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2017

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Re: Merit-Based Incentive Payment System and Alternative Payment Model Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models; Proposed Rule (CMS-5517-FC)

Dear Acting Administrator Slavitt:

The American Society of Hematology (ASH) is pleased to offer comments on the final rule with comment period implementing the Medicare Access and CHIP Reauthorization Act (MACRA) (CMS-5517-FC).

ASH represents more than 17,000 clinicians and scientists worldwide committed to the study and treatment of blood and blood-related diseases. These diseases encompass malignant hematologic disorders such as leukemia, lymphoma, and multiple myeloma and non-malignant conditions such as sickle cell anemia, thalassemia, aplastic anemia, venous thromboembolism, hemophilia, and iron deficiency anemia. In addition, hematologists have been pioneers in the fields of stem cell biology, regenerative medicine, bone marrow transplantation, transfusion medicine, gene therapy, and the development of many drugs for the prevention and treatment of heart attacks and strokes. ASH membership includes physician scientists and physicians working in diverse settings, including universities, hospitals, and private practices.

While ASH appreciates the many changes that were made to the new Quality Payment Program (QPP) in the final rule, the rule is very complicated which will have a major impact on all practices; in particular, our Society is very concerned about the ability of small private practices including those in rural areas to be able to comply. We acknowledge that modifications were made to support small practices, but request that you closely monitor their participation and performance and make further changes to support their success in this program. As many of our members prepare to participate, designating 2017 as a transition year for Merit-Based Incentive Payment System (MIPS) reporting, as well as reducing other reporting requirements and including other flexibilities in the program, will be a great help to ASH members as they try to determine how to successfully report and participate in either MIPS or an advanced alternative payment model (APM). The transition year will afford physicians more time to determine the significant changes that will need to be made to their practice in order to meaningfully participate in the QPP, allowing them to phase in necessary changes over the upcoming year without being subject to the four percent penalty for not successfully reporting under MIPS. The Society believes that this transition period will also provide the Centers for Medicare & Medicaid

Services (CMS) time to further refine the program without subjecting physicians to penalties under standards that need further development, like those in the cost component.

While ASH is supportive of designating year one of the QPP a transitional year and many of the other changes in the final rule, we offer comments on the following portions of the program that require further refinement:

MIPS Quality Component

ASH applauds CMS for the changes made to the MIPS quality component. In particular, we appreciate that the reporting threshold for this component was lowered to 50 percent, as we believe this gives our members a greater chance to succeed. However, we are concerned about the number of meaningful measures available to our members. For 2017, there are only four hematology specific measures included in the program, and, most hematologists will not be able to apply all four to their practice. This is because hematologists specialize in treating rare diseases and so may not have any of the existing measures apply to their practice. CMS must recognize the fact that many specialists, including hematologists, are facing the same obstacle to meaningful participation. Although work is underway within their respective specialty societies to develop applicable measures as quickly as possible, the process of developing and approving measures, takes time and resources. In the interim, CMS should maintain the 50 percent reporting threshold and not increase the number of measures required to be reported in the forthcoming years.

MIPS Cost Component

CMS reduced the weighting of the cost component to zero percent of the MIPS score in 2017 and finalized that the weight would increase gradually to 10 percent in 2018 and 30 percent in 2019. While ASH supports not including cost in the MIPS score in 2017, we urge CMS not to raise the weight for this category until risk adjustment, attribution methodologies, and episode measures are finalized and the public has had an opportunity to provide comment.

ASH strongly believes that CMS and its contractor(s) need more time to evaluate, refine, replace and expand the 10 episode measures included in this final rule and to incorporate the new patient relationship and patient condition identifiers into its cost measurement methodology. We recognize that MACRA called for the creation of “episode groups and patient condition groups,” which account for a target of an estimated half of expenditures under parts A and B (with such target increasing over time as appropriate). We do not think that this language should be read as requiring the rushed development and implementation of new episode measures that have not been adequately vetted or tested.

In addition, physicians should have adequate time to understand how these tools work in practice before CMS uses performance on the re-specified measures to determine a physician’s MIPS cost score. Physicians should have the opportunity to review their cost scores based on at least one full year of performance using the new measures before they are used in the MIPS final score to adjust payment. In addition, in future years, CMS should consider applying the policy of assigning a minimum number of points to new cost measures as well as new quality measures. Based on the agency’s timeline, we expect that performance year 2021 will be the first year in which fully-refined measures using these new patient condition and patient relationship categories may be counted in the MIPS cost score.

MIPS Advancing Care Information Component

ASH appreciates CMS’ efforts to move away from the all or nothing scoring of the meaningful use program. However, while this all or nothing approach has been somewhat limited by the design of the

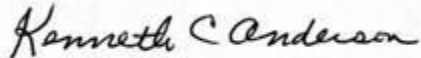
advancing care information (ACI) component, the base score is still scored in this manner. We request that CMS add flexibility to the required reporting and computation of the base score by allowing for partial credit.

Alternative Payment Models

Most of ASH's members who participate in an APM will be enrolled in the oncology care model (OCM). As you know, when practices enroll in this model, they agree to extensive quality reporting requirements and financial risk. While we understand that not all physicians in the OCM or other APMs will meet the revenue and patient thresholds to participate in the QPP's advanced APM track, earning the five percent bonus, we recommend that CMS provide further benefits to those who do not qualify as an advanced APM and remain in the MIPS track. CMS has already modified the MIPS scoring system for "MIPS APMs," but we recommend that the scoring be further adjusted in recognition to the costs associated with the practice transformation required to be in the OCM and the associated financial risk.

ASH appreciates the opportunity to provide comments on this final rule with comment period. If you have any questions or require further clarification about this letter, please contact Suzanne Leous, ASH Director of Government Relations and Practice at sleous@hematology.org or 202-292-0258.

Sincerely,

A handwritten signature in black ink that reads "Kenneth C. Anderson". The signature is written in a cursive style with a clear, legible font.

Kenneth Anderson, MD
President