AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION

Submitted electronically to www.regulations.gov

August 18, 2017

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–5522–P
P.O. Box 8013
Baltimore, MD 21244–8013

RE: Medicare Program; CY 2018 Updates to the Quality Payment Program [CMS-5522-P]

Dear Administrator Verma:

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 191,500 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students. Audiologists and speech-language pathologists (SLPs) practice in a variety of health care settings that bill Part B of the Medicare program. Therefore, we have a keen interest in ensuring both methods for participating in the Quality Payment Program (QPP), whether it be through the Merit-Based Incentive Payment Program (MIPS) or in Advanced Alternative Payment Models (APMs), are structured appropriately to meet the unique needs of nonphysician clinicians, such as audiologists and speech-language pathologists. We have examined the provisions of the proposed rule and offer a series of recommendations, which we believe must be considered to ensure that the QPP is relevant for all Medicare-recognized clinical specialties and achieves its intended goal to improve the quality and value of services for Medicare beneficiaries.

ASHA respectfully offers comments on the following topics:

- MIPS Program Details
- Advanced Alternative Payment Models (APMs)
- Physician-Focused Payment Models

MIPS Program Details

Clinicians Not Initially Considered Eligible for MIPS

Under the Medicare Access and CHIP Reauthorization Act (MACRA), MIPS only applies to physicians and select eligible clinicians (ECs) in the first 2-years of the program (the 2017 and 2018 performance years). In the third performance year (2019), the Secretary has the discretion to expand MIPS to other categories of clinicians, including audiologists and SLPs. To help physicians and other ECs transition to MIPS for the 2017 performance period, the Centers for Medicare & Medicaid Services (CMS) is allowing these providers to "pick their pace" in MIPS if they determine that they are not ready to begin a full-year of MIPS participation. The options are:

- Test: An EC must submit at least one quality measure or improvement activity to avoid a downward payment adjustment
- Partial: An EC must submit 90 days of 2017 data to CMS to potentially earn a neutral or positive payment adjustment
- Full: An EC must submit a full year of 2017 data to CMS to potentially earn a positive payment adjustment

We believe that CMS did a tremendous service by establishing a transition year for calendar year (CY) 2017, and would encourage the Agency to establish a similar on-boarding of MIPS participation for new ECs when the Secretary expands MIPs to include other categories of clinicians for reporting year 2019. A second challenge with expanding eligibility to MIPS—after the first two payment adjustment years—is the inequitable system for payment adjustments without a proposed phase-in period for new ECs. Specifically, in 2019 the payment adjustment is only 4%, but in 2021 (the earliest audiologists and SLPs could be considered MIPS ECs), the payment adjustment could be as high as 7%. ASHA strongly encourages CMS to work with Congress to determine what, if any, authority is needed to ensure the first year of eligibility for MIPS is equitable for new categories of clinicians as they are added. Using the example above, if audiologists and SLPs are not added as MIPS ECs until 2019 performance period, CMS should determine how it could apply a 4% adjustment to these clinicians.

Low-Volume Threshold

In the calendar year (CY) 2017 QPP final rule, CMS defined individual MIPS ECs or groups who do not exceed the low-volume threshold as an individual MIPS EC or group who, during the low-volume threshold determination period, has Medicare Part B allowed charges less than or equal to $30,000 or provides care for 100 or fewer Part B-enrolled Medicare beneficiaries. MIPS ECs who do not exceed the low-volume threshold are excluded from MIPS for that performance period. ASHA understands that CMS is proposing to modify the current low-volume threshold policy for 2018 to increase the dollar amount to $90,000 and the beneficiary count to 200 Part B-enrolled Medicare beneficiaries in order to reduce the burden on individual MIPS ECs and groups practicing in small practices and rural areas.

For the 2019 performance period, CMS is proposing to allow MIPS ECs and groups that would be excluded from MIPS as a result of the increased low-volume threshold to be able to opt-in to MIPS participation if they are excluded because they only meet one of the threshold determinations. For example, in 2018, if an EC meets the low-volume threshold of $90,000 in allowed charges but does not meet the threshold of 200 patients, they are excluded from MIPS. However, for 2019, CMS is proposing to allow this EC to choose whether or not to participate in MIPS (opt-in). ASHA supports CMS's opt-in proposal for the 2019 performance period as a means of expanding options for clinicians and offering them the ability to participate in MIPS. This proposal is of particular interest to ASHA because 2019 is also the first year in which audiologists and SLPs may be eligible to participate in the program. We believe there should be as many options as possible to help our members transition so they can successfully participate. For 2018 and beyond, we also recommend that CMS consider allowing all MIPS individual and group ECs who want to opt-in the opportunity to do so even if they do not exceed either of the low-volume threshold parameters.

Virtual Group

ASHA is generally supportive of CMS's proposal to allow an individual MIPS EC (solo practitioner) or group consisting of not more than 10 MIPS ECs to elect to be a virtual group with one other individual EC or group. We appreciate that CMS is proposing to allow virtual groups the flexibility to determine their own size and composition at this time. This action from CMS signals that they remain steadfast in the commitment to actively engage providers and to support innovative ideas and approaches generated from this group. However, we suggest that CMS waive the low-volume threshold exclusion for virtual groups. It is our position that finalizing this policy may have the unintended consequence of excluding individual and group ECs who are ready to participate in MIPS program via engagement in virtual groups.

Episode-Based Measures

ASHA understands that CMS is proposing to weight the cost performance category at 0% for CY 2018 in order to give clinicians more opportunity to gain familiarity with the cost performance category. We appreciate that CMS is proposing to not include the 10 episode-based measures in the cost performance category for 2018 and, instead, is proposing to continue working with clinicians to develop new episode-based measures, which are being developed in consultation with MACRA Episode-Based Cost Measures Technical Expert Panels. While we recognize that CMS is allowing for more stakeholder involvement in the development of the new episode-based measures, ASHA strongly urges CMS to publish the new episode-based measures in future rulemaking to allow extensive clinician feedback before including them in the cost performance category for the 2019 MIPS performance period.

Facility-Based Measurement

Currently, audiologists and SLPs who work in facility-based settings, such as skilled nursing facilities (SNFs), have their services billed through the facility because they are statutorily required to participate in consolidated billing and are unable to bill individual therapy services on claim forms. Unfortunately, the use of the Taxpayer Identification Number/National Provider Identifier combination as the identifier excludes these providers from participation in MIPS based on their place of employment and claim reporting mechanism.

For 2018, CMS is proposing to allow MIPS ECs who furnish at least 75% of their covered professional services in an inpatient hospital or emergency room setting to be assessed on the quality and cost performance categories based on the facility's Hospital Value-Based Purchasing (VBP) Program scoring to help reduce clinician burden. ASHA supports efforts to identify a mechanism for participation in MIPS by facility-based providers. However, this proposal does not include providers in the post-acute care setting because (a) there are not any measures in the Hospital VBP that are relevant to Part B therapy services and (b) as previously mentioned, Part B therapy providers employed by a facility cannot bill Medicare directly for their services. It appears that this proposal does not address the needs of providers in post-acute care settings, which results in excluding a significant portion of clinicians who provide Part B therapy services to Medicare beneficiaries. Therefore, ASHA suggests that CMS consider expanding this proposal for 2019 to include elements that will allow for participation by ECs in the post-acute

care setting. ASHA remains committed to working with CMS to develop a facility-based measurement mechanism applicable to our members. We believe facility-based MIPS ECs contribute substantively to facility-based measures of quality and cost. The requirement for post-acute care facilities to report IMPACT Act data may be a path forward for determining MIPS quality metrics for individual clinicians within those facilities in the future.

Small Practice Bonus for the 2018 MIPS Performance Period

ASHA supports CMS's proposal to add a small practice bonus of five points to the final score for MIPS ECs participating in a small practice or virtual group with 15 or fewer clinicians for the 2018 performance year. We agree that the bonus acknowledges the challenges that small practices face related to financial factors and access to resources, including health information technology. We do not believe that this bonus should only apply to the 2018 MIPS performance period. Should the Secretary use his discretion to expand MIPS to include audiologists and SLPs in 2019 and beyond, these clinicians should also be afforded the resources and assistance to help them transition and meaningfully participate in the MIPS program. Many of the challenges encountered by physicians in small practices also exist for small practice audiologists and SLPs who were not eligible for electronic health record adoption assistance. We would also encourage CMS to consider extending a rural bonus for clinicians who practice in rural areas.

Advancing Care Information

ASHA recognizes that our providers will be challenged in the advancing care information (ACI) category of the MIPS program, as audiologists and SLPs were not included in meaningful use and many of our electronic health record (EHR) products today do not have Certified EHR Technology status. In addition, many of the ACI measures may not apply to our providers because ASHA members do not prescribe pharmaceuticals or other professional services within the Medicare program. We request that CMS grant the same exemptions to newly eligible ECs for e-prescribing, hardship exemptions for small practices, and reweighting of the advancing care information category when measures are not applicable, as is the case for nurse practitioners and physician assistants currently.

Advanced Alternative Payment Models

All-Payer Option

ASHA supports CMS's proposal to shorten the timeframe of the qualifying participant performance period under the All-Payer option to January 1 through June 30 of the performance year, to allow ECs sufficient time to collect data from commercial payers. Unlike the Medicare option, CMS cannot guarantee that it will receive all of the data necessary from commercial payers to make Advanced APM determinations by December 31. ASHA also supports CMS's proposal to make qualifying participant determinations under the All-Payer option at the eligible clinician level only. We agree that ECs may participate in Other Payer Advanced APMs whose participants do not completely overlap, or do not overlap at all, with the APM entity for which the EC is part of. Therefore, looking at participation in Other Payer Advanced APMs at the individual eligible clinician level may be a more meaningful way to assess the ECs' participation

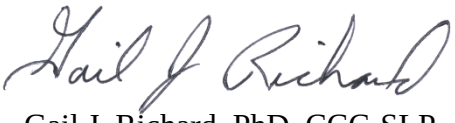
across multiple payers. In addition, those risks and rewards associated with participation in Other Payer Advanced APMs may vary significantly among ECs, depending on the Other Payer Advanced APMs in which they participate.

Physician-Focused Payment Models

In the 2017 QPP final rule, CMS expanded the definition of the physician-focused payment model (PFPM) to state that it is an APM that targets physician services, but also allows for the inclusion of services and participation of other practitioner types (i.e., audiologists and SLPs). ASHA is pleased that CMS was responsive to our recommendation and determined that PFPMs do not have to only include physicians or be exclusively physician-focused. In the 2018 QPP proposed rule, CMS is seeking comment on whether to further broaden the PFPM definition to include payment arrangements that involve Medicaid or the Children's Health Insurance Program (CHIP), even if Medicare is not included as a payer. ASHA recommends that CMS finalize this proposal because, while we realize that broadening the definition to Medicaid will expand the focus of PFPMs on areas beyond Medicare coverage (e.g., pediatrics), it will also engage more stakeholders in designing PFPMs that include more varied populations. Audiologists and SLPs provide therapy services to Medicaid and CHIP beneficiaries and an effort to expand PFPMs models to include these populations aligns better with CMS's goal to move to a health care system that is aimed at improving health through value and patient outcomes across all payers.

Thank you for the opportunity to provide input on this proposed rule. We appreciate your consideration of our comments and would like you to consider ASHA as a resource as you move forward. Should you have any questions regarding MIPS, please contact Sarah Warren, MA, ASHA's director of health care regulatory advocacy, at 301-296-5696 or by e-mail at swarren@asha.org. For questions related to APMs, please contact Daneen Grooms, ASHA's director of health reform analysis and advocacy, at 301-296-5651 or by e-mail at dgrooms@asha.org.

Sincerely,



Gail J. Richard, PhD, CCC-SLP
2017 ASHA President