



December 29, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5522-FC,
7500 Security Boulevard,
Baltimore, MD 21244-1850

Re: Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year; 42 CFR Part 414 (November 16, 2017)

Dear Administrator Verma:

The American College of Radiology (ACR), representing more than 36,000 diagnostic radiologists, interventional radiologists, radiation oncologists, nuclear medicine physicians and medical physicists appreciates the opportunity to comment on the final rule (CMS-5522-FC) updating the Quality Payment Program (QPP).

In this comment letter, we address the following issues:

- 1. Identifying QCDR Quality Measures**
- 2. Clarification on Virtual Group Participation**
- 3. Extreme and Uncontrollable Circumstances Policies for Groups in Affected Areas**
- 4. Assigning Points to Reported Improvement Activities**
- 5. Facility-Based Measurement Applicability (i) General**

Identifying QCDR Quality Measures

The Centers for Medicare and Medicaid Services (CMS) seeks comment on modifying the selection and approval process for the Qualified Clinical Data Registry (QCDR) measures. Specifically, CMS asks if that process should align more closely with the process used for traditional Merit-based Incentive Payment System (MIPS) measures, known as the “Call for Quality Measures”.

The ACR appreciates the opportunity to provide input on the QCDR measure identification and approval standards. Having been a QCDR since 2014, we have seen



improved efficiencies in the QCDR self-nomination process as well as the development, adoption and implementation of these registries. With any quality program, there are always opportunities for improvement.

CMS has previously received feedback from QCDR vendors and many of their associated specialty societies as to the difficulties associated with the annual QCDR self-nomination process. Areas of concern include:

- Inconsistent feedback and decisions from CMS, multiple contractor input
- Seeming lack of understanding of clinical actions for some measures; preliminary review by non-clinical staff resulting in inaccurate measure summary
- Impractical timelines for request for materials and responses from QCDRs
- Lack of rationale for measure rejection
- Approval process is not transparent
- Inappropriate measure consolidation suggestions
- Lack of responsiveness/communication not coordinated
- Annual approval of previously approved measures (provisional approval status)

In this final rule, CMS states that it is interested in elevating QCDR measure identification and approval standards and suggests using the current MIPS measures selection process for QCDR measure identification. That annual process entails these steps:

- 1) Formal CMS “Call for Quality Measures” ending on June 30 annually,
- 2) CMS review of submitted measures,
- 3) Selection and publication of measures on the “Measures Under Consideration” (MUC) list (September),
- 4) National Quality Forum (NQF) convened Measures Application Partnership (MAP) pre-rulemaking review and recommendations of the MUC list, with public comment (December-January)
- 5) CMS review of MAP recommendations and decision-making as to which measures are included in the upcoming Quality Payment Program (or Physician Fee Schedule) proposed rule (April-May)
- 6) Public comment on proposed rule (August)
- 7) Final rule with new measure listing (November)

The MACRA legislation emphasized the benefits and use of QCDRs in the Physician Quality Reporting System (PQRS) program and CMS has routinely stated that it wants to encourage MIPS reporting through QCDRs given their potential for advancing quality care. QCDRs allow physicians to receive more timely and relevant feedback and benchmark information. In addition, QCDRs enable physicians to report on quality measures that are robust, have greater use of clinical data, are outcome oriented, and potentially more applicable to a physician’s patient population compared to traditional MIPS measures.



Additionally, QCDRs have accelerated the implementation of new measures into the MIPS program because they have not been required to go through the Call for Quality Measures process. Primarily sourced from specialty clinical data registries, QCDR measures were designed to promote and improve quality and safety of patient care. In most cases, these measures have gone through multiple rounds of review by the organizations' quality committees and tested in the field for years, which speaks to the validity and soundness of the measures.

While the current QCDR measure approval process is in need of improvement – and greater transparency and consensus is key to that – the ACR is concerned that the Call for Quality Measure process would not result in such change and only burden specialty societies and QCDR vendors even more. For example, Step 3 of the Call for Measures process has similar lack of transparency to the QCDR process. Measures are submitted to CMS and rejected from inclusion on the MUC list with little input or rationale. Although the MAP process does provide a larger forum for discussion, review and ascertainment of measure readiness, and is more transparent than the current QCDR review, it requires a rapid turnaround oftentimes of hundreds of measures with which the MAP committees have struggled. Inserting hundreds of additional measures from QCDRs into this process would severely limit the MAP's effectiveness, unless there was a separate cycle for QCDR measures. However, since measure developer and specialty society staff and member volunteers would typically be the same for MIPS and QCDR measures, a second MAP review would substantially increase their workload. Additionally, the Call for Quality Measures process is over an 18-month period. It requires continuous input and monitoring by measure stewards, without guarantee of measure inclusion, review or approval at any point in the cycle.

We understand that in early 2018 CMS intends to conduct QCDR vendor meetings for outlining CMS' goals for QCDR measures in future years. These should be beneficial for reducing or eliminating issues with the current approval process. The ACR recommends that CMS hold multiple QCDR meetings not only to communicate clearly their expectations and goals for QCDR measure standards but also that CMS considers employing a kaizen approach to improving the process.

The ACR strongly recommends that CMS implement a multi-year or “standing” approval process for QCDR measures, so that a QCDR measure that receives initial approval according to CMS standards does not require annual review and approval. This would mirror the MIPS measure acceptance process. Once approved, MIPS measures rarely go through re-evaluation under the Call for Measures process. The “provisional” approval status that many QCDR measures receive is confusing and frustrating; in many cases QCDRs have previously provided measure data or information requested by CMS to move a measure to full approval status. CMS' reliance on multiple contractors exacerbates this issue, particularly with yearly changes to the contractors. Use of a technical expert panel consisting of clinicians who have the clinical and/or



measurement expertise to provide input and recommendations to CMS would better serve the approval process than use of non-clinical contractor staff.

We look forward to continue working with CMS to ensure that QCDR measures support the Quality Payment Program goals of improving the quality and safety of patient care while offering the clinicians who are being measured valid opportunities for improvement.

Clarification on Virtual Group Participation

Although CMS does not specifically ask for comments on how to apply payment adjustments to clinicians within virtual groups, *the ACR seeks clarification on whether participants in a virtual group who do not meet the low-volume threshold will receive a MIPS payment adjustment based on the final score of the virtual group.* We acknowledge that clinicians reporting as a traditional group are subject to payment adjustments regardless of whether they meet the low-volume threshold, however CMS states that the low-volume threshold determinations are made at the individual and group level, and not at the virtual group level. Further, CMS states that the MIPS payment adjustment would apply only to NPIs in the virtual group who meet the definition of a MIPS eligible clinician at §414.1305 and who are not excluded from the definition of a MIPS eligible clinician under §414.1310(b) or (c). Thus, it is unclear whether the payment adjustment will apply to a participant in a virtual group who does not exceed the low-volume threshold.

Additionally, the ACR seeks clarification on the method of counting eligible clinicians within a virtual group should a group choose to consolidate multiple TINs by forming a virtual group with itself. If the clinicians in a group with less than 15 eligible clinicians are counted as distinct NPI/TIN combinations (i.e. double counted within the virtual group), the group could risk forfeiting small practice status or no longer qualify to form a virtual group.

Extreme and Uncontrollable Circumstances Policies for Groups in Affected Areas

CMS also seeks comment on how CMS should apply the automatic extreme and uncontrollable circumstance policies to groups and virtual groups in future years. For example, how should CMS determine whether a group, which may have multiple practice sites, qualifies under the policy? Should it be based on whether a certain percentage of clinicians in the group are located in the affected area?

The ACR recommends that the policy for applying the automatic extreme and uncontrollable circumstances status to a group should be when $\geq 75\%$ of the group's clinicians are located in an impacted area. This is consistent with other group related policies implemented throughout the QPP.



Assigning Points to Improvement Activities

Although CMS did not specifically seek comments on finalized changes to Improvement Activities, *the ACR would like to point out a discrepancy and an inconsistency in the rule on the weighting of IA_CC_4 TCPI Participation*. In Table G, IA_CC_4 CMS finalized its proposal to down-weight the activity from high to medium based on the rationale that 1) the “Transforming Clinical Practice Initiative (TCPI) has a designation as a MIPS APM, 2) that eligible clinicians participating in a MIPS APM will be assigned an improvement activity score and 3) those who are fully active TCPI participants will participate in additional practice improvement activities and will be able to select [those]”.

We believe this to be incorrect and seek clarification. The TCPI is a non-payment based transformation model. In the CMS Comprehensive list of APMs (<https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Comprehensive-List-of-APMs.pdf>) the TCPI program was not identified as a MIPS APM nor as an advanced APM according to the required criteria:

1. Require participants to use certified electronic health record technology (CEHRT);
2. Provide payment for covered professional services based on quality measures comparable to those used in the quality performance category of the Merit-based Incentive Payment System (MIPS); and
3. Either: (1) be a Medical Home Model expanded under CMS Innovation Center authority; or (2) require participating APM Entities to bear more than a nominal amount of financial risk for monetary losses.

Additionally, on page 710 of the final rule CMS points out, as was done in the CY 2017 rulemaking, that “activities that require performance of multiple actions, such as **participation in the Transforming Clinical Practice Initiative (TCPI)**, ... are justifiably weighted as high (81 FR 77311 through 77312)”.

We would like to reiterate our comments to the CY 2018 QPP proposed rule as shown below and ask that CMS consider reinstating the high weight for TCPI participation.

The TCPI program is not an APM. It is funded under CMMI, but it is a care model not an alternative payment model. Clinicians who are in an APM are not eligible to participate in TCPI Practice Transformation Networks (PTNs). One main intention and goal of the Transforming Clinical Practice Initiative is to transform practices to an alternative payment model. CMS states earlier in the body of the rule (pg. 398) “*activities that require performance of multiple actions, such as participation in the Transforming Clinical Practice Initiative (TCPI), participation in a MIPS eligible clinician’s state Medicaid program, or an activity identified as a public health priority (such as emphasis on anticoagulation management or utilization of prescription drug monitoring programs) are justifiably weighted as high (81 FR 77311 through 77312).*”



Facility-Based Measurement Applicability (i) General

CMS is seeking comments on ways to identify clinicians who have a significant presence within the inpatient setting and address the concerns that we have noted above.

CMS proposed an alternative approach of not requiring an election process but instead automatically applying facility-based measurement to MIPS eligible clinicians and groups who are eligible for facility-based measurement, if technically feasible, if the facility-based measurement score is higher than the quality and cost performance category scores based on data submitted.

For physicians participating in MIPS and Hospital VBP, the ACR supports CMS' alternative scoring approach to use the higher quality and cost performance score. While using this approach would require facility-based MIPS eligible clinicians to continue submitting physician level quality measure data to CMS, it provides the most flexibility.

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 for inpatient hospitals, for purposes of the quality and cost performance categories. The Secretary may not use measures for hospital outpatient departments, except in the case of items and services furnished by emergency physicians, radiologists, and anesthesiologists. CMS considered, but did not propose, an option for facility-based measures scoring in the transition year. For the 2020 MIPS payment year and onward, CMS proposed to implement facility-based measures to add more flexibility for clinicians to be assessed in the context of the facilities at which they work. CMS believes that it is appropriate to implement this scoring option in a limited fashion in the first year by focusing on inpatient hospital measures in certain pay-for-performance (versus pay-for-reporting) programs.

In implementing the facility-based measurement option in future years, the ACR strongly recommends that CMS consider use of the quality measures in the Hospital Outpatient Quality Reporting (HOQR) program; in particular the HOQR Imaging Efficiency measures are relevant to radiology groups.

Conclusion

The ACR appreciates this opportunity to comment on the CY 2018 Final Rule Updates to the Quality Payment Program. The ACR stands ready to assist CMS in helping the



radiology community continue the transition to the Quality Payment Program. Please feel free to contact us any time through Judy Burleson at jburleson@acr.org, Pam Kassing at pkassing@acr.org or Dominick Parris at djparris@acr.org with questions or requests.

Respectfully Submitted,

A handwritten signature in black ink, appearing to read "William T. Thorwarth, Jr.", with a stylized flourish at the end.

William T. Thorwarth, Jr., MD, FACR
Chief Executive Officer

- cc: Molly MacHarris, CMS
Benjamin Chin, CMS
Ezequiel Silva, III, MD, Chair, Commission on Economics
Jacqueline Bello, MD, Chair, Commission on Quality and Safety
Gregory Nicola, MD, Chair, MACRA Committee
Cynthia Moran, ACR
Mythreyi Chatfield, ACR
Pamela Kassing, ACR
Judy Burleson, ACR
Mike Peters, ACR
Dominick Parris, ACR
Alicia Blakey, ACR