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June 27, 2016

Andrew M. Slavitt  
Acting Administrator  
Centers for Medicare and Medicaid Services  
Attention: CMS-5517-P  
Room 445-G  
Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, D.C. 20201

**Re: CMS-5517-P – Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models; Proposed Rule**  
81 Fed. Reg. 28162 (May 9, 2016)

Dear Acting Administrator Slavitt:

The American Cancer Society Cancer Action Network (ACS CAN), appreciates the opportunity to comment on the proposed rule implementing the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive as provided under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). ACS CAN, the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. As the nation's leading advocate for public policies that are helping to defeat cancer, ACS CAN ensures that cancer patients, survivors, and their families have a voice in public policy matters at all levels of government.

Overall, we are pleased with CMS' proposed rule, which we believe the proposed rule represents a good first step towards moving the Medicare program to a modern-day system that supports and encourages the delivery of high-value and high-quality care. The move to value based health care is predicated upon the patient being at the center. Thus, in the future, we urge CMS to require the inclusion of more patient-reported outcomes measures and patient experience measures as a way of more accurately determining the patient's experience. In addition, CMS also should establish better measures that ensure that providers are engaging in meaningful care coordination activities.

We also encourage CMS to closely monitor the effects of MACRA and implementing regulations – notably the Quality and Resource Use categories – on patient access to health care providers, particularly specialty providers, and specialized patient services. We recognize that these policies, may have differing impact on provider specialties, and some of these differences are difficult to mitigate based on currently available quality measures and other factors. CMS must ensure that MACRA policies do not: 1) discourage providers from taking on sicker patients who are likely to have worse outcomes; 2) disadvantage providers that treat the sickest patients; or 3) disadvantage small-practice or community providers. Any of these possible consequences, while unintended, could have a major impact on cancer patient access to providers and treatments. ACS CAN strongly encourages CMS to

create a plan to monitor patient access issues and make course-corrections throughout implementation of the new law.

We also encourage CMS to take a thoughtful and forward-thinking approach in this and future years when implementing the Resource Use section of MACRA, especially as the category is given more weight in the overall MIPS score. We are concerned that the Resource Use section as currently designed may incentivize clinicians to focus on short-term cost savings without taking a longer view. In some cases, up-front investments are necessary to save future, long-term costs. Additionally, sometimes more expensive or innovative treatments are the best choice for the patient – particularly a cancer patient. CMS must closely monitor implementation of MACRA and the Resource Use category to ensure that clinicians are not making treatment decisions solely based on short-term cost savings.

We offer thoughts and comments on specific areas of the proposed rule as follows:

## **II. PROVISIONS OF THE PROPOSED REGULATIONS**

### **E. MIPS Program Details**

#### *5. MIPS Category Measures and Activities*

##### *b. Quality Performance Category*

##### *(3) Quality Data Submission Criteria*

CMS proposes to require the MIPS eligible clinician or group to report at least six quality measures, including one cross-cutting measure (if patient facing) and at least one outcome measure. If an applicable outcome measure is not available, CMS proposes to allow the MIPS eligible clinician or group to report on one other high priority measure (e.g., appropriate use, patient safety, efficiency, patient experience, and care coordination measures). CMS also proposes to allow registered groups to voluntarily elect to participate in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

ACS CAN supports CMS' proposal. However, we note that the current Patient Quality Reporting System requires clinicians to report on nine quality measures – three more than the six quality measures proposed by CMS – and requires that the reported measures cross three National Quality Strategy domains. While we recognize that the implementation of MACRA will represent a significant change for clinicians and groups, we urge CMS to consider requiring clinicians and practices to report on additional measures in future years.

Many stakeholders currently are in the process of developing additional patient-reported outcomes measures (PROMs). While we recognize that it will take time to develop a large selection of PROMs for all conditions and diseases, we urge CMS, in future years, to require clinicians and groups to include at least one PROM. Given that PROMs constitute an important element of patient-centered care, we urge CMS to give greater weight to these quality measures.

*Consumer Assessment of Healthcare Providers and Systems (CAHPS):* CMS proposes to allow registered groups to voluntarily elect to participate in the CAHPS for MIPS survey. The survey will count as one cross-cutting and/or patient experience measure and the group will be required to submit at least five other measures through one other data submission mechanism. Bonus points will be given for clinicians/groups reporting CAHPS data. CMS requests comments on whether the CAHPS for MIPS

survey should continue to be required for groups of 100 or more MIPS eligible clinicians or whether it should be voluntary.

ACS CAN supports the CAHPS survey, which historically has been one of the few surveys that have sought to report on the patient's health care experience. However, we recognize that it is not a perfect instrument. We are concerned with the proposal to eliminate the required participation in the survey. We urge CMS to reconsider mandating the participation in the CAHPS survey for practice groups of a certain size, such as those with 50 or more providers; or, alternatively develop a better tool that more accurately reflects patients' experiences.

c. Selection of Quality Measures for Individual MIPS Eligible Clinicians and Groups

MACRA requires CMS to use its rulemaking authority to establish an annual list of quality measures from which MIPS eligible clinicians may choose for purposes of their assessment for a performance period. For the first year of MIPS, CMS proposes to maintain a majority of previously implemented PQRS measures for inclusion in the annual list of quality measures.

As CMS continues implementing MIPS in the future, ACS CAN urges the agency to include more patient-reported outcomes measures and patient experience measures in MIPS. Where appropriate, clinicians should be strongly encouraged to utilize these measures, which are key to ensuring that the patients are receiving high-quality health care services.

We note that HHS has designated cancer as a national quality priority and that the National Quality Forum (NQF) has recently empaneled a working group to review existing cancer quality measures, determine where gaps exist, and what additional measures may be needed. We are encouraged by HHS' dedication to improving cancer quality and NQF's work in this area. We urge CMS to include more measures related to improved care for cancer patients on the annual list of MIPS quality measures.

f. Clinical Practice Improvement Activity (CPIA) Category

(2) *Contribution to Composite Performance Score (CPS)*

MACRA specified that a MIPS eligible clinician or group that is certified as a patient-centered medical home or comparable specialty practice, as determined by the Secretary, for a specific performance period must be given the highest potential score for the CPIA performance category for the performance period. CMS proposes a patient-centered medical home (PCMH) will be recognized if it is a nationally recognized accredited PCMH, a Medicaid Medical Home Model, or a Medicaid Home Model.

ACS CAN supports CMS' proposal to recognize patient-centered medical homes that receive National Committee for Quality Assurance (NCQA) accreditation as receiving the highest potential score for the CPIA performance category. We recognize the rigorous requirements that NCQA imposes on its PCMH applicants and that these standards surpass those proposed by CMS. Establishing a "medical home" is important for patients, especially for those with multiple, chronic, and/or complex conditions like cancer. Cancer treatment involves many different healthcare providers and care coordination is crucial. We recognize that patient-centered medical homes make coordination easier, and therefore are pleased that MACRA and CMS will support these models.

(6) *CPIA Subcategories*

The Clinical Practice Improvement Activity (CPIA) performance category under MIPS must include the following subcategories: Expanded practice access; Population management; Care coordination; Beneficiary engagement; Patient safety and practice assessment; and Participation in an APM. CMS proposed to add the following additional subcategories: Promoting health equity and continuity; Social and community involvement; Achieving health equity; Emergency preparedness and response; and Integration of primary care and behavioral health. To achieve the highest potential score of 100 percent for this category, CMS requires submission of three high-weighted CPIAs or six medium-weighted CPIAs.

ASC CAN supports CMS' proposal which we believe is a good first step towards achieving the Triple Aim of achieving better care for patients, better health for communities, and lower costs through improvements in health care systems. We are also supportive of CMS' proposed additional CPIA subcategories – particularly those related to health equity. There is a direct link between a person's zip code and the quality of care they receive<sup>1</sup> and we need to do everything possible to ensure that all beneficiaries – regardless of where they live – receive the best care possible. We recognize that MACRA represents a major shift in the way Medicare reimburses providers for their services under Part B, but we are concerned that the proposed CPIA activities represent a low bar for providers to demonstrate they are providing meaningful care.

CMS proposes over 90 CPIA activities across the 11 subcategories and under the proposed rule, in order to achieve the highest score, providers will only need to attest to three high-weighted categories or six medium-weighted categories. We note that many of the proposed activities are overlapping activities – thus, in some cases depending on the nature of the activity, a provider's practice improvement activities could count toward multiple CPIA measures. We also note that the proposed activities lack specificity. Thus, as CMS finalizes its regulations, we urge the agency to provide additional details regarding the specific activities a provider or group of providers must meet in order to be able to attest that they have met these activities.

In addition, we strongly urge CMS to strengthen the CPIA requirements. Currently, eligible physicians and groups only need to attest that they meet the CPIA activities they report to CMS. There are no requirements regarding the quality of their performance in meeting these activities or whether the activities actually lead to better patient experiences or outcomes. In future years, CMS will need to put in place procedures to determine the extent to which providers are meeting these measures.

As CMS implements the MIPS program, we urge the agency to actively monitor the CPIA measures utilized by clinicians. If a majority of clinicians are choosing to report on the same activity, that suggests the activity has received wide-spread adoption and thus CMS should consider removing it from the CPIA list as these activities "top out."

As CMS finalizes the proposed CPIA activities, we urge the agency to consider adding an additional CPIA activity related to palliative care. Palliative care professionals work with patients and their family caregivers to ensure proper communication and coordination, provide expert management of pain, nausea, fatigue, and other symptoms of their disease or condition, as well as support family and other caregivers.

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<sup>1</sup> Robert Wood Johnson Foundation. County Health Rankings and Roadmaps. Available at <http://www.countyhealthrankings.org/>. Accessed June 27, 2016.

We propose the CPIA activity be described as:

- Coordinating or participating in interdisciplinary education efforts to disseminate basic advanced illness and palliative care skills, such as communication, symptom management and inter-professional collaboration.

Extensive research has demonstrated the value of palliative care services to patients both in terms of the overall quality of care provided to the individual as well as reduced health care costs in the form of reduced hospitalizations or re-hospitalizations.<sup>2</sup> Given the importance of palliative care services, we recommend that this proposed CPIA activity be categorized as a “high” value activity.

Finally, we urge CMS to develop a public process for considering possible CPIA measures. We envision that in the future, CPIA measures should be stronger than those proposed by CMS.

We offer comments on specific proposed CPIA activities below:

**Expanded Practice Access**

Expanded Practice Access	Use of telehealth services and analysis of data for quality improvement, such as participation in remote specialty care consults, or teleaudiology pilots that assess ability to still deliver quality care to patients.	Medium
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ACS CAN supports the overall direction of this Expanded Practice Access measure to further explore the potential of telemedicine to improve patient access to quality care. Individuals with cancer – particularly those in rural or frontier areas – often have challenges accessing specialists or oncology services due to geographic limitations. Although accessing specialists is not an impossible task for rural patients, the financial burden of travel costs for the patient and their caregiver is much greater than for their urban counterparts. This is further complicated by the health status of cancer patients. Pain from symptoms, discomfort caused by treatment, and the emotional toll associated with having cancer make it particularly challenging, both mentally and physically, to travel long distances to access treatment.<sup>3</sup>

Research has shown being able to readily access quality specialty care can significantly influence outcomes for people living with cancer.<sup>4</sup> As a result of health technology improvements, a growing number of providers and health care systems are testing telemedicine models specifically targeted to

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<sup>2</sup> For example, a 2008 study of eight diverse hospitals showed that palliative care consultations resulted in adjusted net savings of \$1,696 in direct costs per admission and \$279 in direct costs per day, including significant reductions in laboratory and ICU costs. Morrison RS, Penrod JD, Cassel JB, Caust-Ellenbogen M, Litke A, Spragens L, Meier DE. Cost savings associated with hospital palliative care consultation programs. *Arch Intern Med* 168(16):1783-1790 (2008). Similarly, a 2011 study found that Medicaid patients at four New York hospitals who received integrated palliative care consultations incurred \$6,990 less in hospital costs during a given admission, spent less time in intensive care, and were less likely to die in the ICU. Morrison RS, Dietrich J, Ladwig S, Quill T, Sacco J, Tangeman T, Meier DE. Palliative care consultation teams cut hospital costs for Medicaid beneficiaries. *Health Affairs* 30(3):454-463 (2011).

<sup>3</sup> Doolittle, G. C., & Spaulding, A. O. (2006). Providing Access to Oncology Care for Rural Patients via Telemedicine. *Journal of Oncology Practice*, 2(5), 228–230.

<sup>4</sup> Mandelblatt JS, Yabroff KR, Kerner JF: Equitable access to cancer services: A review of barriers to quality care. *Cancer* 86:2378-2390, 1999.

cancer patients, such as delivering palliative care.<sup>5</sup> Palliative care provides patients proper management of pain, nausea, fatigue, and other symptoms of their disease or condition. The goal of palliative care is to improve the quality of life for the patient (as well as his/her family and/or caregivers) by supporting complex medical decision making, assisting with care planning, and providing psychological and other support. ACS CAN fully supports this Expanded Practice Access measure so that providers and health systems will continue to explore additional telemedicine services such as palliative care. This is critical to ensure patients have access to vital services and may further ease the mental and physical challenges associated with travelling long distances to access treatment. Given the importance of these activities, we recommend that CMS re-designate this proposed activity to be a “high” weight item.

Expanded Practice Access	Collection of patient experience and satisfaction data on access to care and development of an improvement plan, such as outlining steps for improving communications with patients to help understanding of urgent access needs.	Medium
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ACS CAN supports the inclusion of this activity. However, we urge CMS to clarify that the development of an improvement plan must be done as part of a shared decision making process so that the patient’s needs and goals are reflected in the plan. In addition, the plan should be an organic process – one that is revisited, and revised, often throughout the patient’s course of treatment. We also urge CMS to include in this activity a requirement that the improvement plan be incorporated into the patient’s electronic health record (EHR), including a requirement that patients have 24/7 electronic access to their improvement plan via a web portal.

**Population Management**

Population Management	Participating in a Rural Health Clinic (RHC), Indian Health Service (IHS), or Federally Qualified Health Center in ongoing engagement activities that contribute to more formal quality reporting, and that include receiving quality data back for broader quality improvement and benchmarking improvement which will ultimately benefit patients. Participation in Indian Health Service, as a CPIA, requires MIPS eligible clinicians and groups to deliver care to federally recognized American Indian and Alaska Native populations in the U.S. and in the course of that care implement continuous clinical practice improvement including reporting data on quality of services being provided and receiving feedback to make improvements over time.	Medium
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<sup>5</sup> Hennemann-Krause L1, Lopes AJ1, Araújo JA2, Petersen EM2, Nunes RA1. The assessment of telemedicine to support outpatient palliative care in advanced cancer. Palliat Support Care. 2014 Aug 27:1-6.

ACS CAN supports the inclusion of this activity. Community health centers – including FQHCs and RHCs – provide essential community-oriented primary care in areas that are underserved or lack other health care services. We are concerned, however, the proposed activity fails to provide sufficient information regarding the extent to which the provider or group participates with RHC, IHS, or FQHCs. We urge CMS to establish minimum requirements providers and groups must meet in order to satisfy this activity.

Population Management	Take steps to improve health status of communities, such as collaborating with key partners and stakeholders to implement evidenced-based practices to improve a specific chronic condition. Refer to the local Quality Improvement Organization (QIO) for additional steps to take for improving health status of communities as there are many steps to select from for satisfying this activity. QIOs work under the direction of CMS to assist MIPS eligible clinicians and groups with quality improvement, and review quality concerns for the protection of beneficiaries and the Medicare Trust Fund.	Medium
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ACS CAN supports this proposed activity, which could help improve an individual’s access to evidence-based practices that would improve or address an individual’s chronic condition. It is important for stakeholders in order to most effectively implement evidence-based policies and practices that make it easier for cancer survivors to lead a healthy lifestyle. We urge CMS to be more specific in the evidence-based practices appropriate for this activity. For example, evidence shows that eating a healthy diet, being physically active, and maintaining a healthy weight can improve response to treatment and reduce side effects, reduce the risk of a cancer recurrence, and increase the likelihood of survival for those diagnosed with cancer.<sup>6</sup> Evidence is mounting that behavioral change initiatives, such as the Livestrong at the YMCA program for cancer survivors, are effective in promoting a healthy lifestyle for those with a cancer diagnosis. Research from the Diabetes Prevention Program and other chronic disease prevention and management programs shows that even small amounts of weight loss may have a positive impact on a range of health outcomes.

In addition to asking patients about tobacco use and providing cessation support to those who want to quit, clinicians should measure height and weight and calculate the body mass index (BMI) for all patients and ask and counsel about the person’s diet and physical activity type and amount. Research shows that poor diet, physical inactivity, and excess weight increase the risk for several types of cancer,<sup>7</sup> in addition to other chronic diseases. It is essential for clinicians to support patients in leading a healthy lifestyle to reduce their long-term cancer risk.

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<sup>6</sup> Rock CL, Doyle C, Demark-Wahnefried W, et al. Nutrition and physical activity guidelines for cancer survivors. *CA: A Cancer Journal for Clinicians* 62(4).

<sup>7</sup> Kushi LH, Doyle C, McCullough M, et al. and the American Cancer Society 2010 Nutrition and Physical Activity Guidelines Advisory Committee. American Cancer Society Guidelines on Nutrition and Physical Activity for Cancer Prevention. *CA Cancer J Clin* 2012;62:30-67.

We urge CMS to provide additional clarification and set standards regarding the type of activity that would qualify for a provider or group to meet this standard. For example, it is unclear what is meant by the term “take steps”. Conceivably, a provider or group could simply make available in its waiting room a pamphlet for a particular activity – without providing any additional one-on-one discussion with the patient – and meet the standards for this activity. While we support the dissemination of evidence-based practices to improve a patient’s condition, we do not believe that simply passing out a pamphlet should be sufficient activity in order to meet an activity that counts for CPIA purposes. We urge CMS to provide additional clarification regarding the type of activities that would count toward meeting this goal. In addition, we urge CMS to also include a component that the provider or group spent time with the patient discussing the evidence-based practice(s) in order for the activity to count for purposes of meeting a CPIA activity.

Population Management	Take steps to improve healthcare disparities, such as Population Health Toolkit or other resources identified by CMS, the Learning and Action Network, Quality Innovation Network, or National Coordinating Center. Refer to the local Quality Improvement Organization (QIO) for additional steps to take for improving health status of communities as there are many steps to select from for satisfying this activity. QIOs work under the direction of CMS to assist eligible clinicians and groups with quality improvement, and review quality concerns for the protection of beneficiaries and the Medicare Trust Fund.	Medium
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ACS CAN is supportive of this proposed activity, but similar to our comment above, we urge CMS to provide greater clarification regarding what is meant by the term “take steps” to address healthcare disparities.

Population Management	Participation in a QCDR, clinical data registries, or other registries run by other government agencies such as FDA, or private entities such as a hospital or medical or surgical society. Activity must include use of QCDR data for quality improvement (e.g., comparative analysis across specific patient populations for adverse outcomes after an outpatient surgical procedure and corrective steps to address adverse outcome).	Medium
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ACS CAN strongly supports this population management measure. The reporting of accurate and detailed information about diagnosis, treatment and survivorship of cancer patients is an essential component of delivery system reform that is aimed at achieving better outcomes and patient experience of care (including quality and satisfaction) at lower costs. For example, hospital-based cancer registries, which collect complex data on all patients diagnosed with and/or treated for cancer within the facility, capture critical information that hospitals can use to evaluate patient care and drive



quality improvement activities. Even further, these registries can be used to develop additional quality improvement activities by comparing patterns of care among providers, population subsets, or geographic regions through registry data on demographics, diagnosis, cancer biology, treatment and follow-up.

Population Management	<p>Empanel (assign responsibility for) the total population, linking each patient to a MIPS eligible clinician or group or care team.</p> <p>Empanelment is a series of processes that assign each active patient to a MIPS eligible clinician or group and/or care team, confirm assignment with patients and clinicians, and use the resultant patient panels as a foundation for individual patient and population health management.</p> <p>Empanelment identifies the patients and population for whom the MIPS eligible clinician or group and/or care team is responsible and is the foundation for the relationship continuity between patient and MIPS eligible clinician or group /care team that is at the heart of comprehensive primary care. Effective empanelment requires identification of the “active population” of the practice: those patients who identify and use your practice as a source for primary care. There are many ways to define “active patients” operationally, but generally, the definition of “active patients” includes patients who have sought care within the last 24 to 36 months, allowing inclusion of younger patients who have minimal acute or preventive health care.</p>	Medium
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ACS CAN is supportive of the proposed activity. However, we urge CMS to also require that in order to meet this activity, providers must actively engage with the patients who have been empaneled. We are concerned that as proposed, a provider or group could meet the requirements of this activity by simply assigning patients to a given provider and then inform the patient of the assignment (regardless of whether the patient preferred assignment to another provider within the practice). We do not feel that mere assignment of a physician is sufficient to warrant a clinical practice improvement activity.

Population Management	<p>Proactively manage chronic and preventive care for empaneled patients that could include one or more of the following:</p> <p>Provide patients annually with an opportunity for development and/or adjustment of an individualized plan of care as appropriate to age and health status, including health risk appraisal; gender, age and condition-specific preventive care services; plan of care for chronic conditions; and advance care planning;</p> <p>Use condition-specific pathways for care of chronic conditions (e.g., hypertension, diabetes, depression, asthma and heart failure) with evidence-based protocols to guide treatment to target;</p> <p>Use pre-visit planning to optimize preventive care and team management of patients with chronic conditions;</p> <p>Use panel support tools (registry functionality) to identify services due;</p> <p>Use reminders and outreach (e.g., phone calls, emails, postcards, patient portals and community health workers where available) to alert and educate patients about services due; and/or</p> <p>Routine medication reconciliation.</p>	Medium
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ACS CAN is supportive of this proposed activity. However, we urge CMS to require that providers or groups engage in all of the enumerated activities and to not only allow providers or groups to engage in one activity. For example, as currently written a provider who sends a postcard to a patient reminding her of her yearly physical could technically meet the requirements for this activity. However, if the purpose of these activities is to demonstrate clinical practice improvement, we do not believe that a simple postcard reminder system by itself meets that goal.

In addition, as discussed above, we urge CMS to clarify that the individualized care plan constitutes an organic document that is developed in coordination with the patient and revisited periodically. This individualized care plan must also be included in the patient’s EHR to facilitate electronic exchange across providers and care settings.

Finally, we note that none of the CPIA’s identified as “high” priority address prevention of disease. While a few high priority CPIAs address certain chronic conditions, none address management of chronic conditions generally. Therefore, assuming that CMS adopts our suggested recommendations, we would urge CMS to elevate this activity from a “medium” activity to a “high” priority activity.

**Care Coordination**

Care Coordination	Performance of regular practices that include providing specialist reports back to the referring MIPS eligible clinician or group to close the referral loop or where the referring MIPS eligible clinician or group initiates regular inquiries to specialist for specialist reports which could be documented or noted in the certified EHR technology.	Medium
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People with cancer often receive fragmented and uncoordinated care, because their treatments frequently require multiple clinicians including, surgeons, oncologists, primary care physicians, and other specialists. Providing care that is coordinated requires access to all of a patient’s data by all of his or her providers, an essential function that EHRs can provide. As noted in our comment letter on the Stage 3 Meaningful Use proposed rule, ACS CAN strongly supported the requirement that a Summary of Care (SoC) must be sent electronically during transitions of care and referrals, and the requirement of a provider receiving the Summary of Care to incorporate it into the patient’s EHR.<sup>8</sup> This proposed CPIA measure builds on that an effectively closes the referral loop and achieves real-time coordination of care.

Care Coordination	Implementation of practices/processes that document care coordination activities (e.g., a documented care coordination encounter that tracks all clinical staff involved and communications from date patient is scheduled for outpatient procedure through day of procedure).	Medium
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ACS CAN believes that the implementation of practices/processes to document care coordination activities offers little value to ensure care coordination activities are being done. However, we are pleased with CMS’ proposal to ensure care coordination activities are completed with additional care coordination and health information exchange measures in the Advancing Care Information Performance Category.

Care Coordination	Implementation of practices/processes to develop regularly updated individual care plans for at-risk patients that are shared with the beneficiary or caregiver(s).	Medium
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<sup>8</sup> American Cancer Society Cancer Action Network, Comments on Stage 3 EHR Incentive Program, available at <http://www.acscan.org/content/wp-content/uploads/2015/06/ACS%20CAN%20comments%20on%20Medicare%20and%20Medicaid%20Programs;%20Electronic%20Health%20Record%20Incentive%20Program.pdf>.

ACS CAN strongly supports all efforts to improve coordination of care for cancer patients. The fragmentation of care across various settings requires additional effort to ensure care is coordinated across providers. ACS CAN is pleased to see this measure encourage the MIPS eligible clinician to continuously update the care plan as part of an ongoing process throughout the course of treatment. Providing cancer patients and their families with understandable information about a cancer diagnosis, prognosis, the benefits, harms, and costs of treatments as well as discussing patients' options, including revisiting and implementing care plans, are critical elements to improve quality and patient experience of care.

We urge CMS to provide additional clarification regarding what is meant by the term "at risk patients". It is unclear whether CMS is referring to patients at risk for a particular disease, or at risk for complications of a disease they already have. Additionally, it is not clear if CMS refers to patients the provider self-identifies as being "at risk". If so, we are concerned that a provider could choose to identify only those patients who may be more likely to create a more simplified care plan as opposed to patients

In addition, ACS CAN recommends that this measure be modified to include care plans for all patients, regardless of risk. As a part of value based delivery system reform, all patients deserve individualized care plans that are regularly updated and shared with beneficiary or caregiver to ensure truly patient centered care. Assuming that CMS adopts our suggested recommendations, we would urge CMS to elevate this activity from a "medium" activity to a "high" priority activity.

### Beneficiary Engagement

Beneficiary Engagement	In support of improving patient access, performing additional activities that enable capture of patient reported outcomes (e.g., home blood pressure, blood glucose logs, food diaries, at-risk health factors such as tobacco or alcohol use, etc.) or patient activation measures through use of certified EHR technology, containing this data in a separate queue for clinician recognition and review.	Medium
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ACS CAN strongly supports patient access to data. Easy, electronic access to health information can be a useful catalyst for engaging patients in their care and patients who use online access more frequently report a substantial increase in positive impact on knowledge of their health and the desire to do something to improve their health.<sup>9</sup> Patient-generated health data (PGHD) is a source of valuable information that can inform and enhance care. This "non-transactional health data" includes everything from questionnaires on patient health history, symptoms, or a treatment to biometric data collected through traditional medical devices like a blood glucose monitor. As part of our comments on Stage 3 of the Meaningful Use program, we were pleased to see that eligible providers are required to incorporate PGHD into the EHR. If captured appropriately within the EHR, PGHD can provide unique insight into a patient's health that can drive improvements in the quality of care.

<sup>9</sup> National Partnership for Women and Families. Report. Engaging Patients and Families: How Consumers Value and Use Health IT. December, 2014, available at <http://www.nationalpartnership.org/research-library/health-care/HIT/engagingpatients-and-families.pdf>.

At the same time, we are concerned that the proposed activity fails to provide sufficient clarification or requirements regarding the quality of the activities being provided. We also note that the proposed activity does not include a requirement regarding the extent to which the patient is provided information about and/or an opportunity to engage in a discussion regarding the additional activities. As written a provider could instruct a patient to maintain a food log, without providing the patient with information regarding health eating choices and/or a discussion regarding why healthy eating could improve the patient’s disease or condition.

We also urge that CMS clarify that only evidence-based activities should be used and that in order to get credit for engaging in this activity the provider must not only engage with the patient before requesting the patient use the additional activity, but also that the provider monitor the extent to which the patient is engaging in the additional activity. Giving someone a food log doesn’t mean they will use it or understand its utility. As in Stage 3, we recommend PGHD be incorporated into the EHR to ensure this process occurs.

Beneficiary Engagement	Engage patients, family and caregivers in developing a plan of care and prioritizing their goals for action, documented in the certified EHR technology.	Medium
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ACS CAN strongly supports this patient engagement measure. Providing cancer patients and their families with understandable information about a cancer diagnosis, prognosis, the benefits, harms, and costs of treatments as well as discussing patients’ options, including revisiting and implementing advance care plans, are critical elements to improve quality and patient experience of care. We recommend this measure include additional language that recognizes the development of the care plan and patient goals as an ongoing process that is modified and altered throughout the course of treatment. This would require the MIPS clinician to develop and revisit the plan over the course of treatment to ensure the patient is actively engaged in their care and any goals (which may change over time) are being prioritized for action. Assuming that CMS adopts our suggested recommendations, we would urge CMS to elevate this activity from a “medium” activity to a “high” priority activity.

Integrated Behavioral and Mental Health	Tobacco use: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including tobacco use screening and cessation interventions (refer to NQF #0028) for patients with co-occurring conditions of behavioral or mental health and at risk factors for tobacco dependence.	Medium
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ACS CAN strongly supports engaging clinicians in prevention interventions, including tobacco cessation. Approximately 30 percent of all cancer cases are caused by tobacco use,<sup>10</sup> and surveys show that nearly

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<sup>10</sup> American Cancer Society. *Cancer Facts & Figures, 2016*. Atlanta: American Cancer Society, 2016.

7 in 10 tobacco users want to quit.<sup>11</sup> The U.S. Public Health Service Clinical Practice Guideline on Treating Tobacco Use and Dependence recommends screening all patients for tobacco use and offering or referring those who use tobacco to evidence-based tobacco cessation interventions, including counseling and medications.<sup>12</sup> While we support NQF measure #0028, which is focused on tobacco use screening and cessation counseling, evidence shows that tobacco users are most likely to be successful in quitting when they have access to both cessation counseling – delivered in person individually, in a group, and by phone – and all cessation medications approved for that purpose by the U.S. Food and Drug Administration. All patients should be screened for tobacco use and all tobacco users offered cessation support, not just those with behavioral or mental health conditions.

g. Advancing Care Information Performance Category

Overall, ACS CAN supports the objectives and measure reporting proposal for the Advancing Care Information Performance Category to better leverage health information technology (IT) to drive improvements in the quality, delivery and experience of care for cancer patients. ACS CAN is pleased to see both the inclusion and prioritization of specific measures that align with our positions submitted in our Stage 3 Electronic Health Record Incentive Program comments to CMS. Among these include: protection of patient health information (PHI), improved patient access to data through CEHRT, better coordination of care through patient engagement, and greater efforts to ensure meaningful health information exchange and coordination of care across health care settings and providers.

We are pleased to see CMS include public health and clinical data registry reporting measure but are concerned that any reporting beyond immunization registries is optional. We recommend reporting to cancer registries be required as part of the Agency's effort to align the program with the 2015 CEHRT requirement 170.315(f)(4). Accurate and detailed cancer information enables better public policy development by allowing more detailed analysis and tracking of cancer rates and trends over time and across the US population. This has significant implications for public health interventions targeting specific geographic areas or populations with high rates of cancer.

ACS CAN is also pleased to support care coordination measures included this category. We recommend this section be further strengthened by including additional language to ensure the summary of care record, which includes the survivorship care plan, be sent electronically by the specialist to the MIPS eligible clinician and be incorporated into the EHR during transitions of care. This would eliminate confusion regarding provider responsibilities post-treatment and improve coordination of care by closing the communication loop as the patient transitions from specialty to primary care following treatment.

Furthermore, we also recommend CMS modify the base score requirement to include the clinical decision support (CDS) measure. CDS is the primary means of applying best evidence and knowledge at the point and time of care. Based on the advanced rate of scientific discoveries through our understanding of the human genome, newly emerging evidence in the prevention, diagnosis and treatment of cancer must be directly translated into the health care delivery system. Thus, we strongly

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<sup>11</sup> Centers for Disease Control and Prevention. Quitting Smoking Among Adults—United States, 2001–2010. *Morbidity and Mortality Weekly Report* 2011;60(44):1513–9.

<sup>12</sup> Fiore MC, Jaén CR, Baker TB, et al. [Treating Tobacco Use and Dependence: 2008 Update—Clinical Practice Guidelines](#). Rockville (MD): U.S. Department of Health and Human Services, Public Health Service, Agency for Healthcare Research and Quality, 2008.

recommend that the CDS criterion be included as a required measure to ensure the most current evidenced based care is delivered to patients.

8. *Review and Correction of MIPS Composite Performance Score*

a. Feedback and Information to Improve Performance

(1) *Performance Feedback*

CMS proposes to provide confidential feedback on the quality and resource use performance category on an annual basis.

ACS CAN acknowledges that the implementation of MIPS represents a significant change to the Medicare program and that full implementation may take years. We support CMS' proposal to initially provide feedback on an annual basis. However, in future years we urge CMS to encourage more frequent reporting feedback (such as on a quarterly basis). Providing more frequent reporting will help improve clinician's performance as incentives tend to work better the closer the incentive is to the behavior that be is being measured.

(6) *Additional Information – Type of Information*

MACRA requires that beginning July 1, 2018, CMS make available to MIPS eligible clinicians information about Medicare-covered items and services provided by other suppliers and providers of services to the MIPS eligible clinician's patients.

ACS CAN believes this requirement will be helpful in fostering care coordination for Medicare beneficiaries – particularly beneficiaries with chronic care needs who may be seeing multiple providers and utilizing numerous Medicare services. We urge CMS to consider requiring that pharmacies that fill prescriptions under the Medicare Part D benefit provide information to the clinician regarding when and if the beneficiary filled a prescription prescribed by the physician. Currently it can be challenging for providers outside an integrated health care system or in a Medicare Advantage plan to know whether a beneficiary has actually filled a prescription.

**F. Overview of Incentives for Participation in Advanced Alternative Payment Models**

MACRA requires that an incentive payment made to Qualifying APM Participants for participation in eligible alternative payment models (e.g., Advanced APMs). Qualifying APM participants will be eligible for a five percent incentive payment. CMS has identified a preliminary list of current Advanced APMs, which include the Medicare Shared Savings Program (Tracks Two and Three); the Next Generation ACO Model; the Comprehensive End-Stage Renal Disease Care Model; the Comprehensive Primary Care Plus model; and, the Oncology Care Model two-sided risk arrangement.

ACS CAN is supportive of Advanced APMs, which we believe provide high-quality and high-value health care to Medicare beneficiaries. We note that not all innovative payment models will necessarily meet the rigorous standards to become an Advanced APM. Given that clinicians meeting the threshold of participation in Advanced APMs receive higher Medicare payments, the standards to which they are held should be expected to be much higher than the standards for MIPS-eligible clinicians.

ACS CAN supports CMS' preliminary list of current Advanced APMs that would meet the requirements to be a qualifying APM participant. We are particularly pleased to see that CMS recognized the Oncology Care Model two-sided risk arrangement as one of the Advanced APMs as we believe this model has the

potential to improve the lives of beneficiaries who undergo chemotherapy as part of their cancer treatment.

As CMS promulgates the final rule, we urge the agency to further specify the requirements for achieving Advanced APM status. We believe this clarification will be helpful as further models are developed to indicate whether such models will meet the criteria for Advanced APM status. Included in these requirements should be specific requirements that any Advanced APM model must focus on both capturing the patient experience as part of the quality measurement of the model and that the model provide care coordination services. We note that the models identified by CMS meet these criteria.

### **Conclusion**

On behalf of the American Cancer Society Cancer Action Network we thank you for the opportunity to comment on the proposed regulations implementing Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive as provided under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). If you have any questions, please feel free to contact me or have your staff contact Anna Schwamlein Howard, Policy Principal, Access and Quality of Care at [Anna.Howard@cancer.org](mailto:Anna.Howard@cancer.org) or 202-585-3261.

Sincerely,

A handwritten signature in blue ink, appearing to read "Kirsten Sloan", is placed on a light yellow rectangular background.

Kirsten Sloan  
Senior Policy Director  
American Cancer Society Cancer Action Network