ENDOCRINE SOCIETY
Hormone Science to Health

August 21, 2017

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–5522–P
P.O. Box 8016
Baltimore, MD 21244-8013

RE: Medicare Program; CY2018 Updates to the Quality Payment Program (CMS-5517-P)

Dear Administrator Verma:

On behalf of the Endocrine Society (Society), representing more than 18,000 physicians and scientists in the field of endocrinology, we appreciate the opportunity to provide comments on the proposed rule updating the Quality Payment Program (QPP) for the calendar year 2018. Founded in 1916, the Society represents physicians and scientists engaged in the treatment and research of endocrine disorders. Our members are eager to understand the Year 2 QPP requirements of the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs) to effectively care for their Medicare patients.

The Society is extremely supportive of the agency's efforts to reduce reporting requirements and support small and rural practices in this proposed rule. We look forward to working closely with the Centers for Medicare and Medicaid Services (CMS) as implementation of the QPP proceeds and offer comments on the following areas of importance to our members:

1. Further Simplification of MIPS
2. Low Volume Threshold
3. Virtual Group Option
4. MIPS Submission Mechanisms
5. Topped Out Measures
6. Cost Performance Category
7. Complex Patient Bonus
8. Reporting Threshold for Glycemic Screening and Referral Improvement Activity

Further Simplification of MIPS

We support CMS' efforts to simplify the requirements of MIPS and reduce the reporting burden on clinicians. However, we feel there are two areas where the agency can further reduce the burden on participating clinicians: MIPS scoring and reporting.

The scoring for MIPS remains extremely complicated, particularly for the Advancing Care Information (ACI) component. As currently structured, it is extremely difficult for clinicians to predict their score in advance and identify areas for improvement. **We recommend that the agency simplify the composite**

2055 L Street NW
Suite 600
Washington, DC
20036

T. 202.971.3636
F. 202.736.9705

endocrine.org

scoring system so that the weighting of measures and activities is more directly linked to their contribution to the composite performance score.

Despite the agency's efforts to streamline the reporting requirements of the legacy quality programs through the new program, CMS has failed to create one cohesive reporting program and instead maintained a siloed approach to reporting that may create unnecessary confusion or burden for clinicians and their staff. **We recommend that CMS explore ways to create a more streamlined approach, potentially developing focus areas that can be evaluated for all performance categories.** For example, our members could be evaluated on diabetes or thyroid care.

Low Volume Threshold

The Society supports the increase of the low-volume threshold to exclude eligible clinicians that have Part B allowed charges less than or equal to $90,000 or provide care to less than or equal to 200 Part B beneficiaries. This new threshold will prevent small practices and solo providers from being disproportionately impacted by the program's payment adjustments, and we support CMS' efforts to protect those practices that may lack the resources necessary to succeed under the payment system. However, some clinicians who may be exempt are eager to be evaluated under the new reporting requirements. **As such, we urge CMS to implement its proposal to allow physicians who are excluded under the threshold to opt-in beginning in performance year 2019, allowing them to be evaluated under the same standards as other participating clinicians.**

Virtual Group Option

During the rulemaking cycle for the first year of the QPP, CMS declared its intention to create a virtual group option to give solo practitioners and small practices the option to participate in a large group if they chose. We were disappointed that the agency could not implement this proposal for the first year of the program, but support the structure that it is included in this proposed rule.

MIPS Submission Mechanisms

Eligible clinicians are required to submit data for three of the four MIPS performance categories. Providers may choose from several methods to submit the required data including administrative claims; electronic health record (EHR); qualified clinical data registries (QCDR); CAHPS Survey Vendor; and the CMS Web Interface among others. CMS is proposing to allow multiple submission mechanisms as necessary to meet the requirements of the quality, improvement activities, or advancing care information performance categories.

While the Society appreciates CMS' effort to create more flexibility and increase a clinician's ability to receive the maximum number of points available, we are concerned that the proposal to allow multiple submission mechanisms will create confusion and increase the administrative burden that may ultimately negatively impact patient care. **The Society requests that CMS reconsider this proposal and continue to work with specialty organizations to find alternative ways to provide flexibility for physicians to successfully participate in MIPS.**

The Society continues to believe the best way to ensure participating clinicians can meet the requirements of each performance category is to increase the number of meaningful measures available. We welcome the opportunity to work with CMS to ensure this is the case for our members.

Topped Out Measures

CMS outlines a three-year timeline for identifying and removing topped out measures under which a measure will be removed one year after being identified as topped out for three consecutive years. In the rule, six measures were identified as topped out with their first year of eligibility for removal being 2021. The Society agrees with a phased-in approach for identifying and removing topped out measures, but **requests that the agency consider and review the number of measures available to a specialty before removing a measure rather than automatically removing them**. There are still not enough measures for many specialists, including endocrinologists; those who do not specialize in the treatment of patients with diabetes have even fewer measures directly applicable to the care they provide to their patients.

Cost Performance Category

CMS is proposing to maintain the weight of the cost performance category at zero percent for the 2020 MIPS payment year while continuing to educate providers on cost measures and developing more episode-based measures. **We urge CMS to finalize this proposal and appreciate the agency's recognition of the importance of ensuring clinicians have appropriate episode-based measures available. The Society believes that CMS should continue to delay the implementation of the cost performance category until the attribution methodology is developed and there is an opportunity for review and public comment.**

The Society is supportive of CMS' move to engage clinician groups in developing new episode-based measures for use in future rulemaking. During the 2017 MIPS performance year, only one episode-based measure was applicable to endocrinology and that only applied to a narrow subset of endocrinologists. It is important that more episode-based measures are developed that apply across the spectrum of endocrinology, particularly covering diabetes and thyroid conditions. **We encourage CMS to continue to work with stakeholders in developing a larger set of episode-based measures and welcome the opportunity to participate in the development.**

Complex Patient Bonus

CMS has proposed the creation of a complex patient bonus of no more than three points to add to the final MIPS score for the 2020 MIPS payment year for clinicians that submit data for at least one performance category. The bonus would be calculated by finding an average Hierarchical Condition Category (HCC) risk score for each MIPS eligible clinician or group. The Society supports the proposal to create a complex patient bonus as many of the patients that endocrinologists treat have complex diseases.

However, we are concerned with the proposed usage of the HCC risk score as the basis for calculating the complex patient bonus. While the HCC risk score has been used in other programs for the purposes of risk adjustment, its use in this manner is currently unproven and may not adequately discriminate

complexity within certain diseases such as diabetes, measuring only acute and chronic complications. As such, we recommend further study to improve the measurement of risk in endocrinology, and most specifically diabetes. As CMS works to protect both complex patients' access to care and the providers that care for them from being at a disadvantage when participating in MIPS, it is imperative that measurement of patient complexity be reliable. **The Society would encourage CMS to thoroughly study the appropriateness of using HCC risk scores to calculate the complex patient bonus.**

Reporting Threshold for Glycemic Screening and Referral Clinical Improvement Activity

The Society is pleased that CMS has included Improvement Activities (IAs) to recognize the efforts of clinicians to identify patients at risk of developing Type 2 diabetes and preventing the progression through referral to a Diabetes Prevention Program (DPP). However, we are concerned that setting a 75 percent reporting threshold for both activities will be unattainable by most clinicians and will discourage clinicians from selecting these to fulfill the IA requirement. This will have an adverse impact on the diabetes community's efforts to spur greater activity in screening and referring eligible patients to DPP programs.

As the Glycemic Screening IA is new and no quality measure exists with which clinicians are familiar, **the Society suggests that CMS lower the threshold to 60 percent in the first year**. This is the threshold that CMS proposed for similar IAs in the 2017 program year (diabetes management; anticoagulation) and we believe this would be an appropriate threshold for the first year that clinicians perform this activity.

Similarly, the Glycemic Referring Services IA also requires a 75 percent threshold. This threshold is significantly higher than the current referral rates reported in medical literature; many studies and conversations with DPP providers relay that DPP referral rates are in the single digits due to many confounding factors. Furthermore, even if a healthcare provider could achieve a high referral rate, many regions lack an adequate supply of Centers for Disease Control and Prevention (CDC)-recognized DPPs to handle these referrals. **We strongly urge CMS to modify this activity to require that the clinician attest to having instituted a systematic referral process for the first year and suggest that CMS establish a 10 percent threshold with incremental increases over time.** This would allow the demand for DPP classes prompted by provider referrals to more closely match the supply of DPP classes available. If CMS chooses to keep the 75 percent threshold in place, we ask that CMS weight the activity as "high" in recognition of the substantial time, effort, and challenge of meeting such a high standard.

We appreciate the opportunity to provide comments to CMS on this proposed rule. Please contact Stephanie Kutler, Director, Advocacy & Policy at skutler@endocrine.org if we can provide any additional information or assistance as CMS moves forward in this process.

Sincerely,

James R. Rosenzweig, M.D.

James Rosenzweig, MD
Chair, Quality Improvement Subcommittee
Endocrine Society