Oncology Nursing Society
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Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services, Room 445-G
Hubert H. Humphrey Building
200 Independence Ave, S.W.
Washington, DC 20201

June 27, 2016

Re: 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

Dear Acting Administrator Slavitt:

The Oncology Nursing Society (ONS) appreciates the opportunity to provide the proposed rule, titled 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, setting forth proposals for the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

Merit-Based Incentive Payment System (MIPS)

MIPS Program Details

Eligible Clinicians: CMS proposes to define a MIPS eligible clinician as a physician as a physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and a group that includes such professionals. Furthermore, CMS proposes that Qualifying APM Participants, Partial Qualifying APM Participants who do not report data under MIPS, low-volume threshold eligible clinicians, and new Medicare-enrolled eligible clinicians would be excluded from the MIPS. **ONS welcomes the opportunity for our eligible clinicians to participate in the MIPS and supports the proposed exclusions**.

MIPS Eligible Clinician Identifier: CMS proposes to use multiple identifiers that allow MIPS eligible clinicians to be measured as an individual or collectively through a group's performance. The same identifier would have to be used for all four performance categories. For a group practice, the group's billing TIN would be used. For an APM entity, each eligible clinician who is a participant of an APM Entity would be identified by a unique APM participant identifier. However, CMS proposes to use a combination of billing TIN/NPI as the identifier to assess performance of an individual MIPS eligible clinician. **ONS requests additional clarification on this proposal. Particularly, ONS requests specific examples in the final rule as to how a partial QP and individual in a group practice would be assessed the 2019 MIPS payment adjustment based on the TIN/NPI**.

Low-Volume Threshold: CMS proposes to exclude MIPS eligible clinicians from the 2019 payment adjustment who, during the performance period, have Medicare billing charges less than or equal to

$10,000 and provides care for 100 or fewer Part B-enrolled Medicare beneficiaries. **ONS supports CMS' proposals to exclude MIPS eligible professionals for low-volume thresholds**.

Group Practice: CMS proposes to define a group as a single Taxpayer Identification Number (TIN) with two or more MIPS eligible clinicians, as identified by their individual National Provider Identifier (NPI), who have reassigned their Medicare billing rights to the TIN. CMS also proposes to define an APM Entity group identified by a unique APM participant identifier. Groups wishing to participate in the MIPS as a group would not need to register as a group practice if participating in the MIPS using a third party vendor. Groups would only need to elect if participating in the MIPS using the CMS Web Interface or reporting the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS survey for the quality performance category. **ONS supports not requiring registration or election for groups other that those electing to use the CMS Web Interface or reporting the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS survey for the quality performance category. However, we raise questions as to how eligible clinicians within a group would be scored. We suggest CMS state in the final rule that all eligible clinicians participating in a group would be given the same CPS for purposes of the 2019 MIPS payment adjustment. We also hope that, when determining the CPS, CMS provide eligible clinicians within the group the best possible CPS as demonstrated by its eligible clinicians**. **Furthermore, we request that CMS provide examples in the final rule as to how the group practice option would be implemented for the CPIA and ACI performance categories**.

Virtual Groups: ONS is disappointed that CMS did not provide a proposal for virtual groups for the start of the MIPS program. In particular, we encourage the development of a virtual group specific to oncology care.

MIPS Performance Period: For the 2019 MIPS payment adjustment and subsequent payment adjustments, CMS proposes a performance period of a calendar year (that is, January 1 through December 31) occurring two years prior to the application of the corresponding MIPS payment adjustment. Therefore, CMS proposes the performance period for the 2019 MIPS payment adjustment to be January 1, 2017 through December 31, 2019. **For the 2019 MIPS payment adjustment, ONS opposes the proposed reporting period of the 2019 MIPS payment adjustment, January 1, 2017 through December 31, 2017**. Particularly since the MIPS the final rule for these proposals are not expected until November, we do not believe this gives eligible clinicians enough time to learn and understand the requirements for the MIPS prior to the January 1, 2017 start date of the performance period for the 2019 MIPS payment adjustment. Therefore, we urge CMS to delay the performance period of the 2019 MIPS payment adjustment.

Proposed Data Submission Mechanisms for MIPS Eligible Clinicians Reporting Individually as TIN/NPI: ONS supports CMS' proposal to retain the same submission mechanisms available under the PQRS for individuals for the quality performance program: claims, QCDR, qualified registry, and EHR. ONS also supports CMS' proposal to add the QCDR and registry submission mechanisms as options for submitting data for the ACI performance category. In addition, ONS supports continued use of attestation for the ACI performance category. ONS supports the proposed submission mechanisms for the CPIA performance category for individuals: attestation, QCDR, qualified registry, EHR, and administrative data.

Proposed Data Submission Mechanism for Groups: ONS supports CMS' proposal to retain the same submission mechanisms available under the PQRS for groups for the quality performance program: QCDR, qualified registry, EHR, CMS web interface, and a CMS-approved survey vendor for CAHPS for MIPS. ONS

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also supports CMS' proposal to add the QCDR, qualified registry, and CMS web interface submission mechanisms as options for submitting data for the ACI performance category. In addition, ONS supports continued use of attestation for the ACI performance category. ONS supports the proposed submission mechanisms for the CPIA performance category for groups: attestation, QCDR, qualified registry, EHR, CMS web interface, and administrative data.

The Quality Performance Category

Reporting Criteria: CMS proposes that individuals and groups would report at least six measures including one crosscutting measure and at least one outcome measure, or if an outcome measure is not available report another high priority measure (appropriate use, patient safety, efficiency, patient experience, and care coordination measures). If less than six measures apply, then report on each measure that is applicable. Eligible clinicians would report on 80% (for claims) and 90% (for qualified registry, QCDR, and EHR) of their Medicare Part B (for claims) or ALL (for qualified registry, QCDR, and EHR) applicable patients. ONS supports CMS' proposal to report at least six measures as well as its proposal to eliminate use of National Quality Strategy (NQS) domains as a reporting requirement. **However, ONS opposes increasing the data submission threshold to 80% of 90%.** We believe it would be difficult for eligible clinicians to meet these high thresholds, particularly for those reporting via QCDR as clinicians were only required to report on 50% of their patients via QCDR in the PQRS. We also believe that such a high threshold should not be established at the beginning of the MIPS program. We request that CMS allow for more time for eligible clinicians to gain familiarity with the program before such a high threshold is established.

Measures Groups: CMS is not proposing an option to report measures groups for the quality performance category. **ONS requests that CMS include an option to report measures groups, particularly the Oncology Measures Group**. Eligible clinicians who have had success in reporting measures groups may find it difficult to transition into the MIPS if the option to report measures groups is not included in the MIPS. The Oncology Measures Group consists of the following measures:

- 71: Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer
- 72: Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients
- 110: Preventive Care and Screening: Influenza Immunization
- 130: Documentation of Current Medications in the Medical Record
- 143: Oncology: Medical and Radiation – Pain Intensity Quantified
- 144: Oncology: Medical and Radiation – Plan of Care for Pain
- 226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

For the 2019 MIPS payment adjustment, we believe that CMS should retain similar criteria for measures groups as was finalized in the 2016 PFS final rule: **For the 2019 MIPS adjustment performance period, report at least 1 measures group AND report each measures group for at least 20 patients. Measures groups containing a measure with a 0 percent performance rate will not be counted**. According to the 2014 PQRS Reporting Experience, oncologists/hematologists had the sixth largest number of eligible professionals participating in the PQRS using measures groups (using the registry reporting mechanism). As you can see, the ability to submit quality measures data via measures group is critical to oncology care providers, and we do not believe CMS should completely eliminate the option with the introduction of a new program. This is especially important to oncologists, as CMS is not proposing a measure specialty set specific to oncology, as it is proposing for other specialties. **At a minimum, beginning with the 2019 MIPS**

payment adjustment, CMS should finalize an Oncology Measure Specialty Set using the measures in the existing PQRS oncology measures group.

CAHPS for MIPS: CMS proposes to allow registered groups of two or more MIPS eligible clinicians to voluntarily elect to participate in the CAHPS for MIPS survey. **ONS supports CMS' proposal to make CAHPS for MIPS a voluntary reporting option, including for large groups of 100 or more eligible clinicians**.

Global and Population-based Measures: CMS proposes to use the acute and chronic composite measures of Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQIs) in the calculation of the quality measure domain for the MIPS total performance score. CMS also proposes to include the all-cause hospital readmissions measure from the VM. **ONS opposes the use of existing measures, including these global and population-based measures, in the VM for inclusion in the MIPS**.

The Resource Use Performance Category

CMS proposes that the resource use performance category shall make up no more than 10 percent of the CPS for the first MIPS payment year (CY 2019) and not more than 15 percent of the CPS the second MIPS payment year (CY 2020). **Until ONS can determine the true impact of the VM measures on oncology nurses, ONS opposes assigning weight to the resource use performance category. Therefore, ONS requests that CMS reweight the resource use performance category to zero**. We note that application of payment adjustments under the VM has primarily applied to physicians. To the extent that oncology nurses have been assessed under the VM, they have been assessed in conjunction with physicians within their practice. Implementation of the VM for all non-physician EPs would first apply in 2018, the performance period of which occurs in 2016. Therefore, we are unsure how application of existing VM measures would apply to oncology nurses. Until we can determine the true impact of these VM measures specifically on oncology nurses, we recommend that CMSM reweigh the resource use performance category to zero. In addition, ONS requests clarification as to how the measures in the resource use performance category would apply to individual eligible clinicians, as these existing VM measures have traditionally been assessed relative to groups.

The Clinical Practice Improvement Activity (CPIA) Performance Category

CPIA Weight: CMS proposes that the CPIA performance category will account for 15 percent of the CPS. ONS believes the CPIA Performance Category should count for more than 15 percent of the CPS. Specifically, since ONS believes that the resource use performance category should be reweighted to zero, ONS suggests redistributing the proposed weight of 10 percent of the CPS from the resource use performance category to the CPIA performance category. **Therefore, we believe the CPIA performance category should count for at least 25 percent of the CPS**.

CMS proposes a differentially weighted model for the CPIA performance category with two categories: medium and high. CPIAs are proposed to be weighted as high based on alignment with CMS national priorities and programs. CMS requests comments on this proposal, including criteria or factors CMS should take into consideration to determine whether to weight an activity medium or high. **ONS supports CMS' proposal to weigh CPIAs as either medium or high as well as the factors CMS takes into consideration when weighing an activity as medium or high**.

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CPIA Criteria: In order to achieve the highest potential score of 100 percent, CMS proposes the following submission criteria: (1) Three high-weighted CPIAs (20 points each); or (2) Six medium-weighted CPIAs (10 points each); or (2) Some combination of high and medium weighted CPIAs to achieve a total of 60 points for MIPS eligible clinicians participating as individuals or as groups. CMS proposes to accommodate small practices and practices located in rural areas, or geographic HPSAs for the CPIA performance category by allowing MIPS eligible clinicians or groups to submit a minimum of one activity to achieve partial credit or two activities to achieve full credit, regardless of the CPIA weight. **ONS supports CMS' proposed criteria to achieve the highest potential score for the CPIA performance category**. However, we seek clarification in the proposed rule as to what the requirement for group practices would be to achieve the highest potential score for the CPIA performance activity. Would CMS require that all eligible clinicians in a group achieve the highest potential score? We believe this approach would be unfair, as it could potentially penalize every eligible clinician in a group for the inaction of a few eligible clinicians. **Therefore, ONS suggests that, similar to the 50% rule used in the VM for the quality component, a group practice would achieve the highest potential score of 100 percent as long as at least 50% of its eligible clinicians achieve the highest potential score by following the proposed submission CPIA criteria above**.

Required Period of Time for Performing a CPIA: CMS proposes that clinicians or groups must perform CPIAs for at least 90 days during the performance period. **ONS supports this proposal**.

CPIA Activities: CMS proposes 94 activities (11 of which are weighted "high") within the following CPIA subcategories: (1) Expanded practice access, such as same day appointments for urgent needs and afterhours access to clinician advice; (2) Population management, such as monitoring health conditions of individuals to provide timely health care interventions or participation in a QCDR; (3) Care coordination, such as timely communication of test results, timely exchange of clinical information to patients and other MIPS eligible clinicians or groups, and use of remote monitoring or telehealth; (4) Beneficiary engagement, such as the establishment of care plans for individuals with complex care needs, beneficiary self-management assessment and training, and using shared decision-making mechanisms; (5) Patient safety and practice assessment, such as through the use of clinical or surgical checklists and practice assessments related to maintaining certification; (6) Participation in an APM, as defined in section 1833(z)(3)(C) of the Act; (7) achieving health equity; (8) emergency preparedness and response; and (9) integration of primary care and behavioral health. CMS also seeks comment on adding two additional subcategories: (1) promoting health equity and continuity and (2) social and community involvement. **ONS supports these proposed subcategories, include promoting health equity and continuity and social and community involvement. In addition, ONS specifically supports activities related to the use of QCDRs**.

These activities include:

- Use of a QCDR to generate regular feedback reports that summarize local practice patterns and treatment outcomes, including for vulnerable populations.
- Participation in a QCDR, clinical data registries, or other registries run by other government agencies such as FDA, or private entities such as a hospital or medical or surgical society. Activity must include use of QCDR data for quality improvement (e.g., comparative analysis across specific patient populations for adverse outcomes after an outpatient surgical procedure and corrective steps to address adverse outcome).
- Participation in a Qualified Clinical Data Registry, demonstrating performance of activities that promote use of standard practices, tools and processes for quality improvement (e.g.,

documented preventative screening and vaccinations that can be shared across MIPS eligible clinician or groups).
- Participation in a QCDR, demonstrating performance of activities that promote implementation of shared clinical decision making capabilities.
- Participation in a QCDR, that promotes use of patient engagement tools.
- Participation in a QCDR, that promotes collaborative learning network opportunities that are interactive.
- Use of QCDR patient experience data to inform and advance improvements in beneficiary engagement.
- Participation in a QCDR, that promotes implementation of patient self-action plans.
- Participation in a QCDR, that promotes use of processes and tools that engage patients for adherence to treatment plan.
- Participation in a QCDR, that promotes use of processes and tools that engage patients for adherence to treatment plan.
- Use of QCDR data, for ongoing practice assessment and improvements in patient safety.
- Participation in a QCDR, demonstrating performance of activities for use of standardized processes for screening for social determinants of health such as food security, employment and housing. Use of supporting tools that can be incorporated into the certified EHR technology is also suggested.
- Participation in a QCDR, demonstrating performance of activities for promoting use of patient-reported outcome (PRO) tools and corresponding collection of PRO data (e.g., use of PQH-2 or PHQ-9 and PROMIS instruments).
- Participation in a QCDR, demonstrating performance of activities for use of standard questionnaires for assessing improvements in health disparities related to functional health status (e.g., use of Seattle Angina Questionnaire, MD Anderson Symptom Inventory, and/or SF-12/VR-12 functional health status assessment).

In addition, we ask CMS to recognize the following activities as high for the CPIA performance category as they related to oncology nurses:
- Recognize the ASCO/CNS Chemotherapy Safety Administration Standards, potentially under the achieving health equity subcategory. If so, this should be rated as high as CMS weighs an activity that is a public health priority (e.g., emphasis on anticoagulation management or utilization of prescription drug monitoring programs).

The Advancing Care Information (ACI) Performance Category

In general, we note that CMS proposes to largely retain the objectives and measures from the EHR Incentive Program. While we do not particularly oppose the reporting of these objectives and measures, we question whether reporting on these objectives and measures have truly promoted interoperability and integration among EHR systems and other tools that collect data on patient reported outcome measures, such as apps, patient portals, and patient satisfaction surveys. We request that CMS look to revise the requirements for the advancing care information performance category and MIPS in general to emphasize the use of tools (such as QCDRs) that connect information on patient reported outcome measures with patient documentation and plan of care.

Performance Period: CMS proposes to align the performance period for the ACI performance category to

the proposed MIPS performance period of one full calendar year. As we believe the performance period for the 2019 MIPS payment adjustment should be delayed, we also oppose this proposal. **According to the reporting period established previously under the EHR Incentive Program, ONS requests that CMS implement a 90-day reporting period for this performance category**.

Exclusions: CMS proposes several exclusions to the ACI performance category, including an exclusion for clinicians previously not eligible to participate in the Medicare/Medicaid EHR Incentive Programs: nurse practitioners, physician assistants, clinical nurse specialists, and certified registered nurse anesthetists. If an eligible clinician is excluded from the ACI performance category, the ACI performance category would be reweighted to zero. **ONS supports these proposals, including an exclusion for clinicians previously not eligible to participate in the Medicare/Medicaid EHR Incentive Programs: nurse practitioners, physician assistants, clinical nurse specialists, and certified registered nurse anesthetists. In addition, if an eligible clinician is excluded from the ACI performance category, we believe the weight of the ACI performance category should be distributed to the CPIA performance category.** Since the quality performance category already counts for 50% of the CPS, we do not believe further weight should be distributed to the quality performance category, particularly the ACI performance category as the ACI performance category would count for 75% of the eligible clinician's CPS. We believe a more even distribution is favorable and therefore suggest that the weight from the ACI performance category be redistributed to the CPIA performance category.

Third Party Data Submission

QCDRs: The ONS notes its support for the continued use of the Oncology Quality Clinical Data Registry in Collaboration with CECity, as a QCDR in the MIPS. This QCDR collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients. The Oncology Quality Clinical Data Registry in collaboration with CECity, aims to measure, report and improve patient outcomes in Oncology. Some of the features available to its users include: continuous performance feedback reports improve population health and manage VBM quality scores; comparison to national benchmarks (where available) and peer-to-peer comparison; performance gap analysis and patient outlier identification (where available); links to targeted education, tools and resources for improvement; and performance aggregation at the practice and organization level available.

CMS proposes to allow for QCDRs to report data on all MIPS performance categories that require data submission, including the ACI performance category and CPIA performance category. **We thank CMS for proposing the option for QCDRs to submit data for all MIPS performance categories. In addition, until QCDRs can update its systems to submit this additional data, we suggest continuing to make it optional for QCDRs to report data on all MIPS performance categories**.

MIPS Scoring Standards

We find CMS' proposed scoring standards to the MIPS to be very confusing and complex. We note that CMS proposes the use of points, percentages, and averages to combine the scores from each of the four performance categories – quality, resource use, CPIA, and ACI – into the composite performance score (CPS). ONS urges CMS to revise its proposed scoring standard to produce a scoring formula that is streamlined and easier to understand.

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Performance Feedback: MACRA mandates that MIPS eligible clinicians are to be provided with timely (such as quarterly) confidential feedback on their performance under the quality and resource use performance categories beginning July 1, 2017. **ONS supports more timely feedback on performance in the MIPS**.

Review and Correction of MIPS Performance Score: CMS proposes a targeted review process under MIPS where a MIPS eligible clinician may request that CMS review the calculation of the MIPS adjustment factor and the calculation of the additional MIPS adjustment factor applicable to such MIPS eligible clinician for a year. **ONS supports the establishment of a targeted review process. We urge that CMS exercise latitude when determining whether an issue is eligible for targeted review, especially for the first few years of the MIPS**.

Public Reporting on Physician Compare

Prior to posting MIPS information on Physician Compare, we believe it is important for CMS to determine the accuracy of the data posted.

Alternative Payment Model (APM) Incentive

Advanced APMs: CMS is proposing to recognize the following eight models as APMs: (1) Comprehensive ESRD Care (CEC) (LDO arrangement); (2) Comprehensive ESRD Care (CEC) (non- LDO arrangement); (3) Comprehensive Primary Care Plus (CPC +); (4) Medicare Shared Savings Program - Track 1 (MSSP); (5) MSSP- Track 2; (6) MSSP- Track 3; (7) Oncology Care Model (OCM) one-sided risk arrangement; and (8) Oncology Care Model (OCM) two-sided risk arrangement. **ONS supports the proposal to include the Oncology Care Model as an advanced APM**.

Criteria for Physician-Focused Payment Models (PFPMs)

CMS proposes criteria for a PFPM organized into three categories: payment incentives; care delivery; and information availability. ONS supports this proposal, as we believe it is broad enough to continue to implement models related specifically to oncology care. It is clear from the Centers for Medicare and Medicaid Services (CMS) recently released proposed rule on MACRA implementation that nursing and nursing services will be pivotal in care delivery improvements that promote better care coordination, protect patient safety and encourage patient engagement. And, while we recognize that PTAC is not in a position to *set* the PFPM criteria, PTAC has leverage in the assessment of PFPM proposals and the authority to encourage the inclusion and underscore the value of nursing in meeting the Secretary's goals. As such, and given the important role of nursing in meeting the Secretary's goals of paying for higher-value care through PFPMs, **we urge PTAC to encourage developers to highlight the role of nurses in their PFPM proposals**. In addition, **we urge PTAC to closely assess whether nursing has been incorporated in proposals in an effort to meet the Secretary's criteria for PFPMs**, particularly in the area of care delivery improvements. If finalized, PTAC should utilize the "supplemental information elements" mechanism to solicit information on how nursing is incorporated into PFPM proposals.

ONS thanks CMS for the opportunity to provide input on CMS' proposals related to the MIPS, APM incentive, and criteria for PFPMs. We request that CMS continue to provide transparency in determining how policies affect oncology care as these programs, particularly the MIPS, are implemented. We would

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be happy to discuss ways in which ONS may be of assistance to CMS, and would encourage you to contact Alec Stone at astone@ons.org to coordinate a time to discuss our comments. We look forward to engaging in an ongoing dialogue to address issues of importance to ONS and cancer patients.

Sincerely,

The Oncology Nursing Society