

December 20, 2018

Ms. Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1693-IFC
P.O. Box 8013
7500 Security Boulevard
Baltimore, MD 21244-8013

Submitted electronically: <http://www.regulations.gov>

Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program

Dear Administrator Verma:

The American Society for Radiation Oncology (ASTRO) appreciates the opportunity to provide written comments on the “Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program” published in the Federal Register as a final rule on November 23, 2018.

ASTRO members are medical professionals practicing at hospitals and cancer treatment centers in the United States and around the globe. They make up the radiation treatment teams that are critical in the fight against cancer. These teams include radiation oncologists, medical physicists, medical dosimetrists, radiation therapists, oncology nurses, nutritionists and social workers. They treat more than one million cancer patients each year. We believe this multi-disciplinary membership makes us uniquely qualified to provide input on the inherently complex issues related to Medicare payment policy and coding for radiation oncology services.

The proposed rule updates the payment policies and payment rates for services furnished under the Medicare Physician Fee Schedule (MPFS) and modifies requirements associated with the Merit Based Incentive Payment System (MIPS) and Alternative Payment Model (APM), as part of the Quality Payment Program (QPP) effective January 1, 2019. ASTRO appreciates the overall focus on reducing administrative burden and CMS efforts as part of its “Patients Over Paper Work” initiative. In the following letter, ASTRO seeks to provide input on these important initiatives and how they impact the field of radiation oncology. We look forward to opportunities where we may be able to work with CMS and Administration officials to refine and implement many of these initiatives. Key issues addressed in this letter follow:

- Potential Alternative Payment Model for Radiation Therapy
- Update to Direct Practice Expense Inputs for Supply and Equipment Pricing
- Evaluation and Management Code (E/M) Modifications

- MIPS Clinician Eligibility
- MIPS Determination Period
- MIPS Performance Categories
- Qualified Clinical Data Registry
- Alternative Payment Models

Potential Alternative Payment Model for Radiation Therapy

The 2019 MPFS final rule strongly indicated forward momentum on the development of a Radiation Oncology Alternative Payment Model (RO-APM). The rule highlighted the CMS Office of Innovation (CMMI) report to Congress in November 2017, noting that radiation oncology is a “promising” area of health care for bundled payment. Shortly after the issuance of the MPFS final rule, Health and Human Services Secretary Alex Azar announced the forthcoming issuance of new payment models, including a model for radiation oncology. The Secretary also mentioned interest in pursuing mandatory models.

ASTRO is pleased that a RO-APM is getting closer to reality. ASTRO has worked for many years to craft a viable payment model that would stabilize payments, drive adherence to nationally-recognized clinical guidelines and improve patient care. ASTRO believes its proposed RO-APM will allow radiation oncologists to participate fully in the transition to value-based care that both improves cancer outcomes and reduces costs.

ASTRO has aggressively pursued adoption of this proposed model with the CMMI, and we appreciate the opportunities we’ve had to share our ideas with the agency to bring about this needed reform. While ASTRO is enthusiastic about the prospects for a RO-APM, we have concerns about the possibility of launching a model that requires mandatory participation from all radiation oncology practices at the outset. ASTRO recognizes that mandatory and voluntary models can take many different forms, and we look forward to working with Secretary Azar, CMS, and CMMI to determine the best approach for the field of radiation oncology.

ASTRO believes it is important to acknowledge that any radiation oncology payment model will represent a significant departure from the status quo. Care must be taken to protect access to treatments for all radiation oncology patients and not disadvantage certain types of practices, particularly given the very high fixed costs of running a radiation oncology clinic.

ASTRO appreciates CMS maintaining stability in payment under the MPFS for the G codes for radiation therapy treatment delivery and image guidance services, which were frozen through 2018 at 2016 levels under the Patient Access and Medicare Protection Act of 2015. The payment freeze for these G codes was extended through the end of 2019 under the Bipartisan Budget Act of 2018. As CMS takes the final steps toward launching a RO-APM, we look forward to working with Congress and the Administration to ensure that payment stability is preserved for these codes and all radiation therapy services, as these payments will form the foundation of the APM. We believe this stability is critical for radiation oncologists to begin the

transition to value-based payment, which ultimately will drive higher quality and lower cost cancer treatment.

Update to Direct Practice Expense Inputs for Supply and Equipment Pricing

In the 2019 MPFS Final Rule, CMS finalized an update to the Direct Practice Expense (PE) inputs for supply and equipment pricing. ASTRO appreciates CMS' efforts to acquire current pricing information, as well as the Agency's willingness to reconsider some of the significant reductions found in the valuations put forth in the proposed rule. However, we remain concerned that the decision to contract with StrategyGen was done with limited stakeholder input and urge the Agency to pursue similar activities through a collaborative stakeholder process in the future.

ASTRO appreciates that CMS, in the final rule, overturned their proposal to reduce CMS equipment item number ER083 – SRS System, SBRT, Six Systems, Average from \$4,000,000 to \$931,965. However, we believe the current CMS decision to reduce ER083 from \$4,000,000 to less than \$3,000,000 is still incorrect. It is unclear how CMS weighted the data points they received from the contractor for the various SBRT systems. ASTRO encourages the Agency to work with the AMA RUC Practice Expense Committee to review the identified supply and equipment items CMS would like updated. The unexpected 25 percent reduction in the SBRT equipment costs results in significant reductions in reimbursement for CPT Code *77373 Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions*. Undervaluing equipment inputs has the potential to create access to care issues and potentially reduce the utilization of services that provide high quality patient outcomes.

Evaluation and Management Code (E/M) Modifications

In the MPFS final rule, CMS is taking a measured approach to reforming the coding and billing requirements associated with the Evaluation and Management (E/M) codes. While the Agency finalized modifications to reduce documentation burden for physicians, it is delaying the proposal to collapse the codes and establish a blended payment until January 1, 2021.

ASTRO applauds this decision. Physicians should be given more flexibility regarding the documentation of patient services, so they may spend more time focusing on patient care and improving healthcare outcomes. This decision provides physicians with that opportunity, while also providing the time necessary to transition to a revised coding and billing structure.

Merit-based Incentive Payment System (MIPS)

ASTRO appreciates the Agency's continuing efforts to drive consistency in MIPS from the 2018 performance year, but we remain concerned about the eligibility and incentive structure of the program, given the high cost of program compliance. ASTRO continues to recommend CMS streamline the MIPS program so that quality improvement can be achieved without the burden and significant cost of the current reporting requirements.

MIPS should be a path toward participation in Advanced APMs and other value-based care. Despite rule changes and statutory allowances from Congress, MIPS remains a reporting program from the fee-for-service era.

Clinician Eligibility

The final rule continues to set eligibility thresholds at greater than \$90,000 in covered professional services and 200 Medicare Part B beneficiaries, who are furnished covered professional services. In addition, the final rule adds a new eligibility criterion: more than 200 covered professional services under PFS. Exceeding all criteria in the low volume threshold means that a physician or group will be included in the MIPS program for the 2019 performance year. **ASTRO appreciates efforts to refine eligibility criteria; however, we continue to believe this new criterion will not have a meaningful impact and should be removed.** As we have mentioned in previous comment letters, the existing two criteria appropriately identify whether an eligible clinician can participate in MIPS. **We believe that adding services furnished to Medicare enrollees has the potential to incentivize clinicians to focus on volume of services, rather than the value of services provided to patients, and should therefore be removed.**

The Agency also finalized a proposal to allow clinicians or groups to opt-in to MIPS if they meet or exceed one or two, but not all, of the low-volume threshold criterion. **ASTRO continues to support the proposal to allow clinicians to opt-in to the MIPS program; however, as mentioned above, we oppose the addition of the third criterion.** The Agency finalized a proposal that clinicians choosing to opt-in would be required to indicate their decision via the Quality Payment Program (QPP) website to receive a MIPS payment adjustment. ASTRO thanks CMS for allowing new and/or low-volume clinicians the opportunity to test their own data. **ASTRO encourages CMS to quickly develop and provide educational materials to explain the opt-in policy to mitigate potential clinician confusion.**

Determination Period

CMS finalized a single MIPS determination period that would be used for purposes of the low-volume threshold and to identify MIPS eligible clinicians and non-patient facing, small practice, hospital-based, and Ambulatory Surgical Center (ASC)-based, as applicable. The Agency is including the facility-based or virtual group eligibility determination periods or the rural and Health Professional Shortage Areas (HPSA) determinations in the MIPS determination period, as they each require a different process or timeline that does not align with the other determination periods, or do not utilize determination periods. **ASTRO thanks the Agency for finalizing this proposal, as it aims to streamline an already complex process. We appreciate that the Agency recognized the burden placed on clinicians, especially those that may find out late in a performance year that they are no longer eligible to participate in MIPS, after significant resource outlay.**

MIPS Performance Categories

Performance Category Reweighting

CMS is continuing the automatic Promoting Interoperability (PI) exemption for hospital-based practices and hardship applications for the 2019 performance period. The Agency believes this is particularly important for small practices. The category exemptions re-weight the PI category to zero. As in previous years, category points will be reweighted completely to the Quality performance category. **ASTRO is disappointed that the Agency did not finalize its proposal to more equally redistribute weights to the Quality and Improvement Activities categories. We continue to believe redistributing weights to Quality and Improvement Activities more accurately weights the Improvement Activity category, which is the one performance category that we believe has the power to transform a practice and drive true quality improvement.**

Reporting Period for Promoting Interoperability and Improvement Activities Performance Categories

In the proposed rule, the Agency sought comments on changing the reporting period for the Promoting Interoperability and Improvement Activities categories to a full year for future performance years. **ASTRO is pleased that the Agency is keeping a 90-day reporting period for both categories for future years.**

Quality Performance Category: Reporting Period

ASTRO is disappointed that CMS is continuing a full calendar year reporting period for the Quality category. As we have mentioned in previous comment letters, a full year does not allow clinicians to assess measures, implement them into workflows and address quality improvement requirements. When compounded with the 60 percent data completion requirement, a full year of reporting is unreasonable for measures associated with a high volume of a clinician's patient population. Additionally, the year-long reporting period puts undue pressure on measure developers and registry vendors implementing new measures.

Quality Performance Category: Data Completeness

We thank CMS for being consistent by maintaining the data completeness threshold of 60 percent for the 2019 performance year, with a minimum of 20 cases per measure. CMS is also maintaining the 1-point floor for measures that do not meet data completeness requirements. This policy does not apply to small practices who will continue to earn three points for submitting measures that do not meet data completeness.

CMS finalized a proposal that measures impacted by clinical guideline changes, or other changes that CMS believes may pose patient safety concerns, will be given a score of 0 and the Quality performance category denominator would be reduced by 10. If this situation occurs, the clinician would be required to submit data for one less measure. **We appreciate that CMS recognizes that evidence can and does change, and the Agency will notify clinicians in a timely**

manner; however, we are disappointed that the Agency did not establish an easy route of communication, such as a dedicated web portal or email address, for notification by measure developers to CMS of clinical guideline changes. We ask that a clear communication path be established quickly to assist with this important addition to the MIPS program.

Quality Performance Category: Measures

ASTRO also is concerned with CMS placing emphasis on outcome measures, as meaningful outcomes in a calendar year are difficult to measure in some diseases, including cancer. **Given that cancer treatment and meaningful outcomes cannot be measured neatly in the course of one year, ASTRO recommends that CMS continue to support the use of process measures. Additionally, we oppose the removal of non-high priority process measures.**

Quality Performance Category: Topped-Out Measures

ASTRO is disappointed that CMS finalized its “extreme topped out” proposal. For those measures that reach a new designation of “extreme topped out” status (measures that are topped-out with an average performance rate between 98-100%), the Agency may propose removal during the next rulemaking instead of waiting through the four-year cycle. Measure development is a long, resource intensive process, and measure developers need time to develop new measures to take the place of those that are topped out. Further, the current topped out measure designation is still based either on Physician Quality Reporting System (PQRS) data or MIPS data from “Pick Your Pace”, and therefore data is being used to set performance rates that is not representative of the current program. **We continue to urge the Agency to remain conservative in the designation of topped out measures to balance the number of measures removed from MIPS with the number of new measures added to the program.** Removing topped out measures, including extreme topped out measures, from MIPS will significantly reduce reporting options for specialties and small practices.

As part of the extreme topped out designation, the Agency is removing Radiation Dose Limits to Normal Tissue (NQF #0382) measure. **ASTRO opposes the removal of this measure as it promotes patient safety and actively reduces toxicity.**

Cost Performance Category: Total Per Capita Cost and Medicare Spending Per Beneficiary Measures

ASTRO is concerned that radiation oncologists are being scored on both the total per capita cost (TPCC) and Medicare spending per beneficiary (MSPB) measures and urges CMS to adopt specifications more in line with the recent field test. According to the CMS 2018 Merit-based Incentive Payment System Cost Performance Category Fact Sheet, for the TPCC measure, “beneficiaries are attributed to a single TIN-NPI based on the amount of primary care services a beneficiary received, and the clinician specialties that performed those services, during the performance period.” Radiation oncologists generally do not provide primary care services; however, they may have non-physician clinicians in their practice who do. Several ASTRO members received feedback on the TPCC measure in their 2017 Performance Feedback

Reports, which we believe is because a non-physician clinician working in a radiation oncology practice billed for primary care services. However, without beneficiary data, it is impossible for the practice to check the accuracy of the attribution for procedures, patients, or clinicians.

ASTRO appreciates the Agency's explanation that "the total per capita cost measure uses a primary care attribution method in which a specialist would not be attributed a patient unless that patient did not see a primary care clinician (based on the Medicare specialty) during the year."

ASTRO requests that in future feedback reports, CMS provide beneficiary level data when this measure is scored.

In the same Fact Sheet referenced above, the MSPB measure "assesses total Medicare Parts A & B costs incurred by a single beneficiary immediately prior to, during, and 30 days following a qualifying inpatient hospital stay and compares these observed costs to expected costs. Expected costs of an episode are based on the clinical condition or procedure that triggers the episode along with other factors that may influence cost but are not directly related to patient care."

Additionally, the Agency states that "for the [Medicare Spending Per Beneficiary (MSPB)] measure, we do not believe it is appropriate to limit attribution to primary care clinicians as specialists may perform procedures or manage patients in the hospital and can have a significant influence on the overall spending during the hospitalization." ASTRO disagrees with this assessment, as most radiation oncology services are provided in the outpatient setting and are planned prior to beginning treatment delivery. While the patient could be treated with radiation therapy within the 3 days prior to and 30 days after an admission, if the reason for the admission is not related to radiation oncology services, then the radiation oncologist should not be scored on this measure. **We therefore believe that the MSPB measure should be tied to the admitting physician and the services related to the ICD-10 code that generated the admission.**

Finally, ASTRO supports the Agency's plan to "comprehensively reevaluate the measures every 3 years to ensure that they continue to meet measure priorities," and request that this reevaluation be widely publicized to allow for more physician feedback.

Improvement Activities Performance Category: Overall Category

ASTRO appreciates the Agency's decision to maintain most elements of the Improvement Activities performance category. Consistent requirements and expectations help clinicians succeed. CMS has proposed new Improvement Activities and modifications to existing activities and **ASTRO is pleased to see so much focus on the patient experience and overall care.**

Promoting Interoperability Performance Category: EHR Certification

CMS is requiring that eligible clinicians use 2015 Edition CEHRT for the 2019 performance year. **ASTRO is disappointed that CMS is removing the option of using 2014 Edition CEHRT, without putting pressure on the vendor community to update their certifications.** As we have mentioned in previous comment letters, not all radiation oncology EHR vendors have a 2015 Edition available and removing the 2014 Edition option could harm radiation oncologists' chances to succeed in the MIPS program, through no fault of their own. Eligible clinicians do not have control over the EHR products issued by vendors and penalizing providers

for not achieving any level of CEHRT status must be avoided at all cost. **ASTRO again strongly recommends that the Agency require EHR vendors to comply with 2015 Edition requirements.**

We appreciate that clinicians can utilize the hardship application if they do not have access to 2015 CEHRT, and that 2014 CEHRT will not be decertified. We again request information on whether there will be a time limit for the uncontrollable circumstance's hardship for 2014 CEHRT.

Promoting Interoperability Performance Category: Scoring Methodology

The Agency finalized a new scoring methodology based on performance on a set of required measures, with the goal of increasing focus on patient care and health data exchange through interoperability. **While we appreciate the Agency's goals of the new Promoting Interoperability performance category and applaud the alignment between disparate reporting programs, we believe that the new requirements will be very difficult to achieve without mandatory compliance from the vendor community.** Radiation oncology data, for example, is housed in multiple electronic systems, including treatment planning software, oncology specific EHRs, hospital EHRs and others. Most of these systems struggle to interface with one another, making true interoperability difficult to achieve. **We again urge the Agency to mandate that EHR vendors comply with the requirements set forth in the MIPS program and not hold physicians accountable for the lack of EHR interoperability to meet program goals. We also ask that the Agency broaden their scope of interoperability to promote that exchange of data--whether between EHRs, from EHR to registry or to a digital device--be achievable, usable and impactful toward patient care.**

While CMS is further implementing the program, we believe that the new scoring methodology removes much of the flexibility found in past years. These changes, coupled with the requirement for 2015 Edition CEHRT, may level the playing field, but it will increase administrative and financial burdens on clinicians.

The Agency finalized two new bonus measures to the e-Prescribing objective: Query of Prescription Drug Monitoring Program (PDMP) and Verify Opioid Treatment Agreement. **ASTRO appreciates the low-threshold required (1 in the numerator) to receive the bonus, and we understand why CMS is proposing inclusion of these bonus measures; however, we again request that they remain as bonus measures until the Agency can confirm that all health IT vendors have incorporated them into their systems.** The Agency finalized the proposal of requiring these measures beginning in the 2020 performance year and will require that for those clinicians who request an exemption, the points will be redistributed to the e-Prescribing objective. This is problematic for those clinicians, such as radiation oncologists, who already request an exclusion from the e-Prescribing objective. Similarly, the Agency has allowed exemptions in previous years for Health Information Exchange and E-Prescribing measure. **ASTRO again seeks clarification on whether clinicians are excluded from both the e-Prescribing and Health Information Exchange measures. We reiterate our request that reweighting should be more flexible to account for the patient populations of different**

practices and specialties. We recommend consistency with the Quality category rules – if a clinician does not have anything to report, the denominator is decreased.

Promoting Interoperability Performance Category: Measures

CMS finalized its proposal that the Protect Patient Health Information objective and its associated measure, Security Risk Analysis, would remain part of the requirements for the Promoting Interoperability performance category, but would no longer be scored as a measure and would not contribute to the performance category score. The Agency believes that MIPS eligible clinicians should already be meeting the requirements for this objective and measure, as it is a requirement of the Health Insurance Portability and Accountability Act (HIPAA). **ASTRO is disappointed that CMS did not take our recommendation to remove Security Risk Analysis from the MIPS program since it is already mandated by HIPAA compliance requirements.**

Facility-Based Quality and Cost Performance Categories

CMS finalized a proposal to expand facility-based scoring for the 2019 performance year to physicians in on-campus outpatient hospitals, where facility-based clinicians can use their facility's Hospital Value-based Purchasing (VBP) score as a proxy for their Quality and Cost Performance Categories. **We applaud CMS for looking at quality and value in a holistic approach by including this option for the 2019 performance year. We again recommend that CMS include this eligibility with the special status listed on the QPP website early in the performance year to reduce burden for physicians and make the facility scores available to clinicians to help them make informed decisions on their quality reporting.**

Qualified Clinical Data Registry (QCDR)

ASTRO is pleased that CMS finalized a modification to the definition of a QCDR, requiring that an approved entity have clinical expertise in medicine and quality measurement, starting in the 2020 MIPS performance year. **ASTRO appreciates CMS's observations that approved entities should have expertise in medicine and quality measure development and supports this new definition.**

ASTRO is disappointed that the Agency is finalizing a proposal that, starting with the 2020 MIPS performance year, QCDRs must have at least 25 participants by January 1 of the year prior to the performance period. Newly approved QCDRs will not have enough participants by January 1 and will therefore not be able to grow their database.

ASTRO is also disappointed that CMS finalized a revision to an established self-nomination period by moving the submission date earlier by two months. This change could have significant effect on QCDR owners and measure developers and falls prior to the proposed rule for the same performance year, thereby removing any insight and proposals that CMS might offer in the rule.

ASTRO thanks CMS for retaining its existing policy that QCDRs may seek permission directly from measure stewards, rather than implementing a licensing agreement with CMS.

Other Issues

ASTRO requests that within one year of the end of the performance period, the Agency provide specialty-specific feedback for all performance categories to assist with assessing performance in the MIPS program. Specialties require specific data to see where education is needed so that their clinicians can succeed in the program.

Alternative Payment Models (APMs)

Advanced APMs

CMS has finalized several key modifications to the Advanced APM requirements. First, the Agency is increasing the Advanced APM CEHRT threshold to 75 percent of eligible clinicians from the previous threshold of 50 percent. The Agency believes this change aligns with increased adoption of CEHRT among providers and suppliers that is already taking place.

CMS also finalized revisions to the definition of a MIPS comparable measure in the Advanced APM criteria to reduce confusion and reporting burden. Specifically, the Agency is requiring that at least one of the quality measures upon which an Advanced APM bases payment must be finalized on the MIPS final list of measures, be endorsed by a consensus-based entity; or otherwise determined by CMS to be evidence-based, reliable and valid.

In past rulemaking, CMS required outcomes measures, when they are available, for Advanced APMs but has not provided explicit qualifiers for outcomes measures. In the 2019 final rule, CMS explicitly requires the use of at least one outcome measure that must be evidence-based, reliable, and valid. The Agency will continue to recognize that outcomes measures are not available or applicable to all APMs.

Finally, CMS finalized its decision to retain the 8 percent revenue-based nominal amount standard for Advanced APMs through performance year 2024 that was initially established in the 2017 QPP final rule. CMS believes that 8 percent of APM entity Medicare Parts A and B revenues represents an appropriate standard for more than a nominal amount of financial risk.

ASTRO is pleased that CMS finalized its decision to retain the 8 percent revenue-based nominal amount standard for Advanced APMs. This decision provides APM entities and physicians with the stability necessary to achieve sustainable value-based payment over a period of time. MACRA already provides for steep increases in financial risk requirements for Advanced APMs over time by increasing the percentage of participants' revenues that must come through the APM for participants to attain Qualified APM Participant (QP) status.

ASTRO appreciates clarification regarding "MIPS Comparable Measures" requirements for Advanced APMs. **Requiring APMs to include just one MIPS measure that is endorsed by a consensus-based entity; or otherwise determined by CMS to be evidence-based, reliable and valid will reduce the reporting burden. It will also give APMs the opportunity to test other measures that may be more meaningful to achieving the goals of the APM.**

As for outcomes measures, ASTRO appreciates CMS' recognition that they are not widely available or applicable to all APMs. **However, we remain concerned that CMS is placing too much emphasis on outcome measures, particularly given that cancer treatment and meaningful outcomes cannot be measured neatly within a distinct period of time. ASTRO recommends that CMS continue to support the use of process measures until meaningful outcome measures in cancer care are available.**

Finally, ASTRO is disappointed that CMS finalized an increase of the CEHRT threshold requirement from 50 percent to 75 percent. While we appreciate the Agency's goal of promoting interoperability, we believe it will be difficult to achieve and additional time is required. Radiation oncology data, for example, is housed in multiple electronic systems, including treatment planning software, oncology specific EHRs, hospital EHRs and others. Most of these systems struggle to interface with one another, making true interoperability difficult to achieve. **As stated above, we urge the Agency to mandate that EHR vendors comply with the requirements set forth in the MIPS program and not hold physicians accountable for the lack of EHR interoperability to meet program goals. We also ask that the Agency broaden their scope of interoperability to promote that exchange of data--whether between EHRs, from EHR to registry or to a digital device--be achievable, usable and impactful toward patient care.**

Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration

In an effort to encourage greater participation in alternative payment arrangements, CMS has finalized its decision to launch the MAQI Demonstration in 2018. Currently, MIPS eligible clinicians are required to comply with MIPS reporting requirements, even if they are participating in an alternative payment arrangement with a Medicare Advantage Organization (MAO).

The MAQI demonstration exempts MIPS eligible clinicians from MIPS reporting requirements and is designed to test whether excluding MIPS eligible clinicians from MIPS reporting requirements will result in increased or continued participation in other payment arrangements similar to Advanced APMs. MIPS eligible clinicians seeking to participate in the MAQI demonstration must become a designated Qualified Participant (QP). To become an eligible QP the clinician must meet 1) either the patient or payment thresholds required for Advanced APM QP status and 2) submit required documentation regarding the MAO alternative payment arrangement.

The requirements for qualifying payment arrangements under the MAQI demonstration will be the same as the Advanced APM requirements, which include the use of CEHRT, MIPS comparable measures, and the establishment of two-sided risk that involving a nominal amount at risk.

ASTRO appreciates that CMS continues to expand its commitment to the establishment of APMs. We agree that MIPS eligible clinicians participating in alternative payment arrangements with MAOs should qualify as Advanced APM participants, if they meet

established QP Standards. While we appreciate the desire to see more physicians participate in APMs, we remain concerned that the number of available APMs remains limited and we look forward to the development of a RO-APM.

MIPS APMs

In the 2019 MPFS final rule, CMS clarifies the requirement for MIPS APMs to assess performance on quality measures and cost/utilization; modify the Promoting Interoperability (PI) reporting requirement related to the shared savings program; and updates the MIPS APM measure sets.

In the 2017 final rule, CMS finalized the following requirements for MIPS APMs: 1) APM entities participate in an APM under an agreement with CMS or by law or regulation; 2) the APM requires that the APM Entities include at least one MIPS eligible clinician on a Participation List; and 3) the APM bases payment incentives on performance (either at the APM entity or eligible clinician level) on cost/utilization and quality measures.

Stakeholder feedback on the established criteria indicated that there is some confusion regarding the intent of the third criterion. CMS is modifying the criterion to specify that a MIPS APM must be designed in such a way that participating APM Entities are incented to reduce costs of care or utilization of services, or both. According to the Agency, this makes it clear that a MIPS APM could take into account performance in terms of cost/utilization using model design features other than the direct use of cost/utilization measures. **ASTRO appreciates CMS' efforts to clarify the MIPS APM criterion. Because MIPS APMs are a blend of both programs, it is important that there be some flexibility regarding performance incentives that ultimately encourage the successful transition to full APM status.**

Thank you for the opportunity to comment on this proposed rule. We look forward to continued dialogue with CMS officials. Should you have any questions on the items addressed in this comment letter, please contact Anne Hubbard, Director of Health Policy, at 703-839-7394 or anne.hubbard@astro.org.

Respectfully,



Laura I. Thevenot
Chief Executive Officer