, MD
Lancaster General Hospital
Lancaster, Pennsylvania

Secretary

Ali McBride, PharmD, MS, BCPS, BCOP
The University of Arizona Cancer Center
Tucson, Arizona

Immediate Past President

Jennie R. Crews, MD, MMM, FACP
Seattle Cancer Care Alliance
Seattle, Washington

TRUSTEES

Olalekan Ajayi, PharmD
Welch Cancer Center
Sheridan, Wyoming

Catherine Brady-Copertino, BSN, MS, OCN
Anne Arundel Medical Center
DeCesaris Cancer Institute
Annapolis, Maryland

Neal Christiansen, MD
Robert H. Lurie Comprehensive Cancer Center
at Northwestern Medical Faculty Foundation
Lake Forest, Illinois

Melanie Feinberg
Maine Medical Center Cancer Institute
Scarborough, Maine

Krista Nelson, MSW, LCSW, OSW-C
Providence Cancer Center
Portland, Oregon

Laeton J. Pang, MD, MPH, FACR, FACRO
Pacific Radiation Oncology, LLC
Honolulu, Hawaii

Kashyap Patel, MD
Carolina Blood & Cancer Care Associates
Rock Hill, South Carolina

David R. Penberthy, MD, MBA
Southside Regional Medical Center
Petersburg, Virginia

Gail W. Probst, MS, RN, AOCN, NE-BC
Huntington Hospital of Northwell Health
Huntington, New York

Cecilia R. Zapata, MS, MHA
Seattle Cancer Care Alliance
Seattle, Washington

EXECUTIVE DIRECTOR

Christian G. Downs, JD, MHA

August 21, 2017

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, DC 20201

BY ELECTRONIC DELIVERY

Re: Medicare Program; CY 2018 Updates to the Quality Payment Program (CMS-5522-P)

Dear Administrator Verma:

The Association of Community Cancer Centers (ACCC) appreciates this opportunity to comment on the proposed rule published by the Centers for Medicare & Medicaid Services (CMS) on Calendar Year (CY) 2018 Updates to the Quality Payment Program (QPP) (the "Proposed Rule").¹ ACCC is a membership organization whose members include hospitals, physicians, nurses, social workers, and oncology team members who care for millions of patients and families fighting cancer. ACCC represents more than 23,000 cancer care professionals from approximately 1,100 hospitals and more than 1,000 private practices nationwide. These include Cancer Program Members, Individual Members, and members from 34 state oncology societies. It is estimated that 65 percent of cancer patients nationwide are treated by a member of ACCC.

ACCC is enthusiastic about working with CMS to implement the QPP in a manner that appropriately rewards and incentivizes high-quality, cost-efficient care for Medicare beneficiaries and all patients. Our members' first priority is delivering the highest quality care to cancer patients, and we have long been committed to the type of quality and practice improvement activities that the QPP is designed to promote, including participation in many of the leading payment and care delivery models, including Medicare Shared Savings Program (MSSP), Accountable Care Organizations (ACOs), and the Oncology Care Model (OCM).

¹ 82 Fed. Reg. 30,010 (June 30, 2017).

ACCC is pleased to provide these comments on the aspects of the QPP addressed in the Proposed Rule, including important elements of the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Model (APM) incentive. In our comments below, we recommend that CMS:

- Continue to offer clinicians maximum flexibility in participating in the QPP, including through broad availability of alternative reporting options such as virtual groups, facility-based scoring, and MIPS APM reporting and scoring;
- Finalize the increase in the low-volume threshold to \$90,000 in Part B allowed charges and 200 Part B beneficiaries and clarify that the \$90,000 threshold does not include the cost of drugs billed directly by clinicians;
- Finalize its proposal to assign a weight of 0% to the cost performance category for CY 2018 and carefully implement the cost score in the future in a manner that clinicians are assessed and scored against their peers and only for the costs of care for which they are responsible; and
- Clarify that MIPS payment adjustments will not apply to Part B payments for drugs billed directly by clinicians.

We discuss these recommendations in depth below.

I. CMS should continue to offer clinicians maximum flexibility in participating in the QPP, including through broad availability of alternative reporting options such as virtual groups, facility-based scoring, and MIPS APM reporting and scoring.

ACCC believes that the QPP represents an opportunity for meaningful advancement in improving health care quality and reducing the cost of care for Medicare beneficiaries and the Medicare program. Indeed, many of our members can be found on the front lines of innovative value-based payment models. The QPP nevertheless represents a significant administrative burden for clinicians across the country. As CMS knows, the program is likely to be particularly burdensome for clinicians in small or rural practices, or those working to provide health care in underserved areas, that often have just enough resources, personnel, and scale to keep their practices afloat and continue serving their patients.

ACCC thanks CMS for its efforts so far to make the QPP as flexible as possible for all clinicians and to minimize unnecessary administrative burdens. We appreciate CMS's proposals to offer alternative reporting options for CY 2018, including virtual groups, facility-based scoring, and alternative reporting and scoring options for MIPS APMs. We urge CMS to continue expanding the number and scope of these flexible reporting and scoring options that allow clinicians to participate in the QPP to the best of their ability and in a manner that reflects the nature and priorities of their practice and their patients. For example, a number of our members are participating in MIPS APMs that do not qualify for the APM incentive but that do qualify for MIPS APM reporting. Although this option is not perfect, it does reduce some of the burdens of participating in the QPP and allows those clinicians to streamline the administrative work of

participation, thereby freeing up more time and resources to do the work of improving quality of care and reducing unnecessary costs. We strongly encourage CMS to read and exercise its statutory authority broadly (and minimize limits on alternative reporting and scoring options) so that clinicians can streamline their participation in the QPP and derive maximum benefit for patients and the Medicare program.

II. CMS should finalize the increase in the low-volume threshold to \$90,000 in Part B allowed charges and 200 Part B beneficiaries and clarify that the \$90,000 threshold does not include the cost of drugs billed directly by clinicians.

CMS proposes to increase the low-volume threshold for CY 2018 and beyond so that eligible clinicians who either bill \$90,000 or less in Part B allowed charges or see 200 or fewer Part B beneficiaries in the performance period would not be subject to MIPS adjustments for that performance period.² ACCC supports this proposal because we agree with CMS that the proposed increase will further decrease the burden on small practices that are unable to commit the necessary resources to participate in the QPP and earn high performance scores.

In addition, we ask CMS to clarify that the cost of drugs billed directly by clinicians under Part B will not count toward the \$90,000 threshold. Many clinicians would exceed the \$90,000 threshold quickly if the cost of the drugs that they administer to Part B beneficiaries were counted toward that total. But clinicians have no control over the cost of drugs and would have no way to limit those costs other than by simply choosing less costly drugs or treatments for their patients, even if another drug were more clinically appropriate. We urge CMS not to create such an incentive to privilege cost considerations or penalize clinicians for costs of care that they cannot control.

III. CMS should finalize its proposal to assign a weight of 0% to the cost performance category for CY 2018 and carefully implement the cost score in the future so that clinicians are assessed and scored against their peers and only for the costs of care for which they are responsible.

ACCC supports CMS's proposal to assign a weight of 0% to the cost performance category for CY 2018. We believe it is critical that CMS not impose payment adjustments based on cost of care until it has developed a fair and accurate methodology for assessing that cost for each clinician, and we agree that it will be beneficial for CMS, clinicians, and other stakeholders to have additional time to develop that methodology. We look forward to working with CMS in the coming months to develop varied and meaningful cost measures and other reasonable standards for assessing cost of care under MIPS. As CMS begins the process of developing and proposing such measures, we are pleased to bring to CMS's attention some of the high-level concerns that our members and other eligible clinicians have raised with respect to assessment and scoring of cost.

As a guiding principle, ACCC believes that eligible clinicians should be rewarded or penalized only for those costs that they are in a position to control. This is consistent with

² *Id.* at 30,023-26.

CMS's approach to the other performance categories, for example, in exempting facility-based clinicians from the advancing care information score because such clinicians have no control over the facility's use of Electronic Health Record (EHR) systems. It is also consistent with the intent of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to promote more cost-efficient care by providing incentives to limit unnecessary costs – if a clinician has no control over those unnecessary costs, the incentive will have no effect.

We encourage CMS, in considering how to assess cost under MIPS, to keep this general principle in front of mind and to apply it as follows.

Ensure Fair Beneficiary Attribution for Overall Cost Measures. For overall cost measures, CMS should attribute beneficiaries only to clinicians who were responsible for a significant portion of the cost of their care. The beneficiary attribution methodologies that CMS has adopted in the past, including the two-step beneficiary attribution methodology for the Per Capita Cost for All Attributed Beneficiaries, are a helpful first step toward a fair and reasonable attribution methodology, but suffer from significant limitations. For example, under the Per Capita Cost measure methodology, if a beneficiary did not receive any primary care services from primary care clinicians, then the beneficiary is assigned to the Taxpayer Identification Number (TIN) whose specialist clinicians provided more primary care services to the beneficiary than any other TIN. If a patient does not receive primary care services through a primary care physician, then this methodology could result in the beneficiary – and all of his Medicare Part A and Part B costs – being attributed to a specialist practice, even if the beneficiary receives relatively few primary care services there, and even if there are significant and distinct costs (e.g., hospitalization for an accident or unrelated illness) that the specialist practice cannot control.

Establish Narrowly Tailored Episode-Based Measures. ACCC supports CMS's proposal to develop a more comprehensive set of episode-based cost measures in preparation for the use of those measures beginning CY 2019. If they are implemented carefully, episode-based measures may provide a fair and accurate assessment of a clinician's ability to limit unnecessary costs relative to other clinicians working in a similar specialty on similar patients and performing similar procedures, without skewing the comparison by including costs that are unrelated to that clinician's care and that the clinician cannot control. To fulfill this promise, however, episode-based measures must be narrowly tailored to the clinical specialty or sub-specialty being assessed, so that, for example, a pediatric oncologist is accurately measured on the ability to limit unnecessary costs of pediatric cancer care relative to other pediatric oncologists. This can be achieved by carefully establishing parameters for the clinicians who would be scored on the measure and the patients, time periods, and services that would be included in the episode. We look forward to working with CMS to develop such measures in the coming months.

Apply the Discretion to Reweight Performance Categories. CMS also must stand ready to use its discretion to reweight the cost performance category for clinicians or categories of clinicians who cannot be adequately scored on cost. We believe it is likely, especially in the early years of the QPP, that there will be many eligible clinicians who cannot be fairly or accurately scored on cost because they have very few or no beneficiaries attributed to them under the overall cost measures and they do not have any applicable episode-based cost measures. CMS must not hesitate to reweight cost to 0% for such clinicians, as it is authorized to do under the statute, and to reweight the other performance categories appropriately. CMS has appropriately exercised this authority

when it would be inaccurate or unfair to score a clinician on one of the other performance categories because the available measures do not apply to the clinician, the sample size is too small to be accurate, or the clinician cannot control or be held accountable for his or her performance in a category. The same should be true for the cost performance category, and we urge CMS to exercise its authority accordingly.

Recognize the Variable Nature of Costs through Appropriate Risk and Specialty Adjustments and Exclusion of Outliers. By their nature, health care costs are tremendously variable between patients and episodes of care, even within a particular specialty or sub-specialty. ACCC encourages CMS to develop cost methodologies that account for this variability to allow an accurate comparison of cost-efficiency and avoid inappropriately penalizing or rewarding clinicians whose costs happen to fall on the far end of the spectrum. For example, CMS should include carefully designed specialty and risk adjustments, especially for overall cost measures but also for episode-based cost measures, if the episode-based measure is especially volatile or covers multiple specialties or sub-specialties. We also encourage CMS, when appropriate, to consider adjusting for outlier costs that do not accurately reflect a clinician's cost-efficiency relative to other clinicians who did not experience such an outlier case.

We look forward to working with CMS on these and other important aspects of developing a fair and accurate cost score methodology.

IV. CMS should clarify that MIPS payment adjustments will not apply to Part B payments for drugs billed directly by clinicians.

The Proposed Rule suggests that Medicare payment for drugs furnished by an eligible clinician and billed under Part B would be subject to the MIPS payment adjustment (if any) earned by that clinician in the applicable performance year. ACCC strongly opposes applying the MIPS payment adjustment to Part B payments for drugs and urges CMS to clarify that the adjustment will not apply to these payments.

In the Proposed Rule, CMS notes that it has received requests for clarification “on which specific Part B services are subject to the MIPS payment adjustment, as well as which Part B services are included for eligibility determinations.” CMS responds: “For Part B items and services furnished by a MIPS eligible clinician such as purchasing and administering Part B drugs that are billed by the MIPS eligible clinician, such items and services may be subject to MIPS adjustment based on the MIPS eligible clinician’s performance during the applicable performance period or included for eligibility determinations. For those billed Medicare Part B allowable charges relating to the purchasing and administration of Part B drugs that we are able to associate with a MIPS eligible clinician at a National Provider Identifier (NPI) level, such items and services furnished by the MIPS eligible clinician would be included for purposes of applying the MIPS payment adjustment or making eligibility determinations.”³

We are deeply concerned that applying MIPS adjustments to Part B drug payments would represent an unjustified change in agency policy, would create incentives for clinicians to focus on a treatment’s cost rather than whether it is clinically appropriate, would create new barriers to

³ *Id.* at 30,019.

access for patients, and would impose an unequal burden on certain clinicians. We urge CMS not to finalize this policy.

First, applying MIPS adjustments to Part B drug payments would be an unwarranted change from CMS's policy in applying adjustments under the Physician Quality Reporting System (PQRS) and Value-Based Payment Modifier (VM). Under those incentive programs, CMS adopted a policy of applying payment adjustments only to Part B payment for clinicians' professional services, not to Part B drugs or durable medical equipment (DME). Although MIPS was created under a different statutory authority than PQRS and the VM, Congress intended all three adjustments to give clinicians an incentive to provide high-quality, cost-efficient care. As CMS recognized in its interpretation of PQRS and the VM, that Congressional purpose is not served by applying payment adjustments to costs that clinicians cannot control, and we urge CMS to maintain its current policy of not applying adjustments to Part B drug payments.

Applying MIPS adjustments to payments for drugs also would create new and inappropriate incentives for clinicians to focus solely on the cost of a treatment, potentially with negative effects on clinical decision-making and patient access to care. The price of a drug for a clinician will be the same regardless of the clinician's MIPS payment adjustment. As a result, if an eligible clinician knows that she will be subject to a negative payment adjustment in a given payment year, she may have an incentive to modify prescribing and treatment decisions to avoid purchasing and billing for costly Part B drugs because the adjustment will represent a loss that she cannot recover. Likewise, if an eligible clinician knows that he will earn a positive payment adjustment in a given year, he may have an incentive to bill more costly Part B drugs because the adjustment will create pure profit. As a result, patients may be denied or limited access to therapies that are clinically appropriate but that the clinician chooses not to prescribe because of an undue financial incentive. These same incentives could lead to inappropriate shifts in setting of care, for example, if a clinician who expects to receive a negative adjustment chooses not to prescribe drugs that she would purchase under Part B but instead to prescribe drugs that are dispensed through specialty pharmacies or administered in an outpatient setting. Shifts in setting of care, in turn, could increase out-of-pocket costs for patients and overall expenditures for the Medicare program.

Finally, CMS suggests that, in some cases, it may not be "operationally feasible" for CMS to attribute an item or service to one eligible clinician over another. But if CMS applies MIPS payment adjustments to drug payments for some clinicians but not for others, it will create an unequal burden on clinicians who prescribe the drugs to which CMS decides to apply the payment adjustment. This effect contradicts congressional intent and CMS's own stated policy of minimizing disproportionate impact on clinicians.

For all of the reasons above, ACCC urges CMS not to apply MIPS payment adjustments to Part B payments for drugs and DME and instead to maintain its current policy of applying payment adjustments only to professional services furnished by eligible clinicians under Part B.

* * *

Respectfully submitted,

A handwritten signature in black ink, appearing to read 'Mark Soberman', written in a cursive style.

Mark S. Soberman, MD, MBA, FACS
President, Association of Community Cancer Centers