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June 24, 2016

The Honorable Andy Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

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

The National Comprehensive Cancer Network® (NCCN®) is pleased to comment on the CMS proposal for implementing a MIPS and APM incentive under the Medicare Physician Fee Schedule as well as on the proposal for criteria for physician-focused payment models.

As an alliance of 27 leading academic cancer centers in the United States that treat hundreds of thousands of cancer patients annually, NCCN is a developer of authoritative information regarding cancer prevention, screening, diagnosis, treatment, and supportive care that is widely used by clinical professionals. NCCN Clinical Practice Guidelines in Oncology® (NCCN Guidelines®) represent the standard of care for clinicians and policy makers. The NCCN Guidelines® and their derivatives help ensure access to appropriate care, clinical decision making, and assessment of quality improvement initiatives.

We applaud the Centers for Medicare and Medicaid Services' (CMS) commitments to:

- Drive continued quality of care process and improvement
- Incentivize clinician payment based on quality and value of care over quantity of services
- Provide timely and actionable feedback to guide improvement
- Improve data availability and enable the use of certified EHR technology (CEHRT) to support care delivery in a consistent fashion across the health care system

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Cancer Center

Case Comprehensive Cancer  
Center/University Hospitals  
Seidman Cancer Center and  
Cleveland Clinic Taussig  
Cancer Institute

City of Hope Comprehensive  
Cancer Center

Dana-Farber/Brigham and  
Women's Cancer Center  
Massachusetts General Hospital  
Cancer Center

Duke Cancer Institute

Fox Chase Cancer Center

Huntsman Cancer Institute  
at the University of Utah

Fred Hutchinson Cancer  
Research Center/  
Seattle Cancer Care Alliance

The Sidney Kimmel  
Comprehensive Cancer  
Center at Johns Hopkins

Robert H. Lurie Comprehensive  
Cancer Center of Northwestern  
University

Mayo Clinic Cancer Center

Memorial Sloan Kettering  
Cancer Center

Moffitt Cancer Center

The Ohio State University  
Comprehensive Cancer Center -  
James Cancer Hospital and  
Solove Research Institute

Roswell Park Cancer Institute

Siteman Cancer Center  
at Barnes-Jewish Hospital  
and Washington University  
School of Medicine

St. Jude Children's  
Research Hospital/  
The University of Tennessee  
Health Science Center

Stanford Cancer Institute

University of Alabama at  
Birmingham Comprehensive  
Cancer Center

UC San Diego  
Moore's Cancer Center

UCSF Helen Diller Family  
Comprehensive Cancer Center

University of Colorado  
Cancer Center

University of Michigan  
Comprehensive Cancer Center

The University of Texas  
MD Anderson Cancer Center

University of Wisconsin  
Carbone Cancer Center

Vanderbilt-Ingram  
Cancer Center

Yale Cancer Center/  
Smilow Cancer Hospital

Regarding the final bullet point, we wish to point out that NCCN recently responded to the Office of the National Coordinator for Health Information Technology's (ONC) Request for Information Regarding Assessing Interoperability for MACRA. CMS may view NCCN's letter regarding interoperability support and efforts underway at: <http://www.regulations.gov/#!documentDetail;D=HHS-ONC-2016-0008-0028>

### **Quality Data Submission Performance Category**

CMS requests comment on the applicability of specific measures under specialty-specific measure sets. **NCCN believes there is room to add additional quality measure options that address outcomes and performance gaps in cancer care and would be pleased to discuss specific ideas with the CMS.** Furthermore, CMS seeks comment on a proposal to allow reporting of specialty-specific measure sets to meet the quality category submission criteria. **NCCN believes specialists should select and report on the measures most relevant and feasible to them. NCCN also supports the proposal that non-patient-facing clinicians have the option to report on a specialty-specific measures set, have the option to report non-MIPS measures through a QCDR and would not be required to report any cross-cutting measures.**

For group practices reporting MIPS, CMS proposes ending the required CAHPS survey for groups of 100 or more eligible clinicians and instead make it optional with bonus points for participation. **NCCN supports efforts to continuously improve patient experience.** Understanding the patient experience is highly important in care delivery, particularly in cancer care, since patients often face many treatment options and transitions across settings.

Section 1848(q)(2)(C)(ii) of the Act provides that the Secretary may use measures used for payment systems other than for physicians, such as measures used for inpatient hospitals, for purposes of the quality and resource use MIPS performance categories. The Secretary may not, however, use measures for hospital outpatient departments, except in the case of items and services furnished by emergency physicians, radiologists, and anesthesiologists. **NCCN believes that providers who are MIPS eligible clinicians, and work primarily in either an outpatient or inpatient site - or both, as cancer care providers often do - should have the ability to choose the measures most relevant to them.**

Section 1848(q)(2)(D)(iv) of the Act, requires the Secretary to submit new measures for publication in applicable specialty-appropriate, peer-reviewed journals before including such measures in the final annual list of quality measures. **NCCN supports the peer review process.**

### **Resource Use Performance Category**

For the resource use performance category, CMS proposes including total per capita costs under Medicare Parts A and B. **NCCN encourages inclusion of Part D so the whole episode of care is reflected in the resource use calculation.** The emphasis on reducing costs under MIPS may inadvertently incentivize providers to inappropriately steer patients toward Part D drugs where possible to avoid inclusion of high Part B costs in their cost and resource use scores. This is of particular concern in cancer care, and this incentive needs to be balanced with a quality metric to ensure that patients are assessed and given the most appropriate drug to treat their condition, regardless of whether it is covered under the Part B or Part D benefit.

**Furthermore, NCCN asks CMS to explain how the resource use calculation will interact with the Medicare Part B Demonstration, such that no eligible clinician or group is inadvertently penalized.**

**NCCN supports CMS' proposal not to apply any resource use measures to non-patient facing MIPS eligible clinicians or groups.**

## **Advancing Care Information Performance Category**

Under the Advancing Care Information MIPS performance category, CMS proposes to require Eligible Professionals, Eligible Clinicians, Eligible Hospitals and Critical Access Hospitals attest that they have cooperated with ONC's CEHRT surveillance, that the CEHRT was connected in accordance with applicable standards, and that the provider used the CEHRT in a manner of good faith that supported and did not interfere with the exchange of health information with other providers and patients.

**NCCN wholeheartedly supports the objectives of patient electronic information access, coordination of care through patient engagement and health information exchange and interoperability set forth in the Advancing Care Information MIPS category.** In support of these objectives, NCCN encourages use of the NCCN Guidelines® and their derivatives for ensuring access to appropriate care, clinical decision making, and assessment of quality improvement initiatives. NCCN is enabling its content, including NCCN Guidelines® and derivative products, to permit ingestion into all types of technology for use by all stakeholders. As part of this effort, NCCN is transitioning its Guidelines and other clinical information products to database systems with properties linking concepts to controlled terminology sets to normalize information for analysis. NCCN is also exploring the use of the HL7 FHIR standard for provision of chemotherapy orders templates for use by a variety of EHR systems. The goal of these efforts is to help standardize cancer care information to the highest standards across all EHR technology in the patient care continuum.

**NCCN supports the proposal to assign a weight of zero for the Advancing Care Information category to those MIPS eligible clinicians who furnish 90 percent or more of his or her covered professional codes in inpatient hospitals.** We agree that often the health IT decisions in these cases are made at the hospital level and therefore the clinician has little control.

**That said, NCCN respectfully disagrees with CMS' statement that the Clinical Decision Support measure in the EHR Incentive Program no longer contributes meaningfully to Advancing Care Information objectives. NCCN requests that the Clinical Decision Support objective remain in the program.** Although this measure may have had historically high performance overall, it has not had consistently high performance across all provider specialties as not all providers across all specialties may have been participating in or reporting this measure under the current Medicare EHR Incentive Program. As CMS acknowledged on page 81 FR 28253, at this time "...it would be difficult to determine whether a measure is truly topped out or if only excellent performers are choosing to report the measure." Illustrating this point, according to a CMS report, only 2% of the Medicare EHR payments made between 2011-2013 were made to oncologists and hematologists.<sup>1</sup> Furthermore, according to the 2014 PQRS experience report, only 8% of oncologists, 2% of nuclear medicine physicians and radiation oncologists and 1% or less of interventional radiologists, radiologists and pathologists participated via EHR reporting.<sup>2</sup> These data show that there is room for increased EHR adoption in oncology care and opportunity for improved use of clinical decision support.

Aligned with the objective to enhance oncology clinical decision support, NCCN is currently digitizing its 62 guidelines, which include nearly 1,800 pages of decision support algorithm. This is an extremely important effort for empowering oncology care providers to make better care decisions and should be measurable at a local and national level.

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<sup>1</sup> EHR Incentive Programs Data Brief. November 2013.

[https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/downloads/databrief\\_november2013-.pdf](https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/downloads/databrief_november2013-.pdf). Accessed June 20, 2016

<sup>2</sup> 2014 PQRS Experience Report, Including Trends (2011-2015). <https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/pqrs/analysisandpayment.html>. Accessed June 20, 2016

### **Non-Patient-Facing MIPS Eligible Clinicians**

Section 1848(q)(5)(F) of the Act allows the Secretary to re-weight MIPS performance categories if there are not sufficient measures and activities applicable and available to each type of MIPS eligible clinicians, as such clinicians will not have sufficient measures and activities to report under MIPS. CMS proposes to define a non-patient-facing clinician for MIPS as an individual or group that bills 25 or fewer patient-facing encounters during a performance period. **As many NCCN Member Institution providers are specialists such as radiologists, pathologists, and nuclear medicine physicians, who are part of the care team but may or may not be directly involved in face-to-face patient care, we believe this is a reasonable definition.**

### **Excluded Physicians**

**NCCN supports the proposal to exclude new clinicians from the applicable MIPS performance period during which they first enrolled as a Medicare physician.** For example, a physician who enrolls in PECOS during 2017 would not participate in 2017 MIPS and therefore would not receive a MIPS adjustment in 2019 (under the current performance period proposal). **NCCN also supports the proposal to define low-volume clinicians excluded from MIPS as those with Medicare billing charges less than or equal to \$10,000 and provides care for 100 or fewer Part B-enrolled Medicare beneficiaries.**

**However, NCCN does not support excluding MIPS eligible clinicians who are participating in APMs from the first year of MIPS.** The way we interpret this proposal, MIPS eligible clinicians who are also participating in an APM, such as the Oncology Care Model (OCM), would have to report quality and other data separately to both OCM and MIPS. We believe separate reporting such as this to be burdensome and take clinician time and effort away from providing actual quality patient care rather than improving it. If our understanding of this proposal is incorrect, please clarify further in the Final Rule.

### **Group Reporting**

**NCCN supports continued group reporting option (i.e. single TIN) as well as the development of “virtual groups.”** In cancer care, where multidisciplinary care is the norm, a number of practitioners both in and outside the hospital and practice provide a single patient’s care using a share care model and can provide the best picture of quality of care provided to such patients than any one individual clinician or practice alone. **While we appreciate the technological and infrastructure challenges to incorporating virtual groups into MIPS at this time, we believe it can be done through the Qualified Clinical Data Registry (QCDR) reporting mechanism, in which multiple providers could report to one place on the quality of care furnished to the respective patients treated by the care team.** Furthermore, we believe that CMS’ and ONC’s commitments to interoperability and electronic data sharing should continue to further the feasibility of virtual group reporting through EHRs in the future.

### **Performance Period & Timeliness of Feedback**

CMS proposes that the MIPS performance period be the calendar year two years prior to the year in which a MIPS payment adjustment is applied. **While NCCN understands the time it takes to collect and process information needed to assess MIPS performance, we strongly urge CMS to provide feedback on each performance category, as feasible and applicable, more frequently (such as quarterly or biannually), such that providers can take more immediate action to drive quality of care improvement.** Feedback two years after a performance period may help guide improvement in treating future patients but is often too late for provider action on the specific patient cases on which

they had originally reported. **NCCN supports the recommendation for having a shorter time frame following the close of the performance period and/or having a submission period that occurs throughout the performance period, if such changes allowed for more timely provider feedback and did not impose additional provider reporting burden.**

### **Alternate Payment Models and Advanced APMs**

**NCCN agrees with CMS that a scoring standard for MIPS eligible clinicians participating in alternate payment models should reduce reporting burden by eliminating the need for such APM eligible clinicians to submit data both to MIPS and to their respective APM. Doing so would also prevent the same eligible clinicians from being assessed in multiple ways on the same performance activities.**

Section 1833(z) of the Act, as added by section 101(e)(2) of the MACRA, requires that an incentive payment be made to Qualifying APM Participants (QPs) for participation in eligible alternative payment models (referred to as Advanced APMs). **NCCN supports Advanced APMs as a way to further incentivize quality of care improvement and test new care models. However, NCCN believes the criteria to qualify as an Advanced APM, as set forth in the Notice of Proposed Rulemaking, leaves too narrow a pathway for clinicians, particularly specialists, to participate in such models. We encourage CMS to broaden the criteria and open Advanced APM participation to those providers willing to take on financial risk in the interest better value care.**

**NCCN further urges CMS to simplify the criteria for identifying partial QPs versus QPs so that providers are more clear on their respective reimbursement track.**

### **Physician-Focused Payment Models**

Section 1868(c)(2)(A) of the Act requires the establishment of a process that the Physician-Focused Payment Model Technical Advisory Committee (PTAC) could use in its assessment of future physician-focused payment models (PFPMs). **NCCN supports the criteria CMS has proposed for reviewing PFPM proposals, including value over volume, flexibility, quality and cost, payment methodology, scope, care delivery improvements, integration and coordination, patient choice, patient safety, information enhancements, and EHR technology. Additionally, NCCN recommends including two additional criteria: patient access and experience.** Although, these models are physician-focused, the patient is still the end recipient of care delivered. As such, evaluation of PFPMs must ensure that patient access of and experience with care are improved or, at a minimum, not inadvertently worsened under such models.

We again appreciate the opportunity to respond to the MIPS and APMs Incentive Under the Physician Fee Schedule, and Criteria for PFPMs and would welcome further discussions with ONC on how we may partner to achieve greater patient care and outcomes.

Sincerely,



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