RBMA | Radiology Business Management Association

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The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-8013

Submitted electronically via http://www.regulations/gov

RE: CMS 5522-P: CY 2018 Updates to the Quality Payment Program

Dear Administrator Verma:

The Radiology Business Management Association (RBMA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule, "Medicare Program: CY 2018 Updates to the Quality Payment Program," (QPP) as published in the *Federal Register* on June 21, 2017.

ABOUT RBMA

Founded in 1968, the RBMA represents over 2,300 radiology practice managers and radiology business professionals. In the aggregate, RBMA's influence extends to over 24,000 radiologic technologists and 26,000 administrative staff. RBMA is the leading professional organization for radiology business management, offering quality education, resources and solutions for its members and the health care community, and helping shape the profession's future.

COMMENTS

Pick Your Pace

RBMA applauds CMS for their recognition that providers need an additional year of experience with the QPP before applying more stringent requirements. Under the proposal, year two of the QPP will serve as another transition year for physicians adjusting to a value-based payment methodology. This slow ramp-up to full implementation should encourage clinician participation while continuing to build meaningful metrics for outcomes measurement. This proposal marks a significant improvement from the May, 2016 proposal that would have required complete provider participation in the first performance year, and will make a significant impact on small and rural providers who do not have the resources to quickly adopt or adapt to the QPP reporting requirements.

Definition of Hospital-Based Clinicians

RBMA commends CMS for their proposal to include off-campus-outpatient hospital facilities in the definition of hospital-based MIPS eligible clinicians in their proposal. In the 2016 MIPS rule, Place of Service (POS) 19 was not included in the definition of "hospital-based clinicians" thereby complicating these clinicians' ability to meet their MIPS requirements. By adding POS 19 to the existing definition of a hospital-based MIPS eligible clinician beginning in 2018, these providers will be appropriately categorized alongside other hospital-based MIPS eligible clinicians.

Topped Out Measures

In the proposal, CMS suggests that starting with the 2018 performance period, a total of 6 "topped out" quality measures would be capped at 6 points instead of 10 points, and topped out measures would be retired completely after a 3-year lifecycle. These topped out measures are intended to identify where a significant number of providers achieve perfect or near-perfect scores and incentivize providers to submit other measures upon which they can improve and earn future improvement points.

While RBMA agrees that "topped out" measures should be given less weight to encourage providers to focus on improvement within other measures, these "topped out" measures should be maintained at their lower weight to encourage continued provider compliance. Indeed, some measures that may be considered "topped out" are worthy of continued effort due to their critical position in clinical care pathways and the integrity of other metrics.

At least one example of this phenomenon is germane to radiology — the use of Measure #359 Optimizing Patient Exposure to Ionizing Radiation: Utilization of a Standardized Nomenclature for Computed Tomography (CT) Imaging Description. Encouraging standardized nomenclature in imaging is integral for interinstitutional data sharing, clinical trial repositories, integrated multi-institutional collaborative databases, and quality control centers. This taxonomy also enables improved plan benchmarking between clinical institutions and vendors and facilitation of automated treatment plan quality control. Removal of Measure #359 could inadvertently have a negative impact to these positive outcomes possible through its initial inclusion.

For many providers, CMS' inclusion of a measure in the QPP represents the gold standard for clinical care guidelines, and continued inclusion of these measures under MIPS — even at a reduced weight — will motivate high-quality treatment by sending a signal to providers that the agency supports adherence to these standards of care.

Appropriate Use Improvement Activity

RBMA continues to support efforts of the "Appropriate Use" program as created by Section 218(b) of the Protecting Access to Medicare Act (PAMA). We support CMS "Proposed New Improvement Activities Eligible for the Advancing Care Information Performance Category Bonus Beginning with the 2018 Performance Period" (Table 6). Specifically, RBMA is supportive of CMS placing a "High" weight value on a MIPS eligible clinician attesting that they are consulting specified applicable appropriate use criteria (AUC) through a clinical decision support mechanism (CDSM) for all advanced diagnostic imaging services ordered. This proposed Improvement Activity will provide an opportunity for "early adopter" clinicians to receive credit for implementing the AUC consultation program.

Additionally, just as ordering providers will get credit for consulting AUC via a CDSM, RBMA recommends that radiologists and others who furnish the technical and/or professional component of applicable advanced imaging services be incentivized to prepare to receive and submit this information. We suggest that the AUC Improvement Activity be expanded to include imaging providers who accept CDSM information from ordering providers and pass it to their MAC during the testing period in 2018. CMS could consider this either as an expansion of the proposed Improvement Activity or as an additional Improvement Activity.

Further, CMS should continue the AUC Improvement Activity in future calendar years irrespective of the implementation of Section 218(b) to continue the focus upon the importance of Appropriate Use for all eligible clinicians (ECs).

Performance Improvement

RBMA is concerned that year-to-year comparisons of high performing groups is a challenge with regard to performance improvement. In the proposed rule, CMS proposes adding up to 10 percentage points to eligible clinicians or groups whose quality score improves with respect to the prior year score. While this comparison may be an incentive for performance improvement, it may also put already-high-performing physicians or groups at a disadvantage compared to lower-performing practices. Instead of comparing the current year to the previous year, it may be a more representative measurement for CMS to establish a baseline improvement standard and assign points proportionately to reward increases in performance based on the amount of room available for improvement.

For example, if Group A were to go from 80 percentage points in year one to 90 percentage points in year two, that increase would represent 10 of the 20 remaining points (50 percent). Under CMS' proposal, there would be no distinction in improvement score between this group and another group that increases from 50 percentage points to 60 percentage points — still a 10-point increase, but only 20 percent of the 50 points available. In this case, it is much easier for the second group to improve, because they have a much lower baseline. And it would be impossible for a group that received 95 percentage points in year one to improve as much as either of their counterparts. Instead, CMS should consider how to reward groups for improving performance in a manner that is proportional to their potential for improvement. Such a measure would more accurately reflect improvements in high-performing groups, while also maintaining incentives for lower-performing groups to enhance their performance.

Special Status

In the proposed rule, CMS has defined a non-patient-facing MIPS EC as an individual who bills 100 or fewer patient-facing encounters or a group in which more than 75 percent of the NPIs billing under the group's TIN meet the definition of non-patient facing. MIPS eligible providers that are considered hospital-based or non-patient facing are exempt from the Advancing Care Information (ACI) component, and the Quality component will account for 85 percent of the total MIPS score and Improvement Activities will remain at 15 percent. RBMA supports the proposed definition of patient-facing and non-patient-facing individuals and groups

To more accurately define patient-facing encounters for non-exempt clinicians, RBMA would further suggest eliminating patient-facing CPTs that take place in a hospital setting (POS 19, 21, 22, and 23) from the calculation of patient-facing status. When billed in a hospital setting, the EC does not own or can ensure that any clinical information system utilized in the hospital setting meets the ACI. Additionally, this approach allows for a greater alignment between patient-facing and hospital-based EC definitions.

Thank you for your attention to these issues. RBMA stands ready to assist the agency with the Year 2 QPP implementation. Please contact Robert Still, Executive Director (bob.still@rbma.org) if you wish clarification of any of our comments or with to discuss further.

Sincerely,

Thomas C. Dickerson, Ed.D.
President
Radiology Business Management Association