December 19, 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-C, 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 final rule with comment period 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 patients with cancer 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.

As noted in our June 2016 comment letter regarding the MIPS proposal, we applaud the 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

In the MIPS and APM Final Rule with Comment Period, CMS requests additional feedback and input for future rulemaking, including several topics in which NCCN had previously commented.

Virtual Groups

CMS intends to implement “virtual groups” (e.g. multiple Taxpayer Identification Numbers (TINs) considered as one group) for the 2018 calendar year performance period and has requested input on implementation of such groups in MIPS.

As noted in our June 2016 comment letter, NCCN supports virtual group reporting. In cancer care, where multidisciplinary care is the norm, a number of practitioners both in and outside the
hospital and practice provide a patient’s care. This shared care model can provide the best
tpicture of quality of care provided to such patients than any one individual clinician or practice
alone. We believe virtual group reporting can be done through the Qualified Clinical Data
Registry (QCDR) 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.

MIPS Scoring
CMS seeks comment on factors to consider regarding:
• Approaches for non-outcomes measures that cannot be scored (measures that are below
the case minimum, lack a benchmark, or don’t meet data completeness standards)
• Alternative approaches to establishing measure benchmarks and handling topped out
measures
• Stratifying measure benchmarks by practice size in Year 2
If a measure cannot be scored, we believe individual consideration should be given for the
factors making it non-scorable, consistent with CMS’ phased in approach to MIPS participation.
For example, if it is a provider’s first year reporting, perhaps some credit can be given for
attempting to report. Regarding measure benchmarks for topped out measures, NCCN believes
consideration to provider specialty and patient case mix should be considered. For instance, a
measure’s performance could be topped out amongst primary care providers, but perhaps there is
still room for improvement in cancer care. We believe stratifying measure benchmarks are a
good idea, but group size should not be the only factor. Adjustment for case mix, severity of
patients and socioeconomic status should also be considered.

Non-Patient Facing Clinicians
Non-patient facing is a term CMS uses when referring to clinicians that do not have face-to-face
encounters with patients. CMS requests comment on alternative terminology for referencing
such clinicians as well as additional comments on the criteria for designating a group as non-
patient facing.

CMS finalized its definition of “non-patient facing clinician” as an individual MIPS eligible
clinician that bills 100 or fewer patient-facing encounters, as opposed to the proposed 25 or
fewer patient-facing encounters. (For a group, 75% of clinicians must meet the definition of
non-patient facing clinician.) CMS provided an illustrative list of specific types of clinicians
that would be deemed “non-patient facing”:
• Pathologists who may be primarily dedicated to working with local hospitals to identify
early indicators related to evolving infectious diseases;
• Radiologists who primarily provide consultative support back to a referring physician or
provide image interpretation and diagnosis versus therapy;
• Nuclear medicine physicians who play an indirect role in patient care, for example as a
consultant to another physician in proper dose administration; or
• Anesthesiologists who are primarily providing supervision oversight to Certified
Registered Nurse Anesthetists.
As many cancer care providers are specialists such as the ones listed above, who are part of the care team but may or may not be directly involved in face-to-face patient care, we believe CMS' definition of "non-patient facing" to be reasonable, as mentioned in our June 2016 comment letter. Furthermore, we think the term "non-patient facing" is sufficient for use in referencing such clinicians. NCCN also recommends inclusion of non-patient facing clinicians as part of virtual groups. That is, a virtual group may consist of both patient-facing and non-patient facing clinicians. For example, a cancer care virtual group may include medical oncologists, surgeons, pathologists and radiologists.

**Low-Volume Threshold**

For the transition year, the low-volume threshold excludes Medicare Part B clinicians with less than or equal to $30,000 a year in allowed charges or who see 100 or fewer patients. CMS requests comment on approaches for clinicians that are excluded to opt-in and be subject to a payment adjustment.

NCCN supports the low-volume threshold exclusion, as well as encouraging those clinicians to electively participate in MIPS to signal their commitment to high quality care. We believe such clinicians could self-nominate to CMS via letter in the same manner group practices have under the PQRS.

**Quality Performance Category**

CMS requests comment on factors for consideration for cross-cutting measures for future years. Cross-cutting measures are defined as any measures that are broadly applicable across multiple clinical settings and eligible clinicians, both individually and in a group, within a variety of specialties.

NCCN agrees with commenter recommendations that CMS continue to work externally with stakeholders to develop cross-cutting measures for patient-facing and non-patient facing clinicians, as well as measures that are multidisciplinary, foster cross-collaboration within virtual groups, and improve patient outcomes and patient experience. Furthermore, we would like to see measures that are reflective and inclusive of incorporation of individual patient preferences in shared decision-making. As stated in our June comment letter, NCCN would also like to reiterate we believe 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. That said, NCCN also supports a more streamlined and timely process for CMS review and proposal of measures under consideration, so that MIPS quality measurement can include and reflect the most clinically relevant, patient-centric, and outcomes-based measures in a more-timely manner.

**Advancing Care Information Performance Category**

CMS seeks comment on improvement activities’ bonus for the Advancing Care Information Category; threshold for group reporting; and scoring policies and measures and data submission mechanisms for future years.
As stated in our June 2016 comment letter, 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 data base 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 CMS policy to assign a weight of zero for the Advancing Care Information category to those MIPS eligible clinicians who furnish 75 percent or more of his or her covered professional codes in hospital settings. We agree that often the health IT decisions in these cases are made at the hospital level and, therefore, the clinician has little control.

We do request, however, that CMS provides consideration by specialty for the Advancing Care Information objectives. For instance, NCCN disagreed with the CMS proposal to retire the Clinical Decision Support measure in the EHR Incentive Program, due to it being topped out. As explained in our previous comment letter, 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.

Sincerely,

Robert W. Carlson, MD  
Chief Executive Officer