CANCER LEADERSHIP COUNCIL

A PATIENT-CENTERED FORUM OF NATIONAL ADVOCACY ORGANIZATIONS ADDRESSING PUBLIC POLICY ISSUES IN CANCER

June 27, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-5517-P, Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models

Dear Mr. Slavitt:

The undersigned cancer organizations are writing to comment on the proposed rule implementing the Medicare Access and CHIP Reauthorization Act (MACRA) provisions related to a new Merit-based Incentive Payment System (MIPS), Alternative Payment Models (APMs), and Physician-Focused Payment Model Technical Advisory Committee (PTAC). In our comments, we address issues and recommend strategies for MIPS, APM, and PTAC implementation that will "support health care that is patient-centered, evidence-based, outcome driven, efficient, and equitable."[1] We will not concentrate on technical issues related to MIPS reporting but instead will highlight issues of interest to patients and the best approach in MIPS and APMs to encourage patient-centered care.

List of Quality Measures for MIPS Assessment

The proposed rule for implementing MACRA establishes an annual process for submission, evaluation, and publication of quality measures that is generally an open process capitalizing on the expertise of physicians, physician organizations, and other stakeholders. The elimination of the requirement that submitted measures have been reviewed by a measures-endorsing organization encourages a more open process for measure submission.

However, MACRA did not reflect the possibility that "other stakeholders" would include patients and patient advocates who can provide special insights about measurement of 1) patient experience and satisfaction and 2) care planning and coordination, among other elements of

[1] Proposed Rule, Medicare Program, 81 Fed. Reg. 28184, May 9, 2016.

care. The proposed rule generally reflects the fact that MACRA does not specifically reference patient advocates as stakeholders who can advise on quality measurement.

We urge that CMS, in addition to issuing the annual call for quality measures, consider procedures for engagement with patients and patient organizations capable of advising on quality measures. The undersigned organizations are engaged in collaborative efforts to strengthen their understanding of and involvement in quality measurement activities. We believe that a more direct engagement with patients and patient organizations on quality measure submission would in turn strengthen the MIPS measures and ensure that they have adequate focus on patient experience and satisfaction and care coordination and planning.

Choice of Measures for Reporting

Physicians have voiced objections about the reporting requirements of the Physician Quality Reporting System (PQRS), and the MIPS quality reporting standards provide eligible clinicians and groups more flexibility in reporting than they experienced in PQRS. The proposed rule provides that MIPS eligible physicians would report "on at least six measures including at least one cross-cutting measure and at least one outcome measure or, if an outcome measure is unavailable, report another high priority measure (appropriate use, patient safety, efficiency, patient experience, and care coordination measure)."

We support the CMS effort to balance meaningful quality reporting against the burden that reporting represents for eligible clinicians, and we do not object to the reduction in the number of measures to be reported and other flexibility afforded to clinicians. However, we note that the cross-cutting measures that are identified in the proposed rule for use in 2017 are for the most part process measures that do not seem to meet the standard of being truly "cross-cutting." The exceptions are one intermediate outcome measure and one patient engagement/experience measure. The latter is the CAHPS for MIPS Clinician/Group Survey.

Although we appreciate the need for quality reporting flexibility in 2017, we suggest that CMS give serious consideration to classifying the CAHPS for MIPS survey as the cross-cutting measure for reporting in the calendar year. This is one means for ensuring reporting on a cross-cutting measure that is meaningful for patients.

Qualified Clinical Data Registries

Qualified Clinical Data Registries (QCDRs) are given a special role in the transition from a volume-based payment system to a value-based system. The Secretary is required by law to encourage eligible clinicians to use QCDRs to report with respect to quality measures. In addition, the proposed rule would expand the role of QCDRs by giving them responsibility for engagement not only in quality measure reporting but also in reporting on clinical practice improvement activities (CPIA) or advancing care information.

QCDRs may also play an important role in the transition to a value-based system as they provide feedback to clinicians about their performance. These entities will also have responsibility for providing benchmarking data that will permit clinicians to compare their performance to the performance of other clinicians. We see potential advantages associated with the role of QCDRs

in the MIPS program and generally in achieving the goals of MACRA but offer cautions about certain aspects of QCDR utilization.

QCDRs will be permitted to use quality measures that are not on the MIPS quality measures list. These measures must be approved by CMS in the process of approving a QCDR. In the preamble to the proposed rule, the agency discusses the scrutiny that it will apply to non-MIPS measures. CMS states that it will discourage QCDRs from using documentation or "check box" measures. We support the CMS approach to non-MIPS measures, including the caution about "check box" measures. We are concerned that measurement of cancer care planning, for example, could become a check box measure. Instead, we urge that care planning measures be developed as patient engagement/experience measures that would capture whether care planning incorporates shared decision-making.

Clinical Practice Improvement Activities

We were pleased that MACRA included clinical practice improvement activities among the elements that would be assessed in the MIPS score. Through our engagement in discussions related to the design of the Oncology Care Model, we saw the potential of that payment model to foster practice improvements that might boost cancer care quality and patient satisfaction. We also came to understand that improving clinical practice requires investment of money, staff, and time to change the processes and procedures of oncology practice. In our input related to the Oncology Care Model, we recommended that the per patient per month payment be a "generous" payment that would permit the requisite investment in clinical practice improvement. The final design of the Oncology Care Model – although still to be implemented and evaluated – holds promise of encouraging clinical practice improvement.

We are concerned that clinical practice improvement activities emphasized by MACRA will not be successfully implemented under the MIPS system that is outlined in the proposed rule. Clinical practice improvement activities will account for only 15 percent of the total MIPS score in year one. We suggest that serious consideration be given to putting more emphasis on these activities in the total MIPS score, to create a more significant incentive and reward for clinical practice improvement.

Alternative Payment Models

As we indicated above, cancer organizations appreciated the opportunity to be involved in deliberations regarding the design of the Oncology Care Model, and we are pleased that the Oncology Care Model is among those models that may qualify as Advanced APMs. Of course, it is also anticipated that additional physician-focused payment models will be proposed and evaluated for implementation. The proposed rule describes the procedures that the Physician-Focused Payment Model Technical Advisory Committee (PTAC) shall follow in considering proposed alternative payment models, consistent with the provisions of MACRA.

We suggest that additional means be considered for the PTAC to receive advice and feedback from a wide variety of stakeholders regarding proposed alternative payment models. It is anticipated that alternative payment models will be proposed by physician organizations including professional societies, but we encourage PTAC processes and procedures to solicit the advice from additional stakeholders, including patients and patient advocates, regarding the

design and potential benefits of alternative models. The relatively open and collaborative process that the Centers for Medicare & Medicaid Services (CMS) adopted with regard to the development of the Oncology Care Model might be replicated for development of alternative models under MACRA. We believe PTAC procedures for consultation with patients and patient advocates could be defined, consistent with the MACRA statute.

Cost as MIPS Performance Category

In the proposed rule, the drafters note the need to ensure that the MIPS program and the APMs that will be proposed, evaluated, and implemented will foster appropriate utilization of health care resources. For cancer patients who are benefiting from cancer research advances that are increasingly targeted or personalized, appropriate utilization requires proper diagnosis and targeting of care.

We are concerned that annual increases in the weighting of cost as a MIPS performance category could have an adverse impact on patient access to appropriate care. Instead of increasing the weighting of cost, the emphasis should remain on the elements of MIPS and APMS that protect against both under-utilization and over-utilization and instead encourage proper utilization of health care resources. For cancer patients, that would mean care that is targeted according to diagnosis, including molecular diagnosis, and the measurement of delivery of such care.

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We appreciate the opportunity to comment on the proposed rule implementing MACRA and look forward to continued engagement with CMS on physician payment issues.

Sincerely,

Cancer Leadership Council

Cancer Support Community
Fight Colorectal Cancer
International Myeloma Foundation
Kidney Cancer Association
The Leukemia & Lymphoma Society
LIVE**STRONG** Foundation
Lymphoma Research Foundation
National Coalition for Cancer Survivorship
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Ovarian Cancer Research Fund Alliance
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