



August 18, 2017

Ms. Seema Verma  
Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-5522-P  
P.O. Box 8011  
Baltimore, MD 21244-1850

**Re: [CMS-5522-P] Centers for Medicare & Medicaid Services Medicare Program; CY 2018  
Updates to the Quality Payment Program Proposed Rule**

The American College of Rheumatology (ACR), representing over 9,500 rheumatologists and health professionals, appreciates the opportunity to respond to the *Medicare Program; CY 2018 Updates to the Quality Payment Program Proposed Rule*. We welcome the chance to share our concerns on the impact these proposals will have on our ability to provide quality care to the 50 million Americans living with rheumatic diseases.

Rheumatologists provide ongoing care for Medicare beneficiaries with complex chronic and acute conditions that require specialized expertise. Rheumatologists provide face-to-face, primarily non-procedure-based care, and serve patients with serious conditions that can be difficult to diagnose and treat, including rheumatoid arthritis and other inflammatory arthritides, vasculitis, systemic lupus erythematosus, and multiple other debilitating diseases. Early and appropriate treatment by rheumatologists can control disease activity and prevent or slow disease progression, improve patient outcomes, and reduce the need for costly downstream procedures and care compared to care provided solely by primary care providers.

Overall, the American College of Rheumatology (ACR) appreciates many components of the proposed rule. Specifically, we applaud proposals to increase the threshold for Merit-Based Incentive Payments System (MIPS) exemptions, the extension of “Pick Your Pace” flexibility for another year and the delay of electronic health records (EHR) requirements. We are encouraged to see that the Centers for Medicare & Medicaid Services (CMS) have been listening to many concerns of the rheumatology community. We appreciate the opportunity to provide our input on CMS’s proposed rule. Please find our additional comments below.

**I. Executive Summary and Background**

The ACR applauds CMS for the many additional flexibilities and reduction in barriers that will further enhance the ability of small practices to participate successfully in the Quality Payment

Program (QPP). We are pleased to see CMS increase the low-volume threshold to less than or equal to \$90,000 in Medicare Part B allowed charges or less than or equal to 200 Medicare Part B patients as well as the addition of a significant hardship exception from the advancing care information performance category for MIPS eligible clinicians in small practices. The ACR supports flexibility for excluded eligible clinicians to opt into the MIPS program in future years. As the program becomes increasingly operational and greater clarity makes it easier to comply, these excluded eligible clinicians are in the best position to determine the timing of the transition to compliance. We suggest setting an outer limit date in order to provide a smooth transition.

### **Small Practices**

Though we believe it is important to provide bonus points to the final scores of MIPS eligible clinicians who are in small practice, we are asking that CMS allow small practices to be exempted from participation in the QPP. We recommend exempting practices with less than \$100,000 per physician in Medicare charges not including Part B drug costs; practices with 10 or fewer physicians; and rural physicians (practicing in an area with fewer than 100 physicians per 100,000 population). We further encourage CMS to consider exempting specialists who practice in zip codes or other geographic area with low per capita numbers of doctors in their specialty per population.

We continue to have serious and growing workforce concerns in rheumatology, and in order to ensure patient access it is important that soon-to-be retiring doctors who do not have EMR capability should be exempt from the QPP. Based on the 2015 ACR workforce study, baseline retirement for adult rheumatologists was predicted to be 50% and for pediatric rheumatologists was predicted to be 32%<sup>i</sup>. At a minimum, CMS should extend the small practice bonus to physicians who practice in rural areas.

Further, we ask that CMS clarify whether or not Part B drug costs are intended to be included in MIPS calculations. The sentence on line 3001 of the proposed rule: "For those billed Medicare Part B allowable charges relating to the purchasing and 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" has created confusion and warrants clarification.

## **II. Major Provisions for the Merit-based Incentive Payment System (MIPS)**

CMS is proposing a 3-year timeline for identifying and proposing to remove topped out measures. After a measure has been identified as topped out for three consecutive years, CMS may propose to remove the measure through comment and rulemaking for the 4th year. We urge CMS to retain topped out measures and at minimum implement a more systematic and transparent process if CMS insists on removing topped out measures.

CMS is also proposing to change the performance threshold from 3 points to 15 points. We are concerned that drastic fluctuations in threshold numbers could cause cliffs from year two to year three. We recommend caution when changing the performance threshold, making minimal increases at a time.

Additionally, the agency proposes to apply the MIPS payment adjustment factor, and if applicable, the additional MIPS payment adjustment factor, to the Medicare paid amount for items services under Part B and furnished by the MIPS eligible clinician during the year. We ask that CMS provide clarification on which Part B items, services, and facility charges specifically would be included.

The ACR continues to be highly concerned about the nature of Medicare Part B payments that are subject to MIPS payment adjustments. We urge CMS to exclude Part B medication costs from the cost performance category or include both Part D and Part B costs for a fair comparison. The calculation of resource use (i.e., costs) as currently proposed includes medication costs from Part B, but not Part D, which would result in inaccurate MIPS scoring. The ACR continues to advocate for minimizing this inaccuracy. We believe this is a departure from CMS' policy for applying payment adjustments for other programs like PQRS, meaningful use, and the value-based modifier. These programs applied payment adjustments to physician services, but did not apply them to drugs. However, the statute appears to require that CMS apply the adjustment to all Part B "items and services," which includes Part B drugs.

We also believe if MIPS adjustments are being made on very large amounts of money representing specialty drug costs, for which by law providers are reimbursed ASP + approximately 4.2%, then MIPS adjustment would very likely reduce reimbursement by more than the ASP + 4.2 (i.e., it could be -5%; in future years, -9%) and the adjustment could quickly bankrupt a practice. We encourage CMS to consider how this would reduce access to these treatments and increase patient transportation time, etc. We urge CMS to carefully examine their proposed rule along with the statute and provide clarity on this issue immediately.

Further, we ask that CMS more clearly define terms regarding supplier, physician, and DME, as this can be confusing. Physicians need to know if durable medical equipment (DME) (i.e. braces) will be attributed to the prescriber, or to the dispensing entity. In community practice, many rheumatologists dispense braces from their office for patient convenience and administrative simplification. We urge CMS to provide clarity on whether payments will be attributed to the cost of the brace/DME only if they buy and bill it from their office or even if they send a patient out to a brace shop with a prescription.

## **Quality**

The ACR applauds CMS for proposing to maintain a 60% weight for the quality performance category, contingent upon the proposal to reweight the cost performance category to zero for the 2020 MIPS payment year.

## **Improvement Activities**

We are pleased to see that CMS accepted all of ACR's feedback on rheumatology specialty measure sets for 2018. Specifically, our "Improving Patient Outcomes in RA: Disease Activity Measurement to Optimize Treating to Target" submission that will be encompassed under IA\_PSPA\_8 "Use of Patient Safety Tools" found on page 30497 in Table G: Proposed New Improvement Activities for the Quality Payment Program Year 2 and Future Years in the CY 2018 Updates to the Quality Payment Program Notice of Proposed Rulemaking. We also applaud CMS for including the improvement activity "*CDC Training on CDC's Guideline for Prescribing Opioids for Chronic Pain*" which we believe is highly relevant to rheumatology care as well as the current opioid abuse epidemic. We do have significant concerns regarding the "*Use of High-Risk Medications in the Elderly*" measure. The ACR believes this measure goes against the initial strategy of publishing the "Beers list", which was not to prescribe specific treatments on an individual basis; we urge CMS to remove this measure.

CMS has further proposed to modify certain specialty measure sets; we continue to assert that rheumatology does not have a true specialty-specific outcome measure, only hypertension (HTN). We believe this limits the ability of rheumatologists to achieve higher scores. Given the difficulty of developing outcome measures for rheumatology due to the large number of variables that affect outcomes in rheumatic diseases (many of which are out of the provider's control), we encourage CMS to award additional points for specialists that do not have multiple outcomes measures from which to choose. Additionally, daily reporting on the pain measures may be too onerous for rheumatologists, and we instead recommend CMS consider less frequent monitoring, such as every other or every third visit, or a certain percentage of visits.

One of the hallmarks of quality improvement is continuing medical education (CME). Education is fundamental to quality, and vital in order to advance our patients' care, rheumatologists ensure that this is part of our continued clinical training. The ACR strongly believes that CME should count as a qualifying improvement practice for purposes of the CPI calculation.

## **Advancing Care Information**

We applaud CMS for proposing that MIPS eligible clinicians may continue to use EHR technology certified to the 2014 Edition for the performance period in CY 2018. We support CMS's goal of encouraging interoperability of EHRs and information exchange, but our clinicians have experienced significant hurdles in their attempts to participate. We ask that CMS continue to evaluate the requirements to comply to ensure they are not too rigid or take the form of an "all or nothing approach." In addition to many interoperability issues beyond our control, compliance requires a significant investment in time and resources. We urge CMS to offer clinicians a flexible standard while interoperability is pursued.

## **Cost**

We are pleased to see that CMS is proposing to weight the cost performance category at zero percent of the final score for the 2020 MIPS payment year in order to improve clinician understanding of the measures and continue development of episode-based measures that will be used in this performance category. We urge CMS to keep the cost performance category weighted at zero until CMS can develop, with ample stakeholder input, a reliable means of cost attribution that does not penalize rheumatologists who care for patients with chronic and high cost diseases.

We support CMS's proposal to not use the 10 episode-based measures that were adopted for the 2017 MIPS performance period for the 2018 MIPS performance period. We are pleased that CMS is in the process of developing new episode-based measures with significant clinician input. We also encourage CMS to provide clear feedback on these new episode-based cost measures.

## **Submission Mechanisms**

We are pleased that CMS is proposing additional flexibility for submitting data and encourage CMS to explore the difficulties of submitting through multiple routes, specifically, the difficulty of both performing the electronic referral and also the reporting of it through the EHR.

## **Virtual Groups**

The ACR supports CMS's continued development of standards for virtual groups. We believe these groups will provide critical support for small and rural practices participating in MIPS. We support CMS's proposal to waive sections of the statute that would require that all participants in a Virtual Group receive their MIPS payment adjustment based on the Virtual Group score, so that participants in APM entities in MIPS APMs may receive their MIPS payment adjustment based on their APM Entity score under the APM scoring standard.

The resources required to collect quality data and participate in improvement activities are significant, so we continue to advocate for flexible standards for virtual groups, in order to allow practices of all sizes to succeed in MIPS. Further, we believe virtual groups should be aligned with physician practices/groups that have comparable scope of practice and similar characteristics of patient mix and size so that data is comparable in comparing practices, costs and patient needs, or at least be close to having the same types of patients and the same types of access to services, including pharmacies. While there is a focus on minimum standards, it may be better to ensure that the groups themselves are comparable in order to develop and implement virtual groups.

## Scoring

For the 2018 MIPS performance period, CMS is proposing that three performance category scores (quality, improvement activities, and advancing care information) would be given weight in the final score, or be reweighted if a performance category score is not available. We encourage CMS to provide physicians with more credit for participating in specialty clinical data registries under MIPS. Participation in the ACR RISE<sup>®</sup> Registry (Rheumatology Informatics System for Effectiveness), means rheumatologists are meaningfully using electronic health records to improve patient care, outcomes and practice efficiency. ACR strongly urges CMS to increase incentives for physicians to participate in clinical data registries by providing full ACI credit for participation.

## Performance Feedback

We are encouraged to see CMS is proposing to provide Quality Payment Program performance feedback to eligible clinicians and groups. We continue to request that CMS improve the information provided in these reports in order to explain to clinicians how they can improve their scores on conditions that they do not treat and why specific patients are being assigned to the clinician. We support CMS providing performance feedback on an annual basis and in future years, providing performance feedback on a more frequent basis. We believe this a high priority and encourage CMS to explore other options such as real-time updates, updates on demand, or on a frequency requested by providers on an individual basis.

### **III. Major Provisions for Advanced Alternative Payment Models (Advanced APMs)**

The ACR appreciates the desire of the agency to encourage development of physician-focused APMs, and we hope that CMS will make it easier for Physician Focused APMs to achieve "advanced" status by reducing nominal risk. The current nominal risk criterion makes it difficult for smaller practices to attempt the APM track. Smaller groups engaged in Physician Focused APMs should not be held to the same degree of nominal risk as large organizations such as ACOs. We also recommend that CMS lower the payment and patient count thresholds for Physician Focused APMs to allow "qualifying participant" status to be more achievable for smaller practices. We feel this would encourage more small practices to pursue Physician Focused APMs. We also continue to urge CMS to allow the set-up cost of physician-focused APMs to serve as the financial risk, at least for interim basis.

## Advanced APMs

Though we are pleased that CMS is proposing to at least maintain the generally applicable revenue-based nominal amount standard at eight percent (or 8%) of the estimated average total Parts A and B revenue of eligible clinicians in participating APM entities for QP Performance Periods 2019 and 2020, we recommend CMS lower this nominal amount standard for physician focused payment models (PFPMs) to be more inclusive for small practices.

### **Qualifying APM Participant (QP) and Partial QP Determination**

The ACR encourages CMS to lower payment amounts and patient count thresholds to qualify for QP status for PFPs. This will encourage small practice participation as discussed in the above paragraphs. Further, we believe that CMS should allow physicians' participation in Medicare Advantage (MA) APMs to count toward the required thresholds for Advanced APM participation. We suggest the addition of MA patients to non-MA patient data would help reduce the skewing of measurements. Rheumatologists have seen variability in performance measures based on a patient's insurance. We believe if all the patients are in one group, the data is more comprehensive and transparent. We also suggest the QP determination be a 90-day period and not the 60-day period as currently proposed.

### **All-Payer Combination Option**

We believe that risk corridors need to include flexibility to reflect when a model begins. Using rigid deadlines will make it difficult for new models of care to be developed, measured, and refined to allow them to succeed.

CMS is proposing to modify the information submission requirements for the All-Payer Combination Option. CMS is also proposing policies on the handling of information submitted for purposes of assessment under the All-Payer Combination Option. The ACR recommends that the measure developers' submission of their data to a peer-reviewed journal should satisfy the criteria.

### **Physician-Focused Payment Models (PFPs)**

CMS is seeking comments on broadening the definition of PFP to include payment arrangements that involve Medicaid or the Children's Health Insurance Program (CHIP) as a payer even if Medicare is not included as a payer. The ACR agrees with this strategy as long as it increases the likelihood of providers participating in the APM track. It may also increase participation in Medicaid – effectively increasing reimbursement by 5%. We strongly support parity between Medicare and Medicaid payments, both as a way to improve patient access and because of the increased administrative burden associated with providing care for Medicaid beneficiaries including the difficulty with formularies, imaging, and referrals in network.

## **IV. Stakeholder Input**

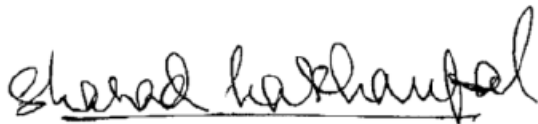
We appreciate that CMS sought stakeholder feedback in developing this proposed rule; the ACR welcomes engagement and open communication with CMS on an ongoing basis as CMS develops the Quality Payment Program in future years.

**V. Conclusion**

The ACR is dedicated to ensuring that rheumatologists and rheumatology health professionals have the resources they need to work with CMS and provide patients with high-quality care. We believe that for CMS, clinicians, and patients to all achieve their objectives, payment programs must be designed to reflect the way practices treat patients. The American College of Rheumatology appreciates the work that CMS does and the opportunity to respond to this proposed rule. We look forward to being a resource to you and to working with the agency.

Please contact Kayla L. Amodeo, Ph.D., Director of Regulatory Affairs, at [kamodeo@rheumatology.org](mailto:kamodeo@rheumatology.org) or (202) 210-1797 if you have questions or if we can be of assistance.

Sincerely,

A handwritten signature in black ink that reads "Sharad Lakhanpal". The signature is written in a cursive style and is underlined.

Sharad Lakhanpal, MBBS, MD  
President, American College of Rheumatology

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<sup>1</sup> Battafarano D, Monrad S, Ditmyer M, Imundo L, Klein-Gitelman M. 2015 ACR/ARHP Workforce Study in the United States: Pediatric Rheumatologist Supply and Demand Projections for 2015-2030 [abstract]. *Arthritis Rheumatol.* 2016; 68 (suppl 10). <http://acrabstracts.org/abstract/2015-acrarhp-workforce-study-in-the-united-states-pediatric-rheumatologist-supply-and-demand-projections-for-2015-2030/>.