

December 14, 2017

Seema Verma  
Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-5522-FC and CMS-5522-IFC  
P.O. Box 8013  
7500 Security Boulevard  
Baltimore, MD 21244-8013

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

**Re:** Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year [CMS-5522-FC and CMS-5522-IFC]

Dear Administrator Verma:

The American Society for Radiation Oncology (ASTRO) appreciates the opportunity to provide written comments on the “Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year” final rule as published in the Federal Register on November 16, 2017. ASTRO is committed to ensuring that all radiation oncologists can fully and meaningfully participate in the Quality Payment Program (QPP). We are dedicating significant resources to educating our membership about the program and working with the Agency to ensure that program requirements are fair and achieve the spirit of the Medicare Access and CHIP Reauthorization Act (MACRA).

ASTRO members are medical professionals, practicing at hospitals and cancer treatment centers in the United States and around the globe, and who make up the radiation therapy 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, and treat more than one million cancer patients each year. We believe this multidisciplinary membership makes us uniquely qualified to provide input on the inherently complex issues related to Medicare payment policy.

The rule finalizes revisions to the QPP effective January 1, 2018. In the final rule, the Centers for Medicare and Medicaid Services (CMS) underscores its commitment to using the initial QPP years as an opportunity to focus on educating clinicians on Merit-based Incentive Payment System (MIPS) program participation and increasing opportunities for clinicians to join Advanced Alternative Payment Models (APMs).

### **Overall Comments**

ASTRO appreciates the Agency’s efforts to provide an incremental approach to the implementation of the QPP. We recognize efforts to further improve the program by addressing the challenges facing small practices, as well as those treating particularly complex patient populations. However, we remain concerned with the rapid pace of change within the QPP program, particularly as it relates to MIPS. Without any data on the first year of participation, CMS finalized significant modifications to the

requirements, scoring, and options for the 2018 performance year. While some of these changes provide clinicians with additional flexibility, the complexity of the MIPS program remains a significant concern. ASTRO continues to urge CMS to consider a more gradual approach to implementation of the QPP in future years. Clinicians and vendors require more time to learn, adapt and prepare for successful participation in the complex MIPS program.

Additionally, ASTRO is concerned with the amount of burden that participation in MIPS places on clinicians. Setting a 60 percent reporting threshold on quality measures for a full calendar year is an example of an unreasonable requirement considering the lack of electronic measures and the inability to readily abstract data from electronic data sources. Additionally, the decision to move forward with more stringent quality reporting requirements is in stark contrast to the Administration's recent "Patients over Paperwork" initiative, which seeks to reduce regulatory burdens on physicians.

ASTRO strongly urges CMS to decelerate the pace of change and implementation of new components. MIPS data should be utilized to inform changes to the program, but as no data is currently available, the Agency is making decisions without a foundation.

In the final 2018 QPP rule, CMS finalizes Advanced APM policies associated with nominal revenue at risk requirements, as well as Qualified APM Participant (QP) performance period and determination status. The final rule also provides additional information regarding the establishment of an All-Payer APM, as well as clarifying information regarding MIPS APMs. While ASTRO appreciates that CMS is providing more details regarding the policies associated with the various APM programs, we remain concerned that the APM program is complex and may be difficult to navigate. ASTRO is committed to ensuring that radiation oncology can fully participate in an Advanced APM that drives greater value in cancer care. We urge the Agency to consider ways in which it can streamline the APM participation process, particularly for Advanced APMs, so that as many physicians as possible can participate.

Finally, ASTRO is pleased that CMS recognizes the hardships caused by extreme and uncontrollable circumstances, and thanks the Agency for not requiring MIPS hardship exemption applications from those affected by the hurricanes of 2017. However, we urge CMS to continue to not require hardship exemption applications in future years as there is no way to predict the extent of damage or hardship caused by extreme and uncontrollable circumstances. By not requiring an application, affected clinicians can focus on getting their practices up and running so that they are able to care for patients.

## **Merit-based Incentive Payment System (MIPS)**

### **General Program**

#### ***Clinician and Group Designations***

**ASTRO is disappointed that CMS did not provide uniformity across clinician and group definitions in the final rule.** For example, small practices are defined as 15 or less eligible clinicians, but groups eligible for virtual groups are defined as 10 or less eligible clinicians. Ideally, these definitions should match and thereby simplify classifications. While we understand that some of these definitions were predetermined by Congress in MACRA, it would benefit the program greatly to establish more consistency.

#### ***Clinician Eligibility***

**ASTRO supports the increased low-volume threshold for eligible clinicians and groups from \$30,000 in Medicare Part B payments AND 100 Medicare patients in 2017 to \$90,000 in Medicare**

**Part B payments AND 200 Medicare patients in 2018.** In the proposed rule, CMS considered adding a third threshold involving the number of patient encounters or procedures associated with a clinician. **ASTRO supports the Agency's decision to not implement this third threshold.**

#### *Opt-in*

In the proposed rule, the Agency intended to allow excluded clinicians to opt-in to the program if they exceed one of the two thresholds beginning in the 2019 performance period, but did not finalize the proposal in the final rule. **As the Agency seeks to revisit this in future years, ASTRO would like to repeat our support of allowing excluded physicians to opt-in to the MIPS program.** In the event an individual or group chooses to participate, we recommend maintaining the same reporting requirements and scoring as those set for eligible participants. Creating another set of program requirements for those who opt into the program is unnecessary.

#### *Composite Performance Score (CPS) Performance Threshold*

In the final rule, CMS increased the CPS performance threshold needed to avoid the payment penalty from 3 to 15 CPS points for the 2018 performance period. MACRA requires that the 2019 threshold be set as the mean or median score from the prior period based on the Secretary's discretion. **We appreciate the possibility of a steep incline in 2019, however, since we are unable to forecast the impact, we accept the 15-point threshold for 2018.** CMS must expedite the analysis of 2017 and 2018 MIPS data to avoid causing confusion if the 2019 CPS threshold is announced late in the 2019 performance year. Between the lack of MIPS data and the Pick Your Pace option for 2017, the mean or median score could be extremely varied. **ASTRO continues to urge CMS to work with Congress to revise this mandate and to pick one determination method for use in future years.** CMS should be able to determine a fair performance threshold based on actual program data.

**ASTRO agrees with the exceptional performance threshold remaining at 70 points for 2018 given there is no program data to support making an adjustment.**

#### *Virtual Groups*

Beginning in the 2018 performance year, solo practitioners and groups with ten or fewer MIPS eligible clinicians may establish a virtual group. Virtual groups must notify CMS of their intention to become virtual groups for the 2018 performance year by December 31, 2017. **ASTRO supports the concept of virtual groups as a means of supporting small practice participation in MIPS.** However, we remain concerned about the complexity of virtual group participation, and it remains unclear what benefit eligible clinicians achieve by participating in a virtual group.

**ASTRO is concerned with the short timeline given to clinicians to identify their eligibility to create a virtual group, establish contact with another group, compare expected performance for 2017, negotiate a contract, and notify CMS before the December 31, 2017 deadline.** It is unclear why the election needs to be made prior to the performance period. ASTRO is disappointed that CMS did not postpone the deadline until the third quarter of the performance period. Ideally, solo practitioners or groups would receive 2017 performance data so they may better position themselves to evaluate and determine whether joining a virtual group will benefit their overall CPS and thereby payment adjustment.

**Finally, ASTRO continues to seek clarifications on the intended benefits of virtual groups.** In some ways, forming a virtual group may penalize some clinicians. For example, a practice defined as a small group could lose the designation by forming a virtual group and exceeding the 15-clinician threshold. In

this case, the group would benefit more from the small practice benefits than the potential benefits of a virtual group.

#### *Complex Patient Bonus*

For 2018, CMS finalized the addition of one to five bonus points to the overall CPS for complex patients using the Hierarchical Conditions Category (HCC) risk score and the number of dual eligible patients treated. The Agency finalized that the complex patient bonus will be calculated by CMS by averaging the HCC risk scores for beneficiaries cared for by the MIPS eligible clinician during the 12-month segment of the eligibility period. This average will then be added to the dual eligible ratio.

According to CMS data, the average HCC risk score for all specialties is 1.75, and the average for radiation oncology is 1.79, just above the average. According to Agency modeling, 22.7 percent of radiation oncology patients are dual eligible. ASTRO appreciates the consideration of complex patients and the effects that treating this cohort may have on MIPS performance. **We are pleased that CMS accepted our recommendation to increase the cap to 5 points. However, we are concerned that CMS will assess whether to continue the bonus and its structure on an annual basis.** ASTRO is comfortable with an annual assessment to determine the amount of the complex patient bonus; however, we recommend that CMS finalize the structure for determining the bonus to avoid uncertainty and confusion.

#### *Rural or Health Professional Shortage Area (HPSA) Designation*

CMS modified the rural practice designation, requiring that more than 75 percent of clinicians in a practice be in a HPSA designated zip code. **ASTRO is disappointed that CMS finalized a 75 percent clinician requirement threshold, as we believe this is too high.** This requirement has the potential to create disincentives for urban and suburban practices from establishing clinics in rural and HPSA designated areas.

**We are also disappointed that CMS did not extend the proposed small practice CPS bonus to rural practices.** We believe that rural practices face significant hardships, like small practices, and therefore should receive the same assistance.

#### *Performance Feedback*

**ASTRO appreciates CMS' endeavor to provide timely performance feedback, however, we are disappointed that instantaneous feedback is not yet available.** We believe that frequent, if not instantaneous, feedback is essential for helping practices identify opportunities and steps to improve for the next performance year.

**Additionally, ASTRO continues to urge CMS to provide specialty societies with aggregated specialty-specific performance metrics at the performance category level (i.e., measure performance) and overall program level (i.e., CPS distribution).** Specialty societies want to support providers in improving care, but require more data on performance and gaps to better tailor information.

#### *Submission Mechanisms*

CMS continues to allow eligible clinicians to submit measures using Qualified Clinical Data Registries (QCDRs), qualified registries, EHRs or Medicare Part B claims. The Agency proposed to modify its requirement that data be submitted using only one of the various reporting mechanisms within a category, however did not finalize this for the 2018 performance year. The proposal would have allowed eligible

clinicians to submit data within a category using one or more reporting mechanisms, increasing flexibility and measure reporting options. **ASTRO is disappointed that the Agency did not finalize this proposal as we support providing clinicians with more options.** We recommend CMS continue to consider multiple reporting options as the program evolves, including potential unintended consequences, such as determining data completeness if a clinician reports the same quality measures via multiple mechanisms. For example, if a clinician utilized two submission mechanisms to report the same measure, will 60 percent data completeness need to be achieved for each mechanism or for the combined data submitted?

Additionally, as stated in the 2018 final rule, “clinicians and groups that have fewer than the required number of [quality measures] applicable and available under one submission mechanism could be required to submit data on additional [quality measures] via one or more additional submission mechanisms...to receive maximum number of points.” If CMS applies the Eligible Measure Applicability (EMA) process to all available reporting mechanisms rather than just the reporting mechanism utilized, this will inadvertently disadvantage providers who have limited measures within one reporting mechanism. Reporting via multiple mechanisms could place significant administrative and financial burden on clinicians; therefore, the clinician should be able to choose whether the added burden will result in a higher overall CPS. **ASTRO believes that while clinicians should have the flexibility to utilize multiple mechanisms, and there should be no negative impact for deciding to utilize only one mechanism.**

#### *Qualified Clinical Data Registry (QCDRs)*

**ASTRO thanks CMS for the revisions to the QCDR nomination process.** The Agency modified the self-nomination submission method and will establish a web-based tool beginning in 2019 that allows simplification of the QCDR approval process if minimal changes have occurred.

#### *Facility-Based Measurement*

**ASTRO appreciates that CMS postponed the proposal to implement facility-based measures that apply to physicians practicing in inpatient or emergency room settings, not outpatient settings for the 2018 performance period.** The Agency stated that facility-based measurement will add more flexibility for clinicians practicing primarily in a hospital to be assessed in the context of the hospital. ASTRO understands CMS’ need to utilize other pay-for-performance programs as a proxy for the MIPS Quality and Cost performance categories. Currently, the Hospital Outpatient Quality Reporting Program (OQR) is a pay-for-reporting program. In the future, if the OQR program were to assess performance, in addition to reporting, we believe outpatient clinicians should be given an option of facility-based scoring.

#### *MIPS Performance Categories*

#### *Performance Category Weights*

In the 2018 QPP proposed rule, the Agency proposed maintaining the 2017 performance year category weights. In our comment letter on the proposed rule, we urged CMS to reduce the weight of the Quality performance category to 50 percent for 2018 and reallocate 10 percent to the Improvement Activities performance category, thereby beginning to balance the performance categories. While CMS did reduce the weight of the Quality performance category to 50 percent for 2018, it reallocated 10 percent to the Cost category, instead of to the Improvement Activities performance category. **ASTRO continues to believe the Improvement Activities have the potential to be the most impactful tool for practices with less reporting and administrative burden.** The Improvement Activities category is highly physician driven and facilitates the innovation necessary for practice improvement, and we believe it is currently undervalued at 15 percent.

Additionally, if CMS is unable to score the Cost category, then the 10 percent shifts back to the Quality performance category. If a clinician is exempt from the Advancing Care Information (ACI) performance category, the ACI weight also shifts to Quality, increasing the weight from 50 to 75 percent of an eligible clinician's CPS score. The existing Quality performance category currently holds too much weight and balancing the categories is important for holistic improvement. **We recommend that in future years any category re-weighting be shifted to Improvement Activities instead of Quality.**

#### *Quality Performance Category: Reporting Period*

The Agency finalized an increase in the Quality performance category reporting period from 90 consecutive days in 2017 to a full calendar year in 2018. **ASTRO strongly opposes this increased reporting period due to the severe burden reporting puts on clinicians and the lack of tools needed to make this feasible.** When compounded with the new 60 percent data completion requirement (see below), a full year of reporting is unreasonable for measures associated with a high volume of a clinician's patient population.

For example, within the radiation oncology measures set, measures #143 (Pain Quantified) and #144 (Plan of Care for Pain) need to be reported for every treatment management visit. For a radiation oncology patient receiving 35 radiation treatment fractions, a physician would need to report data for these measures at least seven times just for one patient. If reporting as a group, the case number could be in the thousands. This level of reporting forces practices to invest significant time and money in systems and infrastructures to collect and report data as the current electronic health records (EHRs) in the radiation oncology field do not capture the necessary data elements and do not submit data on behalf of their clients. The increased burden this requirement places on clinicians reduces time and resources that could otherwise be spent focusing on patients, which runs directly counter to the "Patients over Paperwork" initiative.

The goal of the QPP program is to improve the quality of care for Medicare beneficiaries. Clinicians need to be given an opportunity to review the results of their performance and implement quality improvement within their workflow structure for sustainable change. This cannot be done in a matter of weeks. By increasing the reporting period for the Quality performance category to a full year, CMS undercuts the goals of the program.

#### *Quality Performance Category: Topped-Out Measures*

**ASTRO appreciates the fact that CMS finalized a four-year process for identifying and phasing out "topped out measures." However, ASTRO would like to voice continued concern about the large number of measures that are currently considered "topped out."** In the 2018 QPP proposed rule, CMS establishes that "based on 2015 historic benchmark data, approximately 45 percent of the quality measure benchmarks currently meet the definition of topped out." This is a significant number of measures that will be topped out in coming years, leaving many clinicians with limited non-topped out measures to report. Removing topped out measures from MIPS will significantly reduce the reporting options. **ASTRO recommends that the agency work with specialty societies to make it easier for measure developers to create significant new metrics.**

#### *Quality Performance Category: Three-point Floor*

In the final rule, CMS finalized keeping the 20 Medicare Part B patient case requirement for each measure. At the same time, the final rule increased the data completeness threshold from 50 percent to 60 percent for 2018. In 2017, clinicians that do not meet data completeness requirements receive three points toward their Quality score. For 2018, CMS modified the scoring so that practices will only receive one

point if they do not meet the 60 percent data completeness threshold. This policy will not apply to small practices who will continue to earn three points. **ASTRO is disappointed that the data completeness threshold was increased, and that CMS did not accept ASTRO’s proposal to maintain the three-point floor for measures with any submitted data for all groups, not just for small practices.** Meeting the 60 percent data completeness requirement will be difficult for all clinicians, especially as CMS is requiring a full year of reporting.

*Quality Performance Category: Benchmark Data*

**ASTRO remains concerned that benchmarks will be based on legacy programs to compare clinicians and assign achievement points.** The Physician Quality Reporting System (PQRS) program was substantially different from the current MIPS Quality performance category—especially considering that the PQRS measure groups allowed clinicians to self-select 20 patients, whereas the Quality performance category does not allow the same flexibility for self-selection. In addition, the pay-for-reporting program parameters may result in inflated benchmarks. **ASTRO is disappointed that CMS will not be using 2017 MIPS data to inform MIPS benchmarks for 2018.**

*Quality Performance Category: Improvement Score*

Beginning with the 2018 performance year, CMS will begin scoring improvement in the Quality performance category, if sufficient data is available. The Agency will measure improvement based on changes in the achievement percent score from one performance year to the next performance year. Achievement percent scores are calculated for the Quality category in each performance period, rather than on a measure-specific basis. CMS finalized an overall calculation to allow physicians to retain the ability to report on different quality measures from year to year. Performance periods will be compared to one another to determine if the eligible clinician qualifies for an improvement percent score that is added onto the Quality score. **ASTRO thanks the Agency for inclusion of this proposal.**

*Quality Performance Category: Cross-cutting Measures*

**ASTRO is pleased that CMS did not add a future cross-cutting measure requirement to the Quality performance category for 2018.** Such a requirement would direct attention away from measures that are more relevant to one’s specialty and patient population. We believe that high priority and outcome measures are more pertinent to the quality of care for patients and provide the necessary flexibility to clinicians.

*Advancing Care Information (ACI) Performance Category: Category Exemptions*

**ASTRO thanks CMS for finalizing Place of Service (POS) Code 19 in the automatic hospital-based ACI exemption, as many satellite facilities face the same lack of control over certified EHR technology (CEHRT) as inpatient or on-campus outpatient facilities.**

For the 2018 performance period, CMS finalized a new exemption for small practices that would re-weight the ACI category to zero, shifting an additional 25 percent to the Quality category, similar to ACI exemptions in the 2017 performance year. However, CMS stated that small practices “seeking this exception must demonstrate in the application that there are overwhelming barriers that prevent the MIPS eligible clinician from complying with the requirements for the advancing care information performance category.” ASTRO agrees that small practices should be added to the existing list of ACI hardship exemptions, but argues that practices should not be required to provide proof of burden. ASTRO believes that since other hardship exemptions do not require proof of burden, this requirement should be removed from the small practice hardship proposal. Additionally, since CMS did not define how a small practice

would prove burden, ASTRO seeks clarification on whether this application will be similar to the other available exemption applications.

*Advancing Care Information Performance Category: Category Weight*

**ASTRO thanks CMS for retaining the 25 percent weight for the ACI category as required by MACRA and extending the 90-day minimum performance period through 2018.** ASTRO supports maintaining the current weight and reporting period for this performance category as it gives physicians more time for adoption and analysis of data to determine successes and areas for growth.

*Advancing Care Information Performance Category: EHR Certification*

**ASTRO is pleased that the Agency extended the use of 2014 Edition CEHRT for 2018, and provides 10 bonus points within the ACI category for those eligible clinicians who report the ACI measures for the 2018 performance period utilizing only 2015 Edition CEHRT.** Radiation oncology EHR vendors are currently certified under the 2014 Edition and have not published a timeline to upgrade to the 2015 Edition. The original requirement for the 2015 Edition would have significantly harmed radiation oncologists' chance to succeed in the MIPS program. 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.

*Advancing Care Information Performance Category: Immunization Registry*

**ASTRO commends CMS for maintaining the ACI base measures for the 2018 performance period and making an adjustment to the Immunization Registry Reporting Measure.** Consistent with ASTRO recommendations, CMS finalized that eligible clinicians that cannot fulfill the Immunization measure will be awarded 10 percentage points in the performance score for reporting to any single public health agency or clinical data registry.

*Advancing Care Information Performance Category: E-Prescribing*

**ASTRO is pleased that CMS finalized a retroactive exclusion for the e-Prescribing Measure.** In the 2018 performance period, MIPS eligible clinicians who wish to claim this exclusion will select "yes" to the exclusion and submit a null value for the measure, thereby fulfilling the requirement to report this measure as part of the base score. This level of clarity is helpful to a practice's understanding of the program requirements.

*Improvement Activities Performance Category: Overall Category*

**ASTRO is pleased that CMS did not change the weighting (15 percent) for the Improvement Activities performance category and retained the 90-day minimum performance period.** Additionally, CMS maintained the structure and selection of medium and high weighted activities. Evidence indicators required by ASTRO's Accreditation Program for Excellence (APEX) already map to numerous Improvement Activities, and we believe APEX accredited facilities should receive full credit in this category. CMS added several new Improvement Activities, including clinician leadership in clinical trials or community-based participatory research, and CDC training on their guidelines for prescribing opioids for chronic pain. **ASTRO appreciates CMS maintaining stability in this performance category and the added approved activities.**

*Improvement Activities: Improvement Score*

**ASTRO continues to oppose adding an improvement score to the Improvement Activities performance category in the future, as this is still a new component without a legacy program.** There is no historical data and clinicians are still grappling with activity choice and implementation.

*Improvement Activities: ACI Bonus*

In the 2017 final rule, CMS established a 10-point bonus for eligible clinicians who attest to completing at least one specified improvement activity using CEHRT. In the 2018 final rule, the Agency expanded this policy by identifying additional improvement activities that qualify for the bonus. ASTRO believes that true practice transformation can be achieved through Improvement Activities. By offering more approved improvement activities and an associated ACI bonus, CMS is appropriately promoting the valuable Improvement Activities performance category.

*Cost Performance Category: Episode-based Measures*

**ASTRO supports the development of a new set of episode-based cost measures and looks forward to working with the Agency in their creation.** However, it remains unclear how the Patient Relationship Category Codes that were finalized as voluntary for reporting in 2018, as described in the 2018 Medicare Physician Fee Schedule, are applied to the Cost Category in 2018. This uncertainty is compounded by the fact that the Episode Based Measures are delayed until 2019. We urge CMS to provide clarification so that providers are well informed regarding how they can voluntarily report these codes for the Cost Category in 2018.

*Cost Performance Category: Performance Category Weight*

In the 2017 final rule, CMS established a weight of 10 percent for the Cost category for the 2018 performance year before the MACRA-mandated weight of 30 percent becomes effective in 2019. In the 2018 proposed rule, CMS proposed maintaining a 0 percent weight for 2018 with the understanding that there will be a significant jump to 30 percent in 2019. However, in the final rule, the Agency increased the weight of the Cost performance category to 10 percent for the 2018 performance year. **ASTRO continues to urge CMS to work with Congress to remove the 2019 30 percent category weight mandate. ASTRO recommends a more gradual increase, as the increase from 10 to 30 percent in one year is too great, especially when the new set of episode-based cost measures are only now being developed and tested.**

**Alternative Payment Model (APM) Program**

In the final 2018 QPP rule, CMS seeks to clarify and modify some of the policies finalized in the 2017 final rule related to the establishment of APMs. The 2018 final rule provides additional information regarding the establishment of All-Payer APMs. **ASTRO appreciates the Agency's efforts to clarify specific requirements within the APM program. However, we remain concerned about the complexity of the APM program, as well as the lack of specialty-specific Advanced APMs.** ASTRO continues to devote significant time and resources to support the development and adoption of radiation oncology-focused APMs that meet CMS criteria. We are hopeful that efforts to collaborate with the CMS Innovation Center on the development of such a model will prove fruitful and result in a viable advanced APM option for the field of radiation oncology in 2018.

### *Nominal Revenue at Risk*

In the 2018 final rule, CMS finalized its proposal to retain the nominal revenue at risk requirement for Advanced APMs at 8 percent through performance year 2020. **ASTRO is pleased that the Agency plans to retain the 8 percent nominal revenue at risk standard through 2020. We recognize that CMS will reconsider the nominal revenue at risk standard for 2021. However, we urge the Agency to extend that timeline farther into the future so that adequate data analysis can be performed to determine the appropriateness of the 8 percent nominal risk standard.**

Modification of the nominal revenue at risk creates unnecessary uncertainty for APM entities and physicians. 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 in order for participants to attain Qualified APM Participant (QP) status. APM entities that are accountable for repaying losses under models that involve 75 percent of their 2021 revenues will be at a higher financial risk than in the years when the QP thresholds are set at 25 and 50 percent of revenues coming through the APM. **ASTRO is concerned that if CMS does not provide for long-term stability in the financial risk standard, it may discourage physicians from working to design and participate in Advanced APMs or place those that are participating in Advanced APMs in financial jeopardy after an initial period of success.**

The risk associated with modifications to the nominal revenue at risk are particularly acute for specialties with high fixed costs. Radiation oncology clinics have significantly higher fixed costs compared to other specialties, where the fixed costs are lower due to less reliance on capital-intensive technology and equipment. Practices with significant fixed costs have limited variable costs, and savings are typically generated on reducing variable costs, not fixed costs.

The minimum total capital required to open a freestanding radiation oncology center is approximately \$5.5 million. These facilities require an additional minimum \$2 million in annual operating and personnel expenses. These significant fixed investments far outweigh the variable costs of operating a radiation oncology clinic and should be given consideration as part of any alternative payment model "nominal risk adjustment". While it is important to reduce the cost of care and drive value in healthcare, it is also important to ensure that efforts to generate savings do not cause access to care issues for patients treated by specialties with high fixed costs. This is particularly important for practices operating in rural areas. **ASTRO urges CMS to consider a 5 percent cap on nominal revenue at risk for practices that exceed a predetermined fixed to variable cost ratio.** This is the same amount applied to Medical Home Model APMs.

### *Qualified APM Participant (QP) Performance Period and Status Determination*

The 2017 final rule established the definition of QPs, as those eligible clinicians who have met the established Medicare Part B beneficiary or Medicare Part B expenditure thresholds for participation in an Advanced APM, thus exempting them from MIPS participation. In the 2018 proposed rule, CMS proposed replacing the term "QP Performance Period" with a definition for an "All Payer QP Performance Period" and a "Medicare QP Performance Period". The All Payer QP Performance Period would begin January 1 and end on June 30 of the calendar year that is two years prior to the payment year. The Medicare QP Performance Period as currently defined begins on January 1 and ends on August 31 of the calendar year that is two years prior to the payment year. CMS did not finalize this proposal in the 2018 final rule, instead the Agency aligned the All Payer QP Performance Period with the Medicare QP Performance Period.

In the 2018 final rule, CMS also finalized its policy regarding the timeframe for which payment amount and patient count data are included in the QP threshold determination for Advanced APM status. CMS recognizes that not all APM entities can participate in Advanced APMs within the full January 1 to August 31 performance period, and finalized a policy recognizing participation for a continuous 60-day period as sufficient to determine Advanced APM QP status. This policy does not apply to those APM entities that had an opportunity to participate in an Advanced APM during the full performance period but chose not to do so.

CMS also provided clarification in the final rule that it will use the entire performance period to make QP determination for those eligible clinicians participating in multiple Advanced APMs. Additionally, should an APM Entity, either voluntarily or involuntarily, terminate from the Advanced APM, then the eligible clinicians will no longer be designated as QPs.

**ASTRO appreciates CMS' decision to align the Medicare Part B and All Payer QP performance periods. We are particularly pleased that CMS reduced the performance period requirement from an 8-month period to a 60-day period.**

*Physician Focused Payment Models (PFPMs)*

CMS established the parameters around the development of Physician Focused Payment Models and the process by which they are considered and approved for recommendation to CMS by the Physician Focused Payment Model Technical Advisory Committee (PTAC) in the 2017 final rule. In the 2018 final QPP rule, the Agency seeks additional comments regarding the role of PTAC and the resources required of PTAC participants as part of the PFPM application process. On August 4, 2017, PTAC Chairman, Jeffrey Bailet, MD, provided the Secretary with a list of areas requiring additional focus that will enhance PTAC efforts, including individualized technical assistance; access to data and analysis; data sharing of HIT; limited scale testing of innovative payment models; and the removal of barriers to innovation in current payment systems. ASTRO supports Chairman Bailet's request and urges CMS to provide PTAC with the resources necessary so that the Committee can begin collaborating with the Center for Medicare and Medicaid Innovation (CMMI) on the establishment of viable alternative payment models across a broad range of specialties.

In the past, ASTRO has joined the AMA and others in urging CMS to make claims and other data available to groups that are developing an APM proposal or testing an APM. In the development of the Radiation Oncology APM (RO-APM), we have found it difficult to obtain the data necessary to sufficiently analyze or refine our proposed model. **We continue to urge CMS to work with specialty groups such as ASTRO on securing relevant data in an easily interpretable format, so that APMs can be modeled.**

ASTRO appreciates the opportunity to provide comments on the 2018 QPP final rule. Questions regarding our comments can be directed to Anne Hubbard, ASTRO Director of Health Policy, at 703-839-7394 or at [Anne.Hubbard@ASTRO.org](mailto:Anne.Hubbard@ASTRO.org).

Sincerely,



Laura I. Thevenot  
Chief Executive Officer