

VIA ELECTRONIC SUBMISSION: <http://www.regulations.gov>

June 27, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5517-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-5517-P: Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models

Dear Acting Administrator Slavitt:

The American Academy of Audiology (the “Academy”) is the world's largest professional organization of, by, and for audiologists, representing over 12,000 members. The Academy promotes quality hearing and balance care by advancing the profession of audiology through leadership, advocacy, education, public awareness, and support of research. The Academy respectfully submits comments on the proposed rule addressing the establishment of the Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models. Those comments are below.

General Considerations for the Profession of Audiology

Eligibility of Audiologists to Participate in MIPS

For the first two years of MIPS, audiologists are not considered MIPS eligible clinicians. The Academy understands that the Secretary may broaden the list of MIPS eligible clinicians to include specialty groups like audiology as early as 2019, the third year of the program. Despite the fact that audiologists are not included in the initial group of eligible clinicians, the Academy requests that audiologists remain active stakeholders in the MIPS implementation process, as the policies determined as the result of this rulemaking process will reshape the Medicare reimbursement landscape and greatly impact how audiologists practice in the future.

The Role of Non-physician Providers in the Health Care Delivery Model

In reviewing the proposed rule, there is a strong emphasis on physicians and how such policies will impact physician practice. The Academy appreciates the need for CMS to focus its immediate attention on how the implementation of MIPS and APMs will impact physicians, as these and other providers are the first provider stakeholders subject to MIPS. However, we encourage CMS to consider the critical role that non-physician providers play in the health care delivery model and their role in providing high

quality, low cost health care to the Medicare population. We hope the Agency will keep non-physician practitioners in mind as the final rule takes shape. Such providers can and will play a critical role in improving quality and patient outcomes. For example, there is a strong emphasis on Physician-Focused Payment Models (PFPM), and the review of these proposed models by the Physician-Focused Payment Models Technical Advisory Committee (PTAC). The Academy understands that PFPM proposals submitted to the PTAC must be physician-focused. The Academy encourages CMS to broaden these requirements to include submissions from non-physician providers. We believe it is necessary for CMS to put in place at least a basic framework to ensure that the program will be functional when non-physician providers enter the system.

MIPS Program Overview

Feedback Reports and Voluntarily Reporting

The Academy is encouraged by CMS' proposal to include information on the quality and resource use performance categories in the performance feedback. As providers adapt to the MIPS reporting requirements, access to comprehensive performance feedback from CMS will allow these individuals to monitor and improve their participation in the MIPS program. As referenced above, though audiologists will not be considered MIPS eligible clinicians until at least 2019, they will have the option to voluntarily participate in the program until that time. The Academy requests that CMS provide audiologists, and other providers who are ineligible for participation in MIPS but who are reporting voluntarily, with the same access to performance feedback as MIPS eligible clinicians. Audiologists find detailed feedback reports vital in assessing performance in the Physician Quality Reporting System (PQRS), and have spoken to representatives at CMS about the importance of comprehensive feedback reports in ensuring successful reporting and participation in quality programs. Access to feedback reports will be invaluable in assisting providers, like audiologists, in their transition to becoming MIPS eligible clinicians.

CMS proposes to provide performance feedback on an annual basis and notes that in future years the Agency may consider providing performance feedback on a more frequent basis as well as adding performance feedback on the performance categories of clinical practice improvement activities (CPIA) and advancing care information. Because the performance category of CPIA is new and will likely undergo modifications through future rulemaking, the Academy feels that detailed feedback reports highlighting options for CPIAs and discussing incorrect reporting would be helpful in acclimating providers to this new reporting category. The Academy also suggests that a geographic component be included in these reports, so that providers could gain an understanding of clinical practice improvement activities within a specified geographic area. The Academy supports frequent access to detailed feedback reports in all performance categories.

Performance Period

In the proposed rule, CMS maintains a two-year performance period. CMS proposes to use 2017 as the performance period for the 2019 payment adjustment. The Academy has concerns about maintaining a two-year performance period, especially with the implementation of a new program and performance

categories. The Academy reiterates the importance of CMS delivering thorough, frequent, accessible, provider-friendly performance feedback reports so that providers may assess their performance in these new programs in a timely manner. Delayed access to feedback reports, especially given the two-year performance period, may prevent providers from recognizing or correcting issues with reporting, and will impede their ability to provide the highest quality care to patients under MIPS.

Reporting Requirements

The Academy appreciates that with MIPS CMS has tried to lessen the burden of measure reporting for providers by reducing the number of measures a provider must report in the quality performance category and eliminating the domain requirements. These changes allow providers to have more reporting options, and reduce potential barriers to reporting. CMS has also recognized the need for meaningful reporting that will improve patient outcomes and increase quality of care, and has proposed moving towards a stronger focus on outcome measures.

Outcome Measures

The current Medicare regulatory definition places audiologists in the “Other Diagnostic Procedures” benefit classification, which is limited to the exclusive diagnostic only areas of hearing and balance healthcare. Developing measures of quality and outcomes for this narrowly defined benefit classification, as well as participating in interdisciplinary measures that require outcomes or treatment management of the patient has been challenging within these regulatory confines. The Academy is encouraged by CMS’ attempts to ensure flexibility in the types of measures required for reporting in the quality performance category, but also asks that CMS continue to consider that due to statutory limitations, requiring a certain number of outcomes-based or other “high-priority” measures puts specialties like audiology at a disadvantage. The Academy continues to work with other audiology stakeholders in developing appropriate outcomes measures.

MIPS Composite Score

The MIPS composite score categories appear to provide flexibility to eligible clinicians, allowing them to earn points in a number of ways, including a broad array of CPIAs. The Academy notes that many providers required to participate in MIPS are relatively immature in meeting quality reporting requirements under existing programs like the Physician Quality Reporting System (PQRS) and the Value-based Payment Modifier (VM). The Academy is specifically concerned for audiologists, as audiologists have relatively few quality measures to report under the PQRS program, with just three eligible measures in 2015 and six eligible measures in 2016. The Academy has observed that after years of education, training, and adjustment, audiologists have become meaningful participants in the PQRS program, and have adapted their practices to meet reporting requirements.

With the transition to MIPS, audiologists will now have a minimum of a two-year period when no quality reporting will be required. This, compounded with the fact audiologists are not included in the application of the VM, and are statutorily excluded from Meaningful Use of EHR, raises concerns for the profession of audiology. Even with the Academy’s best efforts to promote voluntary reporting in the two year reporting gap, when audiologists are finally considered eligible clinicians, they will have to both learn to report and improve performance on new measures simultaneously to be successful within the

MIPS program. In reviewing the proposed rule, it also appears that there are a number of policies or considerations unique to the first two years of the MIPS program, such as the quality measure category being worth 50 percent in the first year, with resource use category being worth only 10 percent, as directed by the statute. Such policies are necessary in developing the MIPS program and onboarding MIPS eligible clinicians in the first two years of the program. The Academy urges CMS to ensure continued flexibility or additional consideration for providers eligible in 2019, who will not have had the opportunity to learn and evolve with the MIPS program in the first two years.

Reweighting of Performance Categories

The Academy is encouraged to see that providers, like audiologists, who may have no eligible scored measures in a given performance category, i.e. advancing care information and resource use, can have their scores for those categories reweighted. These providers could potentially receive a zero weight in the categories for which they are ineligible or have insufficient measures, and that score could be redistributed to other categories for which they have sufficient measures, such as CPIA or quality performance. The Academy sees many benefits to this approach, including allowing for maximum scoring and participation in MIPS, despite existing limitations. Reweighting does provide opportunities for full participation, yet the fact remains that MIPS is based on a four category weighting system.

Through MIPS, CMS will make critical improvements to existing programs. Despite these improvements and flexibility within in the program, MIPS does not equitably apply to all provider types within the Medicare program. Again, as CMS shapes this final rule for the first set of provider stakeholders, we encourage the Agency to be mindful of the long term and down-stream impacts that this first rulemaking will have on non-physician providers.

Resource Use Performance Category

As mentioned above, at this time, audiologist will have no scored measures in the resource use performance category. The Academy believes that there may be future opportunities for resource use measures or episodes of care that include audiology. One such example relates to current trends for the diagnosis and management of dizzy patients. Vestibular testing is an objective and sensitive battery of tests using voluntary and involuntary eye movements (known as nystagmus) to assess the peripheral and central vestibular systems. Most information obtained through vestibular testing cannot be obtained by other means. Additionally, diagnosing a benign vestibular disorder often safely rules out a worrisome stroke or brain lesion. Due to highly problematic changes in payment policies related to vestibular testing, i.e. a steep reduction in the valuation of vestibular services by CMS, we have seen a marked decrease in patient access to and utilization of vestibular testing since 2008. At the same time, we have seen an increased use of neuro-imaging in the assessment of dizzy patients. For example, cranial CT scans were ordered on 39 percent of dizzy patients in 2011.¹ The Academy believes decreased access to vestibular testing has led to an increased use of neuro-imaging with more patients visiting the emergency room (ER) for complaints of dizziness. With the increased use of neuro-imaging, the estimated costs for ER services are estimated at \$4 billion per year as of 2011. It is estimated that with policy changes and education, these services could be reduced by \$1 billion per year. The Academy strongly encourages CMS to consider the diagnostic testing of dizzy patients when engaging in the future

¹ onlinelibrary.wiley.com/enhanced/doi/10.1111/acem.12168

development of resource use or cost savings measures and in the development of APMS. The Academy would be happy to provide in depth resources and supporting data to assist CMS in these efforts.

Data Submission Criteria: Emphasis on Using CEHRT, QCDRs, and Other Electronic Sources

The Academy understands that the Medicare Access and CHIP Reauthorization Act (MACRA) requires the Secretary to encourage the use of quality clinical data registries (QCDRs) in carrying out MIPS. MACRA also requires the Secretary to encourage MIPS eligible clinicians to report on applicable measures with respect to the quality performance category through the use of QCDRs, certified electronic health record technology (CEHRT), and other electronic sources. In reviewing the CPIA data submission criteria outlined in the proposed rule, CMS plans to allow for the submission of data for the CPIA performance category using the qualified registry, EHR, QCDR, CMS Web Interface and attestation data submission mechanisms. CMS further states that if it is technically feasible, they will use administrative claims data to supplement the CPIA submission. The Academy is troubled by this proposal. Under the current proposals, audiologists are limited in how they will be able to participate in MIPS when the Secretary determines them to be eligible clinicians. Audiologists will likely be able to participate fully in the quality performance category. They have been statutorily excluded from Meaningful Use of EHR, which prevents or limits their participation in the advancing care information performance category. At this time, it is unclear how audiologists would be evaluated in the resource use category, especially given their exclusion from the VM and the statutory limitations of being in the category of "other diagnostic tests." The Academy hoped that the CPIA performance category would be a category in which audiologists could meaningfully participate and report on activities; however, the submission criteria proposed by CMS may further limit their participation.

The majority of audiologists report PQRS via claims-based reporting. As reporting in both MIPS and APMs moves towards electronic sources like QCDRs and CEHRT, CMS should recognize that not all providers have the ability to participate in or report via these electronic reporting mechanisms. Restricting data submission requirements for the CPIA performance category to the electronic sources listed above may prove to be a barrier for audiologists' participation in MIPS, and further impede reporting opportunities when these opportunities are already limited for audiologists. The Academy estimates that adoption of EHR systems among audiologists is relatively low due to a number of factors, including cost, the applicability of such platforms to audiology practices (many are physician-focused), and the fact that audiologists are not considered eligible professionals in the Medicare EHR Incentive Program. The Academy encourages CMS to maintain the option for claims-based reporting to ensure providers like audiologists are able to participate in MIPS.

Further, CMS provides bonuses for eligible clinicians who choose to report quality measures through an EHR, qualified registry, QCDR or web-interfaces, recognizing the cost to report through electronic sources. If eligible, a provider could earn one bonus point per each reported quality measure reported through an electronic source with a cap (up to a maximum of five percent of the denominator of the quality performance category score). While such bonuses may incentivize some providers, the Academy does not feel that the requirements to meet such bonuses apply the majority of providers, including most audiology practices. The Academy believes that this model further disadvantages professions like audiology, who are already struggling to understand how they fit into the MIPS/APM framework. Not only are these professions unable to report in all four performance categories, but they are also limited in their ability to receive such bonuses.

APMS

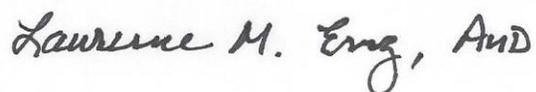
The Academy continues to review and discuss CMS' actions and rulemaking related to the implementation of MIPS and the role of APMs in encouraging high quality, cost effective care. The Academy has reviewed the information related to APMs and struggles to understand how audiologists fit into these APMs, especially with the current focus on PFPMs. The Academy will continue to look for opportunities with both physician and non-physician stakeholders to pursue meaningful involvement in APMs. We would encourage CMS to consider the role of audiologists in the health care delivery model and how that translates to participation in APMs.

Providing Medicare beneficiaries increased access to audiology services both reduces cost and improves quality of care- two critical areas that define both MIPS and APMs. As evidenced by the example provided regarding the treatment and management of patients reporting dizziness, audiologists play a critical role in the diagnosis, treatment, and management of patients requiring both hearing and balance care. The Academy firmly believes that our scope of practice and clinical expertise in this area earns us a role as valued and contributing members of APMs.

* * * * *

The Academy appreciates the opportunity to comment on the proposed rule addressing the MIPS and APM Incentive under the Physician Fee Schedule, and Criteria for PFPMs. Please contact Kate Thomas, director of payment policy and legislative affairs, by phone 703-226-1029 or via email at kthomas@audiology.org should you have any questions regarding the Academy's comments.

Sincerely,



Lawrence M. Eng, AuD
President, American Academy of Audiology