September 10, 2018

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; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program (CMS-1693-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) related to payment policies under the Physician Fee Schedule (PFS) and other revisions to Part B, the Quality Payment Program (QPP), and other programs for Calendar Year (CY) 2019 (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 – including the following undersigned state societies: The Arizona Clinical Oncology Society (TACOS), Indiana Oncology Society (IOS), Iowa Oncology Society (IOS), Minnesota Society of Clinical Oncology (MSCO), Virginia Association of Hematologists and Oncologists, West Virginia Oncology Society (WVOS).

[1] 83 Fed. Reg. 35,704 (July 27, 2018).

It is estimated that 65 percent of cancer patients nationwide are treated by a member of ACCC.

ACCC is pleased to respond to this request for comments. ACCC and the undersigned state societies appreciate the work from CMS to decrease administrative burden with the efforts of their "Patients Over Paper Work" initiative. In the following letter, ACCC seeks to provide input on these proposals and how they will impact members of the multidisciplinary cancer care team across the United States. We hope to work with CMS and other officials in the coming months to refine these proposals. In our comments below, we recommend that CMS:

- Not finalize its proposal to further reduce payment for drug administration procedures in the non-facility setting;

- Not implement its proposed changes to payment for evaluation and management (E/M) visits and other services furnished on the same day and work with stakeholders to study the impact of any such changes on patients and providers, in specialties such as oncology, before making any further proposals;

- Finalize its proposals to pay separately for services provided using communication technologies;

- Not finalize its proposal to drastically reduce reimbursement for stereotactic body radiation therapy (SBRT) and other services based on reductions to direct practice expense (PE) inputs that are not adequately explained or documented by CMS or its contractor; and

- Continue to implement the Quality Payment Program (QPP) in a manner that promotes physician flexibility, fair and effective measurement of physician performance, and robust participation.

I. CMS should not finalize its proposal to further reduce payment for drug administration procedures in the non-facility setting.

In the Proposed Rule for CY 2019, CMS proposes to significantly reduce payment for several drug administration Current Procedural Terminology (CPT®)[2] codes, including several codes whose payment was already significantly reduced in CY 2018. ACCC strongly opposes these proposed reductions, which in some cases are as large as 10 to 18 percent from 2018 to 2019, and up to 34 percent when compared to payment rates in 2017.

CMS again proposes to reduce payment for several drug administration codes that the agency previously identified as potentially misvalued. In many cases, the reduction in payment is

[2] CPT Copyright 2017 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association.

significant. For example, the payment rates for codes 96360 (intravenous infusion, hydration; initial, 31 minutes to 1 hour), 96372 (therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular), 96374 (therapeutic, prophylactic or diagnostic injection IV push, single or initial substance/drug), and 96375 (therapeutic, prophylactic or diagnostic injection; each additional sequential IV push of a new substance/drug) would be cut by 15 to 19 percent under the Proposed Rule. CMS already implemented major cuts in payment for the same codes in CY 2018, and the combined impact if the proposed reduction is finalized would be between 31 and 35 percent for these codes over just two years. Without adequate reimbursement for certain drug administration services, cancer patients across the country could potentially see changes to care delivery, particularly in more rural settings throughout the country. In addition, CMS's proposed changes to the PE relative value units (RVUs) for codes 96360 and 96372 would continue to be phased in over the next two years, leading to a reduction in PE RVUs of 50 to 59 percent since 2017. We urge CMS not to implement these reductions. Should the agency move forward with them, it is essential for CMS to carefully monitor the effect of these changes on access to care.

CMS also proposes significant reductions in payment for other critical drug administration codes, without clearly explaining the proposed cuts. For example, the following chemotherapy CPT codes are proposed to have reduced PE RVUs, which would reduce total payments by 9 to 11 percent: 96409 (chemotherapy administration, intravenous push technique); 96413 (chemotherapy administration, IV infusion, up to 1 hour); 96415 (chemotherapy administration, IV infusion, each additional hour); and 96417 (chemotherapy administration, each additional, sequential infusion (different substance) up to 1 hour). CMS's proposal to implement such large payment reductions for these codes is not based on any reduction in the direct PE inputs; in fact, the input costs are proposed to increase. These codes also are not subject to any continued phase-in of reductions that were finalized in CY 2018. We urge CMS not to finalize these reductions because there was no meaningful opportunity to comment on the reasons for the proposed changes.

ACCC is deeply concerned about the potential impact of these reductions on patient access to care, especially in rural settings or other settings where patients would be required to travel long distances to seek care in hospitals if physicians are not reimbursed adequately for administering drugs and biologicals in their offices.

We also are troubled by the effects of these cuts on CMS's alternative payment models, including the Oncology Care Model (OCM). Several of our members participate in the OCM and are committed to achieving the model's goals of improving cancer care and overall value to the patient while reducing costs to the Medicare program. They have made considerable investments in technology and staffing based on expected future reimbursement levels, but changes in the conventional Medicare payment systems, including the PFS, that form the basis for the OCM and other new payment models, create challenges for participants in these models. Programs that have implemented the OCM have made an investment in the future of value-based

care, focusing on increased coordination of care for patients while also decreasing overall expenditures. These proposed reimbursement cuts would not only affect physicians' expected levels of reimbursement, but would affect all Medicare beneficiaries and cancer patients under the umbrella of this model and all other value-based care initiatives. In particular, large reductions in payment for the drug administration and hydration services that are central to many cancer treatment regimens can upend a practice or hospital's plans to expand services over the coming years and complicate efforts to achieve the improvements in care that are the heart of the OCM and other new payment models. It is difficult to plot a path forward toward new payment and care delivery models when CMS keeps changing the terrain.

Again, we urge CMS to not implement the proposed reductions in payment. If the agency proceeds to implement the cuts as proposed, we believe it is essential for the agency to monitor patient access to care.

II. CMS should not implement its proposed changes to payment for E/M visits and other services furnished on the same day, and should work with stakeholders to study the impact of any such changes on patients and providers, in specialties such as oncology, before making any further proposals.

For CY 2019, CMS proposes to consolidate payment for the CPT codes describing E/M services from five levels of complexity to two levels. CMS proposes to adopt a set of RVUs for E/M office-based and outpatient visit levels 2 through 5 for new patients (CPT codes 99202 through 99205) and a set of RVUs for visit levels 2 through 5 for established patients (CPT codes 99212 through 99215).[3] CMS proposes that physicians would continue to bill the CPT code corresponding to the level of the E/M visit, but that Medicare would pay the same rate under the PFS for any visit within levels 2 through 5, even if the visit was at the highest level of complexity. Consolidating E/M codes devalues the complexity of cancer care programs and could have a detrimental impact on patient care. Most cancer patients are seen at a level 4 or 5 E/M visit, and with a cut to reimbursement for these visits CMS is devaluing the complex care needed to treat these patients with multiple co-morbidities, likely treatment issues, and more.

To mitigate the effect of the proposed change to the base payment rates, CMS proposes to implement new add-on Healthcare Common Procedure Coding System (HCPCS) G-codes, which would be intended to compensate for some of the additional work performed in complex E/M visits by primary care physicians and certain specialties and for prolonged E/M service. Services such as care coordination, which are vital to treatment for cancer patients, are already under reimbursed, and proposals such as these would significantly alter the reimbursement landscape for oncology, and, in turn, directly devalue the level of care needed to address the often-complicated cases of cancer patients. CMS explains that these proposals are based on its desire to simplify the documentation requirements for billing these codes, which stakeholders

[3] 83 Fed. Reg. at 35,839-40.

have long viewed as unduly burdensome and outdated.[4] CMS also proposes to reduce payment by 50 percent for the least expensive service furnished by the same physician on the same day as a separately identifiable E/M visit.[5]

ACCC has serious concerns about the proposals to consolidate payment for E/M codes, establish new add-on codes, and reduce payment for other services furnished on the same day as an E/M service, and we urge CMS not to implement the proposed changes for CY 2019. We offer more detailed comments on these proposals below.

A. The proposed reductions in payment for complex E/M visits would have a significant financial impact on physician practices, even after accounting for payment for the add-on G-codes.

Our analysis of the proposal to consolidate payment for more complex E/M services shows that the proposal would have a significant negative financial impact on physician practices, and we urge CMS not to finalize this proposal. Paying the same rate for visits at four levels of complexity would devalue the E/M services provided by cancer centers and physicians in other complex specialties, and effectively would result in up to a 10 percent reduction in reimbursement for many physician practices.

It is inevitable that such a large reduction in payment would have a harmful impact on patient access to care. Effective cancer care relies on careful management of each patient's treatment, which usually means patient visits involving detailed consultation and evaluation of the patient's cancer and other health conditions, treatment results and options; shared decision making; and coordination of care with other providers. The proposed payment reduction for complex E/M services would disproportionately harm cancer patients and other patients with complex conditions who get the greatest clinical benefit from adequate payment for those services.

The payment reductions would be exacerbated by CMS's proposal to reduce payment by 50 percent for procedures, including drug administration procedures, if the procedure is the least expensive service furnished by the same physician on the same day as a separately identifiable E/M visit.[6] CMS explains that this 50 percent reduction in payment is intended to reflect "the efficiencies associated with furnishing an E/M visit in combination with a same-day procedure." But the fact that the physician is billing the E/M visit separately in the first place indicates that the E/M visit and the other procedure are separate services, each of which requires the physician to perform the work and incur the costs associated with each of those services, and that there are few, if any, efficiencies to achieve in furnishing these services on the same day. CMS should not finalize this proposal.

[4] *Id.* at 35,839.
[5] *Id*. at 35,841.
[6] *Id*.

The effects of the proposed change in Medicare policy would be compounded by the follow-on impact with private payers, and we urge CMS to study this impact before finalizing any change to E/M payment or coding policy. In many cases, the RVUs adopted by Medicare for E/M codes are pulled directly by private payers under their contracts with providers, meaning that CMS would be cutting reimbursement for complex E/M services not just for Medicare beneficiaries but for many privately insured patients as well. CMS indicated on an August 22, 2018, call with stakeholders that the agency did not consider the impact of its proposal with respect to private payers, and the Proposed Rule does not address any such impact.

We do not believe that the proposed add-on G-codes would be sufficient to make up for the significant reductions that physicians would experience as a result of the Proposed Rule. Indeed, our projections show that CMS significantly underestimates the effective reimbursement reduction for more complex visits. While CMS estimates a reduction of only 1 to 2 percent, we are aware of some models projecting more than a 10 percent reduction for hematology and oncology-specific services, including chemotherapy administration, even after accounting for the impact of the proposed add-on codes. Similar to CMS's proposal to cut drug administration payments further, the reductions to payment for complex E/M visits could force some physician practices to stop providing cancer care, driving Medicare beneficiaries to larger hospitals farther from where they live. The cut in E/M payments then will put a financial squeeze on hospitals, which already serve a higher than average share of Medicare beneficiaries. The add-on G-codes also likely will not fully mitigate the follow-on impact with private payers, because those payers do not always fully or cleanly adopt changes in CMS policy, and it is possible that a payer would use the new E/M RVUs without also adopting the add-on G-codes.

B. The proposed reductions in payment for complex E/M visits would discourage use of preventive services and improved coordination of care and would undermine physician participation in value-based payment initiatives.

The proposed consolidation of payment for E/M visits also conflicts with CMS's goals of promoting better health care for beneficiaries and better financial health for the Medicare program. Reducing reimbursement for physicians' time and cognitive skills simply makes them more dependent on procedures and takes away from the complex care cancer patients often require. The proposal devalues lower-cost preventive and management services in favor of expensive procedures down the road, which flies in the face of CMS's longstanding effort to promote effective coordination of care, value-based payment, and preventive treatment. If CMS wants to promote the financial health of the program as well as beneficiaries' health, it should pay more for complex E/M services, not less.

Similarly, the proposed changes in payment for E/M services would be destabilizing for participants in the OCM and other alternative payment models. As we discussed above, many ACCC members participate in the OCM. E/M services are a core component of all cancer care

and are particularly important to understanding the patient's response to therapy and changing needs over the course of treatment. OCM participants invest in the resources needed to participate successfully in the program based, in part, on the type and frequency of E/M services they expect to provide to their patients. Changing the reimbursement model, including new payment rates and implementation of new codes, in the middle of the OCM would be destabilizing for these practices and could confound measurement of their performance.

C. CMS should study the impact of the proposals further and make appropriate refinements before implementing any change to payment for E/M services.

To avoid the serious consequences of a reduction in payment for complex E/M services, we urge CMS not to implement the proposed changes for CY 2019. Instead, CMS should continue to evaluate the potential impact of the proposed changes during the CY 2020 rulemaking cycle. This impact analysis should include a review of all the considerations addressed above, including whether the proposal disproportionately impacts certain specialties, the likely impact of follow-on changes among private payers and how to mitigate that impact, and how to structure a system of add-on G-codes or another means of ensuring adequate reimbursement for more complex E/M visits despite the reduction in base payment rates.

Any proposal to establish add-on G-codes to mitigate reductions in payment should include clear definitions for those G-codes and provide clear guidance on when physicians may report each G-code. We are concerned that the Proposed Rule does not adequately explain which physicians may use the proposed add-on G-codes and under what conditions – and this would adversely impact the patient at the end of the day. For example, CMS indicates that the proposed G-code for primary care services can be used for essentially every primary care-focused E/M visit for an established patient, but the agency also states that the code also could be reported "for other forms of face-to-face care management, counseling, or treatment of acute or chronic conditions not accounted for by other coding."[7]

Similarly, the proposed G-code for specialty care services would be available for E/M services "associated with" a specified list of physician specialties, including hematology/oncology. But it is not clear from the Proposed Rule how CMS will determine whether an E/M service is "associated with" a particular specialty. The Proposed Rule also suggests that physicians could bill multiple add-on G-codes for the same visit, but the Proposed Rule does not include clear guidance on when it would be appropriate to do so, and in fact allowing physicians to bill multiple add-on G-codes could make the proposal non-budget-neutral.

ACCC is concerned that the absence of clear guidance on how the add-on G-codes may be used will make physicians hesitant to use them (and therefore unable to bridge the gap in reimbursement due the base rate cuts) or will create risk of negative audit findings and

[7] *Id.* at 35,842.

overpayments down the road if a physician misuses the codes. We urge CMS to issue clear guidance on the appropriate use of add-on G-codes as part of any future change in E/M coding.

D. CMS should continue to develop and pursue proposals to simplify documentation requirements and enhance physician flexibility in meeting those requirements.

Apart from the proposal to consolidate payment for more complex E/M services, ACCC appreciates and supports CMS's other proposals to simplify documentation requirements for E/M services. We believe the proposed changes would help to reduce the burden on physicians as they perform these critical patient management services. Our members appreciate CMS's emphasis on "patients over paperwork," but too often we do not see resulting changes in CMS policies.

We encourage CMS to work with ACCC and other stakeholders to reduce excessive documentation requirements even further, by offering maximum flexibility to physicians in how those requirements are met, both for initial payment and upon post-payment review. For example, physicians should be able to meet documentation requirements for E/M and other services with any supporting document available to the physician at the time of service, whether in an on-site medical record or in another medical record available through interoperable EHR. In addition, physicians should be able to support their claims for E/M and other services with documentation completed by the physician or by other non-physician practitioners, who often are responsible for furnishing and documenting such services under the supervision of a physician. When considering paperwork burdens on physicians, CMS also should consider how best to align its documentation requirements with similar requirements of accreditation and other organizations, such as the Quality Oncology Practice Initiative (QOPI) and Commission on Cancer (CoC) Oncology Medical Home accreditation program.

III. CMS should finalize its proposals to establish separate payment for communication technology-based services.

ACCC strongly supports CMS's proposal to pay separately for health care services provided via communication technologies, which can facilitate timely access to health care, save money for beneficiaries and the Medicare program, and promote effective coordination of care. Accordingly, we support CMS's proposals in the Proposed Rule to pay separately for the following codes:

- Proposed HCPCS code GVCI1 (Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related [evaluation & management (E/M)] service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5–10 minutes of medical discussion).

- Proposed HCPCS code GRAS1 (Remote evaluation of recorded video and/or images submitted by the patient (e.g., store and forward), including interpretation with verbal follow-up with the patient within 24 business hours, not originating from a related E/M service or procedure within the next 24 hours or soonest available appointment).
- Interprofessional internet consultation codes
    - 994X6 (Interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 or more minutes of medical consultative time),
    - 994X0 (Interprofessional telephone/internet/electronic health record referral service(s) provide by a treating/requesting physician or qualified health care professional, 30 minutes),
    - 99446 (Interprofessional telephone/internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5–10 minutes of medical discussion),
    - 99447 (Interprofessional telephone/internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 11─20 minutes of medical discussion),
    - 99448 (Interprofessional telephone/internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 21─30 minutes of medical discussion), and
    - 99449 (Interprofessional telephone/internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 31 minutes or more of medical discussion).[8]
- 990X0 (Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment).
- 990X1 (Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days).
- 994X9 (Remote physiological monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month).[9]

Providing separate payment for these services will help to support physicians' efforts to improve communication with their patients and with other professionals treating the patient and will help

[8] *Id.* at 35,723-25.
[9] *Id*. at 35,771.

to improve the quality of care provided. We urge CMS to finalize these proposals and to continue seeking new ways to facilitate and pay for health care services provided via communication technologies.

IV. CMS should not finalize its proposal to drastically reduce reimbursement for SBRT and other services based on reductions to direct PE inputs that are not adequately explained or documented by CMS or its contractor.

ACCC is deeply concerned about CMS's proposal to reduce the direct PE inputs for numerous services using a "market research study" of prices for supplies and equipment developed by CMS's contractor, StrategyGen.[10] CMS proposes to adopt the new inputs based on the prices identified in StrategyGen's report without providing any information about how these prices were determined. We strongly oppose CMS's adoption of the prices in the report and the severe reductions in reimbursement that they would cause if the proposed PE inputs are implemented. In particular, we are deeply concerned about CMS's proposal to reduce the price of equipment input ER083, "SRS [stereotactic radiosurgery] system, SBRT [stereotactic body radiation therapy], six systems, average" by 77 percent, from the current CMS price of $4,000,000 to StrategyGen's price of $931,965.479 when fully implemented. CMS proposes a four-year phase-in for these new inputs, but the reduction for the first year alone would contribute to a 22 percent reduction in payment for code 77373 (Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions).

CMS has not provided enough information to allow for meaningful comment on the proposed input. We acknowledge that Social Security Act (SSA) section 1848(c)(2)(M)(i) and (ii) allows CMS to collect "information on the resources directly or indirectly related to furnishing services for which payment is made" under the PFS from "any eligible professional or any other source," and to use that information "in the determination of relative values." However, if CMS chooses to use such information, the SSA also requires the agency to "disclose the information source and discuss the use of such information in such determination of relative values through notice and comment rulemaking." Congress required this transparency to ensure that the pricing data CMS uses to set Medicare payment rates accurately reflect the market price for that input.

The information CMS provides in the Proposed Rule is not sufficient to meet the statutory obligation. Although CMS summarizes StrategyGen's methods and makes the StrategyGen report available on its website, none of these materials actually provides any evidence or explanation to support the proposed price for ER083. The report itself states only that the price is based on the "researched commercial price," without disclosing or explaining what this "researched commercial price" is, the source of the price, the name of the equipment supposedly sold at that price, the vendor whose price is quoted, or the date on which that price

[10] *Id.* at 35,719-20.

was offered.[11] The report does not name the equipment whose prices StrategyGen reviewed, leaving stakeholders to guess whether StrategyGen analyzed prices for multiple types of equipment or only one, and whether prices for relevant equipment may have been left out of StrategyGen's analysis. In contrast, when CMS considered updating the price of this input in the CY 2012 rulemaking cycle, it listed the specific invoices it had received and the reasons the agency chose not to rely on them, including CMS's concern that the invoices "included line items that [CMS] would not accept as part of the cost of the equipment."[12] CMS must adhere to the same rigorous standard of transparency in explaining why it would rely on the prices in the report.

Transparency is all the more important in this case because the price recommended by StrategyGen quite simply does not reflect the market price for this input. We understand that the price recommended in the StrategyGen report does not come anywhere close to the market price of any SRS system currently available. Indeed, the StrategyGen recommended price is closer to the price of an upgrade to an existing system than the six-system average for a new system. CMS should not use the StrategyGen recommended price for this input, and it should not revise the price of this input without the source of the recommended price making fully transparent to stakeholders.

V. CMS should continue to implement the Quality Payment Program (QPP) in a manner that promotes physician flexibility, fair and effective measurement of physician performance, and robust participation.

ACCC thanks CMS for its detailed proposals to continue implementation of the QPP, including the Merit-Based Incentive Payment System (MIPS), and we look forward to working with CMS to ensure that the QPP creates effective incentives to improve quality of care and reduce unnecessary costs while ensuring adequate reimbursement and patient access to treatment. We offer the following specific comments on the Proposed Rule for CY 2019:

A. Gradual Implementation of Cost Scoring and Further Development of Episode-Based Cost Measures

ACCC supports CMS's general approach of gradually implementing the cost performance category. We believe it is critical that CMS limit the weight of the cost performance category, as Congress has authorized for the first five years of MIPS, until the agency has developed a fair and accurate methodology for assessing that cost for each clinician. ACCC continues to believe that eligible clinicians should be rewarded or penalized only for those costs that they are in a position to control. This is consistent with the intent of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to promote more cost-

[11] StrategyGen Co., Direct Practice Expense Input Market Research Report, Attachment B – DPEI Report Attached Table B (July 23, 2018).
[12] 76 Fed. Reg. 73026, 73214 (Nov. 28, 2011).

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.

In particular, we encourage CMS to ensure fair beneficiary attribution for overall cost measures by attributing 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.

We also urge CMS to continue developing 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. We look forward to working with CMS to develop such measures in the coming months. Similarly, we urge CMS to consider the variability of costs between specialties by incorporating appropriate 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.

B. Proposed Changes to Promoting Interoperability Performance Category

CMS proposes several changes to the promoting interoperability performance category. Most notably, CMS proposes to simplify the reporting requirements and scoring methodology to offer clinicians greater flexibility in achieving a high score for the category. As part of this proposal, CMS emphasizes its desire to align the MIPS promoting interoperability category with the Medicare Promoting Interoperability Program for eligible hospitals and critical access hospitals, and with the overarching goal of providing flexibility to eligible clinicians under the

QPP.[13] ACCC endorses CMS's proposals and appreciates the agency's ongoing efforts to allow eligible clinicians multiple paths to achieving strong performance under MIPS and the QPP. In particular, we are grateful for CMS's effort to align the requirements of different CMS programs and initiatives, which reduces unnecessary burden for clinicians and allows them to keep their focus on delivering high-quality care to patients.

C. Maintaining a Robust Pool of Eligible Clinicians

CMS proposes a further expansion of the exclusion from the QPP for clinicians with a low volume of Medicare patients, and maintains other exclusions and special scoring rules for other categories of eligible clinicians that it adopted in previous rulemaking. ACCC appreciates and supports the continued exemption of clinicians who do not see Medicare patients or for whom there are other compelling reasons why Congress would not have expected the QPP to apply. However, we also recognize that the QPP requires a robust pool of eligible clinicians to participate in order for the system of positive and negative incentives to be effective. We encourage CMS, in this and future rulemaking, to tailor exclusions and special scoring rules narrowly to achieve a specific purpose that is consistent with Congress's and CMS's overall effort to promote high-quality and cost-efficient care among all Medicare-participating physicians.

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ACCC greatly appreciates the opportunity to comment on the PFS Proposed Rule. ACCC reiterates its commitment to promoting access to effective cancer treatments for all Medicare beneficiaries who need them. If you have any questions about our comment letter or would like to discuss in further detail, please contact Blair Burnett, Senior Policy Analyst, ACCC, at (301) 984-9496, ext. 213.

Respectfully submitted,

Thomas A. Gallo, MS, MDA
President, Association of Community Cancer Centers

[13] 83 Fed. Reg. at 35,914.