August 21, 2017

Seema Verma, MPH
Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-5522-P
P.O. Box 8013
Baltimore, MD 21244-8013

RE: CMS-5522-P: Medicare Program

Dear Administrator Verma:

The Renal Physicians Association (RPA) is the professional organization of nephrologists whose goals are to ensure optimal care under the highest standards of medical practice for patients with kidney disease and related disorders. RPA acts as the national representative for physicians engaged in the study and management of patients with kidney disease. We are writing to provide comments on selected portions of the Medicare Program; CY 2018 Updates to the Quality Payment Program Proposed Rule.

- Complex Patient Bonus
- Increased Low Volume Threshold
- Nominal Risk
- Virtual Group Participation
- Advancing Care Information
- Use of Third Party Intermediaries for MIPS Data Submission
- Custom Measures in QCDRs
- QCDR Application Process
- Topped Out Quality Measures

Complex Patient Bonus

In the proposed rule CMS outlines plans to provide a bonus for complex patients to both protect access to care for complex patients and provide them with excellent care, and to avoid placing MIPS eligible clinicians who care for complex patients at a potential disadvantage. Given RPA’s comments in response to previous MACRA rulemaking opposing elimination of the specialty-specific risk adjustor, we commend CMS for addressing patient complexity on a specialty-specific basis via use of the Hierarchical Condition Category (HCC) risk scores.
With the dual concepts of protecting access to care for complex patients and not disadvantaging or disincentivizing the physicians caring for them in mind, RPA strongly recommends that CMS apply the use of the HCC risk scores, a specialty-specific risk adjustor, or some other variable that accounts for patient complexity in the Cost component of the MIPS program. As noted in previous comments, the exceptionally vulnerable health of ESRD patients (and even those patients with CKD and AKI) and the difficulties of physician attribution for patients with multiple chronic illnesses speak to the need for a specialty adjustment to account for the case mix differences that are inherent in the care of ESRD patients. This applies to the costs associated with providing this care. The vulnerable status of dialysis patients inherently and routinely requires a degree of resource use exceeding that of other disease states.

*RPA strongly recommends that CMS apply the use of the HCC risk scores, a specialty-specific risk adjustor, or some other variable that accounts for patient complexity in the Cost component of the MIPS program.*

**Increased Low Volume Threshold**

CMS proposes in the NPRM that the threshold for low volume providers in Part B of the Medicare program be increased from less than or equal to $30,000 or 100 patients to less than or equal to $90,000 or 200 patients. RPA is encouraged by the Agency’s responsiveness to concerns regarding the ability of small or solo providers to be compliant with MIPS program requirements and avoid penalties, and we support this change. We would note that the threshold could result in a conundrum for some practices seeking to report as a group in which there may be some individual providers who would be above the low volume threshold, while other providers such as nurse practitioners who may be below it.

More broadly, we urge the Agency to consider all of the downstream ramifications of raising the low volume threshold. As noted, we believe CMS’ sensitivity to the concerns of small and solo practices is appropriate, and we commend efforts to address the ability of these practices to survive and thrive as MIPS implementation ensues. That said, increasing the low-volume threshold is a policy revision not without unintended adverse consequences. First, it will negatively impact those physicians and practices (small, medium, and large) who in good faith have sought to participate in the MIPS program by limiting the denominator in a budget-neutral system, and thus limiting the available bonus funding pool for successful participants. Second, smaller practices (that have inherent barriers to maximal success) that voluntarily participate will have fewer peer groups of similar size, increasing the likelihood that they will be at the lower end of the performance scale. Third, once these smaller groups are transitioned to MIPS participation, they will be even less prepared to participate than they are today, the stakes will be higher, and the likelihood of success (i.e. avoiding a penalty and/or earning a bonus) will be lower. Finally, it is worth noting that given the preponderance of Medicare billing in nephrology because of the ESRD program, raising the low volume threshold provides minimal relief for small nephrology practices. The likelihood of a nephrologist seeing fewer than 200 Medicare beneficiaries or billing Medicare less than $90,000 per year has little relationship with the size of their practice (since the vast majority of nephrology practices have 15 or fewer providers with National Provider Identifiers—NPIs).
RPA recognizes the rationale for increasing the low volume threshold, and supports the decision to do so. However, we urge CMS to account for the unintended consequences caused by this determination in future rulemaking.

On a separate point, acknowledging that in many if not most cases it would be broadly advantageous for a practice to report as a group, RPA suggests that CMS evaluate whether the higher threshold creates an inconsistency for practices with practitioners on both sides of the threshold that the Agency wants to address.

Nominal Risk

The NPRM sets forth CMS’ proposal to maintain the generally applicable revenue-based nominal amount standard at 8 percent of the estimated average total Parts A and B revenue of eligible clinicians in participating APM Entities for QP Performance Periods 2019 and 2020. RPA believes it is critically important for entities such as the nephrology practices participating in the ESRD Seamless Care Models (ESCOs) as part of the Comprehensive ESRD Care Model that there to be stability and predictability in the definition of nominal risk.

RPA supports CMS’ proposed decision to maintain the nominal risk standard at 8 percent.

Virtual Group Participation

RPA believes that the QPP rule proposals to establish virtual groups are innovative, forward thinking, and once again responsive to the needs of small and solo practices. Any proposal that allows small practices to aggregate their data and thus have a larger denominator over which to spread risk and thus mitigate the impact of adverse outlier situations is generally positive for participants.

RPA believes that the proposals pertaining to Virtual Groups need to be substantially more detailed, with specific plans for rollout and implementation, before any proposals could be included in a final rule.

Advancing Care Information

Within the Advancing Care Information (ACI) component of the QPP, the proposed rule states that CMS will allow MIPS eligible clinicians to use either the 2014 or 2015 Edition Certified EHR technology (CEHRT) in 2018, a modification from previous policy where use of the 2015 Edition was to be mandated for the 2018 performance year. CMS does provide an incentive for use of the 2015 Edition, as those providers doing so will receive a 10% bonus within the ACI component. RPA believes this strikes an appropriate balance between not holding physician practices accountable for CEHRT-related compliance issues out of their control, and rewarding those practices that took the structural steps necessary to successfully use 2015 Edition CEHRT.

RPA supports the proposals in the NPRM to provide greater flexibility and clarity with regard to decertification and hardship exceptions.
Third Party MIPS Data Submission

In the CY 2017 Quality Payment Program final rule, CMS finalized policy stating that MIPS data may be submitted by third party intermediaries on behalf of a MIPS eligible clinician or group by: (1) A qualified registry; (2) a QCDR; (3) a health IT vendor; or (4) a CMS approved survey vendor. Additionally, the 2017 rule finalized that third party intermediaries must meet all the criteria designated by CMS as a condition of their qualification or approval to participate in MIPS as a third-party intermediary. The proposed rule indicates that CMS plans to allow third party intermediaries to directly submit MIPS data to CMS, with a requirement that all data submitted to CMS by a third party intermediary on behalf of a MIPS eligible clinician, group or virtual group must be certified by the third party intermediary to the best of its knowledge as true, accurate, and complete.

RPA supports the proposal to allow third party intermediaries to submit data to CMS, and the requirement for accuracy and completeness. Given the challenges that many practices and individual clinicians will encounter with MIPS compliance, expansion of the options available for effective submission to the Agency is a positive step in addressing those challenges. RPA encourages the Agency to explore a collaborative process to aid in the development of defined processes and services for QPP-related data aggregation and validation, as well as requirements for “certifying” data is “true, accurate, and complete.”

Custom Measures in QCDRs

RPA is encouraged that the QPP NPRM also includes a nephrology measure set and outlines a list of the measures to be used in the Comprehensive ESRD Care (CEC) AAPM that is comprised of the ESRD Seamless Care Organizations (ESCOs). We believe that the absence of a nephrology measure set in the QPP previously was an easily addressed gap, and we appreciate the Agency taking action to address this shortfall.

However, RPA has several concerns with the nephrology measure set:

- While many of the CMS-proposed measures may be commonly used by nephrology practitioners, others, such as Diabetes: Medical Attention for Nephropathy, may be more appropriate for primary care providers than nephrologists (given that once a patient is seeing a nephrologist, medical attention for nephropathy can likely be assumed);
- Some of the measures in the CMS proposed measure set are limited to pediatric patients only. While we support the inclusion of pediatric-specific measures, we are concerned that it may appear that adult nephrologists have access to more custom measures than is actually the case;
- There continues to be an absence of incentives for clinicians to use custom measures through specialty specific QCDRs; RPA strongly urges CMS to consider creating such incentives to spur participation in QCDRs.
- Specifically, RPA strongly suggests that CMS consider:
Giving QCDRs time to develop and deploy new measures BEFORE demanding harmonization or removal of a measure (minimum of 3 years);

- Designate an “in testing” status for QCDR-reported, specialty-developed quality measures in their first 3 years of deployment (3-year time limit or until adequate benchmarks established)

- Offer bonus points for MIPS Eligible Providers (MEPs) in Quality category for submitting data on “in testing” quality measures, if these reported measures are in addition to the 6 required chosen measures

- Offer Improvement Activities (IA) for clinicians and practices reporting on new quality measures, such as offering 20 points for reporting on 2-3 measures or 10 points for 1 measure without clear benchmarks that are designated as “in testing.”

There continues to be an absence of incentives for clinicians to use custom measures; RPA strongly urges CMS to consider creating such incentives to spur participation in Qualified Clinical Data Registries (QCDRs).

**RPA urges CMS to reevaluate the nephrology measure set to remove measures more appropriate for primary care specialties, and to explicitly delineate which measures apply to either or both adult and pediatric dialysis care. Further, the Agency should heavily incentivize the use of custom measures in QCDRs, with consideration to the specific recommendations above.**

**QCDR Application Process**

In the NPRM, CMS proposes a simplified process in which existing QCDRs or qualified registries in good standing may continue their participation in MIPS by attesting that their approved data validation plan, cost, approved QCDR measures (applicable to QCDRs only), MIPS quality measures, activities, services, and performance categories offered in the previous year’s performance period of MIPS have no changes. QCDRs and qualified registries in good standing may also make substantive or minimal changes to their approved self-nomination application from the previous year of MIPS that would be submitted during the self-nomination period for CMS review and approval.

**RPA supports the effort to reduce administrative burden for QCDR owners, but recommends expanding the simplified process to include custom QCDR measures.**

**RPA also believes that by granting QCDR measure approval for two or more years, rather than the current annual timeframe, CMS will better support the long-range view that it has proposed applying to the review of topped out measures. RPA believes that approving measures for two or more years would greatly improve the value of the measures and of the QCDRs themselves, as it would allow for true quality improvement among users.**

Furthermore, approving QCDR measures for a multi-year period will encourage electronic health records and other vendors to make any necessary changes to their discrete data fields to ensure they are able to populate these measures as they know the measure will be available for more than a year.
Topped Out Quality Measures

In the NPRM, CMS proposes a 3-year timeline for identifying and proposing to remove topped out measures. After a measure has been identified as topped out for three consecutive years, the measure may be designated for removal through comment and rulemaking for the 4th year.

*RPA commends the Agency for taking a thoughtful and long-range view in addressing the lifecycle of a measure in a way that considers specialty, case mix, and rural providers before determining that a measure is topped out, specifically whether there is still room for improvement among certain specialist groups and to ensure that rural provider improvement is recognized. Additionally, ensuring that the decision for removal of a measure will occur through the comment and rulemaking process will provide appropriate transparency as evaluations of specific measures are conducted.*

As always, RPA welcomes the opportunity to work collaboratively with CMS in its efforts to improve the quality of care provided to the nation’s kidney patients, and we stand ready as a resource to CMS in its future work on QPP implementation. Any questions or comments regarding this correspondence should be directed to RPA’s Director of Public Policy, Rob Blaser, at 301-468-3515, or by email at rblaser@renalmd.org.

Sincerely,

Michael D. Shapiro, MD, MBA, FACP, CPE
RPA President