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August 15, 2017

The Honorable Seema Verma
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-5522-P, Medicare Program; CY 2018 Updates to the Quality Payment Program

The National Comprehensive Cancer Network® (NCCN®) is pleased to comment on the CMS proposal for the calendar year 2018 Quality Payment Program (QPP) as it relates to NCCN's mission of improving the quality, effectiveness, and efficiency of cancer care so that patients can live better lives.

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. NCCN Guidelines are the recognized standard for clinical policy in cancer care and are the most thorough and frequently updated clinical practice guidelines available in any area of medicine.

Additionally, since 2008, CMS has recognized the NCCN Drugs & Biologics Compendium ([NCCN Compendium](#)®) as a mandated reference for establishment of coverage policy and coverage decisions regarding the use of drugs and biologics in cancer care, and in 2016 NCCN was recognized by CMS as a qualified provider-led entity (PLE) for the Medicare Appropriate Use Criteria (AUC) Program. Through this qualification, CMS recognizes NCCN as a group qualified to develop AUC and establish policy and decision-making for diagnostic imaging in patients with cancer. NCCN Imaging AUC™ are available free of charge to registered users of NCCN.org and can be accessed at NCCN.org/ImagingAUC.

As noted in our June and December 2016 comment letters regarding the QPP program, we applaud 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

Fred & Pamela Buffett
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

In the CY 2018 QPP Proposed Rule with Comment Period, CMS requests additional feedback and input for future rulemaking, including several topics in which NCCN has previously commented.

Potential Application of the Merit-Based Incentive Payment System (MIPS) Performance Payment Adjustments to Part B Drugs

For those participating in the Merit-based Incentive Payment System (MIPS), CMS proposes applying the MIPS performance payment adjustment to the reimbursement of Part B drugs and durable medical equipment (DME), in addition to traditional physician services. Specifically, CMS notes the following:

“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 or administration of Part B drugs that we are able to associate with a MIPS eligible clinician at an 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.”

NCCN respectfully disagrees and requests that CMS reverse this proposed policy. We believe the intention of the Medicare Access and CHIP Reauthorization Act (MACRA) was to improve physician performance and autonomy, not to fundamentally change the average sales price (ASP) methodology for reimbursement of Part B drugs. NCCN is concerned that providers receiving a negative MIPS payment adjustment will be unable to purchase Part B drugs, which will result in reduced patient access to lifesaving cancer treatments.

Advancing Care Information Performance Categories

In 2016, CMS recognized NCCN as a qualified provider-led entity (PLE) for the new Medicare Appropriate Use Criteria (AUC) Program for developing AUC and establishing policy and decision-making for diagnostic imaging in cancer patients. NCCN Imaging Appropriate Use Criteria Compendium (NCCN Imaging AUC Compendium™) support clinical decision-making around the use of imaging in patients with cancer by outlining all imaging procedures recommended in the NCCN Guidelines®, including radiographs, computed tomography (CT) scans, magnetic resonance imaging (MRI), functional nuclear medicine imaging (PET, SPECT), and ultrasound.

For the 2018 MIPS performance period, CMS proposes adding a new improvement activity that MIPS eligible clinicians could choose if they attest they are using AUC through a qualified clinical decision support mechanism for all advanced diagnostic imaging services ordered. **NCCN fully supports the proposed inclusion of the consultation of an AUC using clinical decision support when ordering advanced diagnostic imaging as a new proposed Improvement Activities (with a HIGH rating).** NCCN is committed to assuring that the most up-to-date recommendations are available and reviews and updates the NCCN Imaging AUC™

on a continual basis to ensure that the recommendations take into account the most current evidence.

Virtual Groups

CMS proposes to add Virtual Groups as a participation option for year 2, which would be composed of solo practitioners and groups of 10 or fewer eligible clinicians who come together “virtually” with at least one other such solo practitioner or group to participate in MIPS for a performance period of a year.

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 are responsible for providing a single patient’s care using a care coordination model and can provide the best picture of high-quality cancer care. 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 virtual 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 proposes to continue the 2017 performance year weighting for the MIPS composite score categories as follows:

- Quality: 60%
- Advancing Care Information: 25%
- Clinical Practice Improvement Activities: 15%
- Cost: 0%

While CMS proposes again not to weight the cost category, the agency seeks comment on whether the weighting for the cost category should be 10 percent for the 2018 performance year. **NCCN supports CMS’ consideration to give clinicians experience with the cost category being weighted before this category is weighted at 30 percent in 2019; however, NCCN recommends that CMS makes this a voluntary option for clinicians as opposed to mandatory.**

CMS also proposes to make adjustments for clinicians caring for complex patients for year 2. **NCCN supports this proposal, as we believe that consideration to provider specialty and patient case mix is important.**

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. **NCCN supports CMS maintaining the 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.**

As noted in both our June and December 2016 comment letters, since many cancer care providers are specialists 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. CMS proposes that for improvement activities for year 2, non-patient facing MIPS eligible clinicians, groups, and virtual groups can report fewer activities (2 medium or 1 high activity) and achieve a maximum improvement activities performance score. For advancing care information for year 2, CMS proposes that non-patient facing MIPS eligible clinicians, groups, and virtual groups qualify for the reweighting policy, which sets the performance category weight to zero and reallocates the points to other performance categories. **NCCN supports CMS's intent to reduce burden on physicians by limiting the requirements for both the improvement activities and advancing care information categories in the 2018 MIPS performance period for non-patient facing MIPS eligible clinicians, groups, and virtual groups.**

Low-Volume Threshold

CMS proposes for year 2 that the low-volume threshold excludes MIPS eligible clinicians or groups who bill less than or equal to \$90,000 in Part B allowed charges or who provide care for less than or equal to 200 Part B enrolled beneficiaries during the performance period or a prior period. Consistent with last year, CMS again maintains that individual MIPS eligible clinicians and groups who are excluded may voluntarily participate in MIPS, but would not be subject to the MIPS payment adjustments.

As noted in our December 2016 comment letter, 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 Physician Quality Reporting System (PQRS).

Optional Voluntary Facility-based Measurement

CMS proposes for year 2 to implement an optional voluntary facility-based scoring mechanism based on the Hospital Value Based Purchasing Program (Hospital VBP) for facility-based clinicians who have at least 75% of their covered professional services supplied in the inpatient hospital or emergency department setting.

NCCN supports CMS' proposal to implement facility-based measurement that assesses clinicians in the context of the facilities within which they work in order to better measure their quality, as well as to derive scores using the data at the facility where clinicians are treating the highest number of Medicare patients. NCCN believes this proposal creates a clear path forward for nuanced specialists to participate in MIPS and ensures that the metrics these clinicians are being measured against are relevant to the services they are rendering.

We again appreciate the opportunity to respond to the CY 2018 Updates to the Quality Payment Program. If you have any questions, we would welcome the chance to discuss our comments further on how we may work together to ensure access to high quality, high value care for patients with cancer.

Sincerely,

A handwritten signature in black ink, appearing to read "Robert W. Carlson".

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