



Sound Policy. Quality Care.

October 5, 2020

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1734-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted online via regulations.gov

RE: Medicare Program; CY 2021 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Quality Payment Program; Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs; Electronic Prescribing for Controlled Substances for a Covered Part D Drug Under a Prescription Drug Plan or an MA-PD Plan; Payment for Office/Outpatient Evaluation and Management Services; Hospital IQR Program; Establish New Code Categories; and Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy (CMS-1734-P)

Dear Administrator Verma:

On behalf of more than 100,000 specialty physicians, the undersigned members of the Alliance of Specialty Medicine (the "Alliance") write in response to proposals outlined in the aforementioned proposed rule, which includes proposals to update the Medicare physician fee schedule for CY 2021 and the Quality Payment Program in Year 5. The Alliance is dedicated to the development of sound federal health care policy that fosters patient access to the highest quality specialty care. To facilitate your review of our comments, below is a list of key recommended actions:

1. Work with Congress to eliminate the negative impact of the many changes in evaluation and management (E/M) payment and related policies;
2. Establish policies that expand access to telehealth and virtual care services while addressing utilization and program integrity vulnerabilities;
3. Create pathways that enable meaningful specialist participation in Medicare Shared Savings Programs;
4. Extend the timeframe for updating certified electronic health record technology (CEHRT);
5. Delay implementation of the MIPS Value Pathways (MVPs) and make key improvements to the program;
6. Allow clinicians in MIPS APMs to continue to benefit from Cost and Improvement Activity category scoring efficiencies regardless of what Quality measures they report;
7. Retain the current (Year 4) MIPS Quality and Cost performance category weights and performance thresholds, in light of COVID-19 disruptions;
8. Make COVID-19-related hardship exemptions available during CY 2021 for MIPS eligible clinicians; and
9. Adopt a streamlined approach to APM incentive payments that permits payment to individual QPs.

Impact of E/M Changes on the Medicare Physician Fee Schedule (MPFS) Conversion Factor

In the rule, CMS estimates a 10.61 percent reduction in the CY 2021 MPFS conversion factor – a \$3.83 decrease from the current CY 2020 conversion factor – which will have a profound and deleterious impact on many specialty physicians, including those represented by the Alliance. The estimated cut largely stems from multiple CMS’ policies — previously finalized as well as proposed — associated with office and outpatient evaluation and management (E/M) services, including:

- The increased valuation for office/outpatient E/Ms;
- A new “add-on” code for complex patient care (i.e., GPC1X); and
- The translation of increased E/M values to other services, such as:
 - Maternity care;
 - The “Welcome to Medicare” visit and subsequent annual wellness visits;
 - Emergency department visits;
 - Therapy services;
 - Behavioral health services; and
 - Other services where E/M services are linked, correlated or have a direct or indirect relationship.

Despite recommendations by the American Medical Association (AMA) Relative Value System Update Committee (RUC), which were supported by the Alliance, CMS did not incorporate the increased E/M values to the global surgery codes.

We recognize CMS’ mandate to ensure budget neutrality; however, the steep cuts in Medicare physician payments — particularly in the midst of the current COVID-19 pandemic — will have serious financial consequences for most specialists. Many specialty practices have not resumed full-scale operations and have limited ability to see patients and performance medically necessary services, as the pandemic continues. Key challenges our specialists face include limited COVID-19 testing and supplies, inadequate personal protective equipment (PPE), reduced operating and procedure room time, insufficient infusion capabilities and locations, and most troubling, concerns from vulnerable patients about leaving their homes to receive recommended care and treatment for fear of contracting the novel coronavirus.

Many of our organizations agree with the AMA that the agency can use its authority under the public health emergency declaration to waive budget neutrality requirements concurrent with the prompt implementation of the new E/M values. In contrast, others submit that CMS must eliminate or — *at a minimum* — reduce the impact of the cuts on those who face the greatest reductions. We note that even under the previous Medicare physician payment system — the flawed sustainable growth rate (SGR) formula — the conversion factor never reached this wholly unsustainable level. In fact, the MPFS conversion factor has not been this low since 1993¹.

We request that CMS identify a solution — independently or with the assistance of Congress — that will address the aforementioned concerns and eliminate the negative financial impact of its policies on many of our specialty physicians.

Telehealth, Virtual Care Services and Related Policies

The Alliance greatly appreciates the flexibilities for Medicare telehealth and virtual care services provided through CMS’ COVID-19 blanket waivers and interim final rules with comment (IFCs). These temporary policies

¹ Under the Medicare Volume Performance Standard (VPS), the MPFS included distinct conversion factors for three categories of services – primary care, surgical and nonsurgical. In 1993, the nonsurgical conversion factor was set at \$31.2490 and the surgical conversion factor was set at \$31.9620.

have enabled many specialty practices to provide essential specialty medical care throughout the pandemic — particularly for those patients with chronic diseases. Using its authorities under the public health emergency declaration and those granted by Congressional action, CMS was able to quickly ensure that beneficiaries — those most susceptible to, and likely to have a severe and devastating outcome from, COVID-19 — could receive care and treatment from their homes using a variety of technology, including audio-only telephones.

Given the positive impact telehealth and virtual care delivery has had on most Alliance specialties, many of our members are making sizeable investments in virtual platforms, indicating their intent to incorporate more telehealth and virtual care services into their practice mix. These practices note that their patients are comfortable receiving medically necessary care virtually, where clinically appropriate and indicated.

While there is broad support across the House of Medicine for increasing access to telehealth and virtual care services, we recognize the challenges CMS faces as it contemplates how and to what extent to make these flexibilities permanent, including the potential for increased utilization and spending and emerging program integrity vulnerabilities. ***The Alliance is committed to assisting CMS as it works toward establishing policies that balance these important issues and makes the following suggestions.*** Above all else, CMS should make clear that telehealth services must be provided consistent with applicable physician supervision requirements, state scope of practice and licensure², professional training, and all applicable state and local laws³. Moreover, initial telehealth expansion efforts should address access to specialists, particularly in shortage areas, including by improving chronic disease care and management through enhanced monitoring.

Medicare Shared Savings Program

For several years, we have submitted that specialists are generally limited in their ability to participate in the Medicare Shared Saving Program (MSSP), or Medicare accountable care organizations (ACOs). While the Medicare Payment Advisory Commission (MedPAC) continues to purport that 60 percent of ACO-participating physicians are specialists, it is unclear which specialties are predominately engaged and what their engagement looks like. We have repeatedly asked the agency to publicly report data on specialty participation in alternative payment models (APMs), including ACOs, to no avail.

We have made several recommendations to improve speciality participation in ACOs, but it is unclear whether they have been considered by agency officials. Now, CMS proposes to pare back the number of ACO quality measures, making speciality participation is even *less* likely.

We contend that ACO participation is important for many specialists given ongoing challenges in the Merit-based Incentive Payment System (MIPS) for some specialties. ***We ask CMS to consider our [prior recommendations](#) and provide a formal response in the final rule, as well as work with us to identify pathways to specialty participation in Medicare ACOs.***

Updates to CEHRT

Updates to Certified Electronic Health Record (EHR) Technology due to the 21st Century Cures Act Final Rule

² According to the Federation of State Medical Boards (FSMB), forty-nine (49) state boards, plus the medical boards of District of Columbia, Puerto Rico, and the Virgin Islands, require that physicians engaging in telemedicine are licensed in the state in which the patient is located. Twelve (12) state boards issue a special purpose license, telemedicine license or certificate, or license to practice medicine across state lines to allow for the practice of telemedicine, and six (6) state boards require physicians to register if they wish to practice across state lines. For details, visit https://www.fsmb.org/siteassets/advocacy/key-issues/telemedicine_policies_by_state.pdf.

³ Note that states have jurisdiction over the establishment of a patient-physician relationship via telemedicine. More details can be found on the AMA website: <https://www.ama-assn.org/system/files/2018-10/ama-chart-telemedicine-patient-physician-relationship.pdf>.

CMS proposes that clinicians participating in the QPP would be required to use only technology that is considered certified under the Office of the National Coordinator's (ONC) Health IT Certification Program according to the timelines finalized in the 21st Century Cures Act final rule. This would mean that until August 2, 2022, clinicians could use technology certified to either version—the current 2015 Edition certification criteria or the certification criteria finalized in the 21st Century Cures Act final (i.e., the 2015 Edition Cures Update). However, after this transition period, clinicians would be required to use technology certified to only the updated version (the 2015 Edition Cures Update) to meet the CEHRT definitions and demonstrate meaningful use under MIPS.

While CMS suggests that this timeline would give clinicians a full 27 months to make this transition (i.e., from May 1, 2020, until August 2, 2022), in reality, this is not the case. Most EHR vendors require practices to first enter an implementation queue, at which point it could still take more than 12 months for the practice to actually test and fully install any updates. ***While vendors may be able to develop, test, and make available to customers their upgraded products within a two-year period, we believe that clinician practices should be given more time to work with EHR vendors to install, customize, test and train providers on these new feature and functions.*** Rushing this timeline will only add to the administrative burdens that practices already face, result in clinician confusion and frustration, and divert attention away from high quality patient care.

We also remind CMS that the August 2, 2022, deadline falls in the middle of the MIPS performance year, which will result in additional confusion as well as misalignment across CMS program priorities.

Quality Payment Program (QPP)

MIPS Value Pathways (MVPs)

In the CY 2020 PFS final rule, CMS finalized the definition of an MIPS Value Pathways (MVP) as a “subset of measures and activities established through rulemaking” and stated its intent to apply the MVP framework in the 2021 performance year. However, due to the COVID-19 pandemic national public health emergency, CMS limited its MVP proposals to guidance necessary for the collaborative development of MVPs, including updates to the MVP guiding principles and development criteria and a proposed process to guide MVP implementation beginning with the 2022 MIPS performance period/2024 MIPS payment year. ***The Alliance supports CMS' proposal to delay the roll out of MVPs given the challenges that specialty societies have faced over the past year working with CMS to find common ground on specific MVP proposals, as well as the ongoing need for CMS to better specify requirements related to this new participation pathway.***

At the same time, we are concerned about CMS' intent to simultaneously propose an initial set of MVPs, along with implementation policies during the CY 2022 rulemaking cycle. ***In order for specialty societies to feel comfortable investing in the development of MVPs, and for specialists to view MVPs as a viable participation option, we would first need assurances that the finalized implementation policies offer flexibility to test more innovative strategies to ensure a more cohesive and meaningful participation experience for specialists.***

CMS reaffirms in this rule that the MVP framework will incorporate a foundational layer consisting of Promoting Interoperability and administrative claims-based quality measures focused on population health. Over time, CMS intends to provide greater amounts of population health measurement data using administrative claims information while decreasing the amount of clinician reported measurement data used for MIPS. CMS envisions that MVPs will be optional for clinicians and that “traditional” MIPS participation options will remain. However, it also intends to build a robust inventory of MVPs and expects that in the future it may propose that all MIPS eligible clinicians would be required to participate in MIPS either through an MVP or an APM Performance Pathway (APP), discussed later in this rule.

In response to these and other proposals regarding the MVP framework, the Alliance reiterates the following priorities that are aimed at incentivizing more meaningful engagement by specialists:

- **Preserve clinician choice.** It is critical that MVPs remain voluntary. Although CMS is currently presenting MVPs as a voluntary option, language in the rule suggests that all MIPS eligible clinicians could be required to participate in MIPS either through an MVP or APM Performance Pathway (APP) in the future. It is critical that clinicians maintain the ability to participate in either an MVP or remain in the traditional MIPS pathway. Similarly, CMS must maintain a diverse measure inventory and preserve choice in terms of the most feasible data collection/submission mechanisms.
- **Adopt new participation mechanisms and scoring rules that support more meaningful engagement by specialists.** The current MVP framework seems to simply repackage the current program without fundamentally improving it. CMS must address certain foundational aspects of MIPS before the MVP framework can improve the clinician participation experience, result in more useful information to inform medical decision-making, and more concretely impact the overall value of care. These include:
 - **Permitting sub-group reporting.** CMS notes that MVPs will enhance comparative performance data as they allow subgroup reporting that comprehensively reflects the services provided by multispecialty groups, yet at the same time, recognizes that subgroup reporting is not currently an option under MIPS. The Alliance strongly urges CMS to create a voluntary group reporting mechanism (available through both MVPs and traditional MIPS) that would allow a portion of a TIN to select the most relevant set of measures and activities to report and be scored on. Many specialists are currently disengaged from the program since they practice in larger, multi-specialty TINs where practice administrators strategically select measures and activities that result in the highest score for the group as a whole. Subgroup reporting would incentivize more meaningful and active engagement by specialists and more comprehensively capture the range of services furnished by specialists and subspecialists, particularly in large group practices. CMS' ability to offer the virtual group reporting mechanism demonstrates that it has the authority and ability to offer an alternative participation pathway that does not rely on full TIN reporting.
 - **Remove scoring caps on measures that lack a benchmark.** Before MVPs can offer specialists a more meaningful participation experience, CMS also must address certain scoring policies. For example, CMS currently caps the number of performance achievement points that can be earned on measures that lack a benchmark, which disincentivizes the development and use of more specialized measures. As a result, these measures are not used and are eventually removed from the program. CMS should remove scoring caps applied to measures that lack a benchmark or adopt other scoring policies (e.g., bonus points) that better incentivize the use of new and innovative measures.
- **Avoid the use of administrative-based population health measures.** Although these measures are meant to reduce reporting burden, they are not meaningful to specialists and do not result in actionable feedback. They also fail to provide an accurate and complete picture of a clinician's quality due to the limitations of billing data. Furthermore, they require a large sample size to produce reliable results, making them more appropriate for facility-level or alternative payment model (APM)-level programs than for clinician-focused programs such as MIPS. We urge CMS to evaluate other more effective ways to minimize reporting burden, while also ensuring more impactful performance assessments. One example is to work with specialty societies to explore better ways to tie claims data to more robust clinical data collected by registries.
- **Provide more flexibility in regards to Promoting Interoperability requirements.** It is critical that CMS work with specialty societies to develop alternative pathways to comply with the Promoting Interoperability category that look beyond EHR functionality and instead recognize diverse and innovative ways of sharing and otherwise making use of electronic health data to improve clinical outcomes (e.g., implementation of practice improvements based on clinical data registry data that incorporates EHR data). We appreciate CMS moving in this direction with the recent addition of the voluntary "Query of a Prescription Drug Monitoring (PDMP)" measure, which provides MIPS clinicians

with the flexibility to query a PDMP using data from CEHRT in any manner allowed under their State law. We also support CMS' proposal to add another new, but optional measure for 2021 titled "Health Information Exchange (HIE) Bi-Directional Exchange" that could take the place of two existing measures and relies on a yes/no attestation regarding HIE bi-directional engagement. We urge CMS to continue to adopt measures that follow this more adaptable model.

- **Allow for more innovative thinking with regards to cost measures.** Despite CMS' efforts to develop more focused episode-based cost measures, many specialties still lack relevant cost measures. We encourage CMS to evaluate alternative options for developing and considering cost measures outside of the Acumen process. While we value aspects of the Acumen process, it is time-consuming, restricted by the limitations of claims data, and generally does not allow for the testing of more innovative ideas. We are encouraged by CMS' proposal to consider a quality measure for 2021 MIPS that relies on a 3-year measurement period. We urge CMS to consider similar outside-of-the-box strategies in regards to cost measurement under MVPs specifically, but also MIPS generally.
- **Enhanced transparency and iterative feedback.** In this rule, CMS notes that since MVPs must be established through rulemaking, CMS will not communicate to the stakeholder whether an MVP candidate has been approved, disapproved, or is being considered for a future year prior to the publication of the proposed rule. While we understand the limitations imposed by rulemaking, we believe that CMS could adopt a more transparent and iterative vetting process that relies on substantive feedback and a balanced two-way dialogue. We are concerned that the MVP vetting process will be similar to the current Improvement Activities vetting process, where stakeholders submit proposals and CMS responds with little, if any, substantive feedback and provides no follow-up opportunity for submitters to respond with additional rationale. In this rule, CMS also asks if it should consider the use of an advisory committee or technical expert panel to review MVP candidates, or the review of MVP candidates by an interdisciplinary committee, similar to what is used for MIPS quality measures under the Call for Measures or a public process such as the NQF convened Pre-rulemaking process. We warn against CMS adopting these approaches since they would layer on an additional and unnecessary level of bureaucracy that would slow down the consideration of more innovative ideas.

APM Performance Pathway

Starting in 2021, CMS proposes to end the APM Scoring Standard, which is the current MIPS scoring methodology for clinicians participating in a MIPS APM. It was designed to reduce reporting burden by eliminating the need for these clinicians to submit data for both MIPS and their respective APMs, and to ensure they were not assessed in multiple ways on the same performance activities. CMS also proposes to create a new APM Performance Pathway (APP) that would be available only to participants in MIPS APMs. Similar to the APM Scoring Standard, under the APP, the Cost category would be weighted at 0% since MIPS APM participants already are responsible for cost containment under their respective APMs, and the Improvement Activities (IA) category score would generally automatically be assigned to a MIPS APM based on the requirements of the MIPS APM (in 2021, APM participants reporting through the APP will generally earn a score of 100%, unless an individual MIPS APM Participant reports at the individual level and does not actually perform an improvement activity for which the MIPS APM would otherwise receive credit). The Quality category would be composed of six measures that are specifically focused on population health. Quality measures reported through the APP also would automatically be used for purposes of Medicare Shared Savings Program quality scoring, thus satisfying reporting requirements for both programs.

The Alliance is concerned that this approach fails to reduce MIPS burden for specialists who invest the time and resources to participate in MIPS APMs, and in fact increases burden for such specialists relative to existing rules. In policies finalized in the CY 2020 final rule, CMS already finalized that specialists could report separately under the APM Scoring Standard using measures that are relevant to their practices, and that scores under such reporting would be used to calculate the APM Entity's quality score, unless the APM Entity reports quality at the APM Entity level. Under those previously finalized rules, specialists would continue to benefit from the Cost and

IA performance category scoring rules under the APM Scoring Standard. However, CMS is now proposing that specialists cannot benefit from the Cost and IA performance category scoring rules unless they report on measures that are not clinically meaningful to the care they provide and for which they have little control over clinical outcomes. For MIPS APM participants whose APM Entities do not report at the APM Entity level, specialists' reporting burden will therefore increase substantially. Furthermore, CMS proposes that those MIPS APM participants who choose to report at the individual level – even if they are reporting through the APP – will be responsible for assessing which IAs are assigned to the MIPS APM and whether they are satisfying the requirements of such IAs; to the extent such assessment falls short, these MIPS APM participants may need to report separate IAs that are more relevant to their practice (if such option is even available under the APP, which is not clear in the proposed rule). We are concerned that such burden will create incentives for specialists to terminate their participation in MIPS APMs, which would be contrary to the Administration's value-based transformation goals. To ensure that burden does not increase for MIPS APM participants who have committed to performance accountability and invested time and resources in APM participation – and especially for the specialists for whom the APP quality measures are not clinically meaningful – ***the Alliances requests that CMS ensure that any MIPS APM participant continues to benefit from 0% weighting of the Cost performance category and full credit under the IA performance category consistent with the score assigned at the APM Entity level, regardless of which quality measures they report and whether they report under MIPS at the APM Entity, TIN, or individual level. MIPS APM participants should not be required to use the proposed APP quality measure set in order to take advantage of this pathway.***

MIPS Performance Category Measures and Activities

Cost Category Concerns

CMS proposes to decrease the Quality category weight from 45% to 40%, while simultaneously increasing the Cost category weight from 15% to 20%. ***We strongly oppose CMS' proposal to shift additional weight from the Quality category to the Cost category for the following reasons:***

- ***CMS should limit the number of changes to MIPS at a time when clinicians are struggling to keep up with the demands and expense of daily practice due to the COVID-19 pandemic.***
- ***The pandemic has caused major disruptions in practice that will impact CMS' ability to make accurate determinations about appropriate levels of quality and cost performance.***
- ***The Alliance also continues to have concerns about the appropriateness of using total cost measures (i.e., the Total Per Capita Cost measure and the Medicare Spending Per Beneficiary measure) for a clinician-level accountability program. Most clinicians still lack a clear understanding of these measures and feel they do not capture costs over which they have direct control. These measures also do not provide actionable information to help physicians determine the extent to which unwarranted variation in spending exists and how to make changes to improve practice. Recently, the National Quality Forum's (NQF) Cost and Efficiency Technical Expert Panel (TEP) reviewed the MSPB measure and voted to not support the measure. The TEP could not reach consensus on the TPCC measure.***

In addition to maintaining the current weight of the Cost category, ***we request that CMS make available to the public the performance year benchmarks used for cost measure scoring and data regarding trends in Cost category performance.*** Currently, the cost measure benchmarks are only available through the secure performance feedback portal, which is often only accessed by practice administrators. We urge CMS to release to the general public a spreadsheet that outlines the performance year benchmarks for each cost measure, similar to how CMS releases updated spreadsheets that include historic benchmarks for quality measures each year. Furthermore, we strongly urge CMS to release data on cost category performance trends, including average performance scores per measure, broken down by specialty and practice size, as well as average overall cost performance scores, also broken down by specialty and practice size.

Quality Category Concerns

In this rule, CMS proposes to use performance period, not historical, benchmarks to score quality measures for the 2021 performance period out of concern that it may not have a representative sample of historic data for CY 2019 due to the PHE, which impacted MIPS data submission in 2020, and could skew benchmarking results. CMS also proposes to update its scoring policy for topped-out measures, so that the 7-point cap will be applied only if the measure is identified as topped out based on the established benchmarks for both the 2020 and 2021 performance periods.

While performance year benchmarks are not ideal because they do not provide clinicians with a target to aim for going into the performance year, we agree with CMS' concern about relying on potentially incomplete and unrepresentative data from 2019. As a compromise, we recommend that CMS consider evaluating performance based on historical (i.e., 2019) benchmarks, as well as performance year (i.e., 2021) benchmarks, and using whichever results in a more favorable score for each measure. This will at least give clinicians a baseline of information to guide measure selection decisions going into the 2021 performance year. In addition, to account for the PHE's potential impact on performance data from 2019 through 2021, we also strongly urge CMS to adopt a universal scoring floor of 5 points would help mitigate the disruptive effects of the PHE on benchmarks, help struggling practices avoid payment reductions, and generally incentivize participation among clinicians who might have otherwise opted to apply for a hardship exemption. This could also incentivize clinicians to report more specialized measures that have historically lacked a benchmark, which could result in the accrual of data for future benchmarking, which in turn could increase use of these traditionally under-reported measures going forward.

In light of COVID-19, we also request that CMS suspend the topped out measure scoring caps for 2021. In general, the Alliance continues to oppose policies that result in capped scoring or the elimination of topped out measures. As we have noted in the past, current determinations of topped out performance may not be accurate due to shifting program requirements from year to year. They also might only reflect the performance of a portion of clinicians who self-select the measure because of expected high performance, rather than true performance across all eligible clinicians. Furthermore, high performance rates do not necessarily mean that a measure is no longer meaningful to patients and clinicians and should stopped being tracked. In fact, removal of such measures could lead to serious unintended consequences if declining performance becomes difficult to track over time. We believe that all of these concerns are amplified in light of the COVID-19 pandemic.

Promoting Interoperability (PI) Category Concerns

The Alliance continues to urge CMS to think outside the box when considering measures for this category and to consider a more flexible and diverse inventory of PI measures that offer more relevant options for specialists. As noted earlier, this should include measures that look beyond EHR functionality and instead recognize innovative ways of sharing and otherwise making use of electronic health data to improve clinical outcomes (e.g., implementation of practice improvements based on clinical data registry data that incorporates EHR data). We are encouraged by CMS' proposal to include an optional, attestation-based measure titled "HIE Bi-Directional Exchange" in the PI category for 2021. The Alliance supports CMS relying on yes/no measure attestations for this category as much as possible, which would minimize clinician reporting burden and aligns with how clinicians attest to Improvement Activities.

MIPS Performance Threshold

As noted earlier, the Alliance is concerned about any attempt to make substantial changes to MIPS at a time when our healthcare system is under significant strain and the care provided by specialists may not be reflective of normal practice patterns or volumes. As such, ***we oppose CMS' proposal to increase the overall MIPS performance threshold in 2021 from 45 points to 50 points. To whatever extent possible, we request that CMS maintain the status quo.***

COVID-19 MIPS Exceptions

The Alliance very much appreciates CMS supporting clinicians on the front lines by providing burden relief via previously announced extreme and uncontrollable circumstances policy exceptions for 2019 and 2020 that account for the COVID-19 PHE. ***We urge CMS to continue to make these hardship exceptions available to those clinicians who feel they still need them during the 2021 performance year.*** Even if the PHE has officially ended by that time, many clinicians and practices will continue to experience the repercussions of a strained and disrupted healthcare system, including financial challenges and abnormal practice patterns and patient volumes.

APM Incentive Payment

CMS intends to continue to reward achievement of Qualifying APM Participant (QP) status through participation in Advanced APMs by disbursing APM Incentive Payments to TINs that are affiliated with an APM Entity through which the QP has achieved QP status. However, CMS has faced challenges issuing these incentive payments as a result of the two-year gap between the performance and payment year and the fluidity of clinicians across TINs, APMs, and the Medicare program, in general, during that time. As such, CMS proposes to establish in regulation a revised approach to identifying the TIN(s) to which CMS makes the APM Incentive Payment. CMS proposes to apply a sequential hierarchy for determining who to make the 5% incentive payment to if the NPI is not with the same TIN in the payment year as the performance year. This approach would prioritize, when the QP is no longer affiliated with the original TIN through which they achieved QP status, identifying and paying TINs with which QPs are affiliated at the time the APM Incentive Payment is made.

The Alliance appreciates CMS' interest in improving the process for distribution of APM Incentive Payments, given the challenges it has experienced to date. However, we are concerned that CMS' proposed 8-step approach is overly complicated, relies on direct engagement with individual QPs only during the final step, and creates the potential for APM Incentive Payments to be forfeited in that final step if QPs fail to act upon a public notice that might not even come to their attention. ***The Alliance therefore recommends that CMS adopt a more streamlined approach that allows for direct engagement with and payment to the individual QP from the outset, which we believe would reduce burden and confusion for QPs and ensure that the individual clinicians who earn QP status benefit directly from the APM Incentive Payment.***

We appreciate the opportunity to share feedback and recommendations for action. Should you have any questions, please contact us at info@specialtydocs.org.

Sincerely,

American Academy of Facial Plastic & Reconstructive Surgery
American Association of Neurological Surgeons
American College of Osteopathic Surgeons
American College of Mohs Surgery
American Society for Dermatologic Surgery Association
American Society of Cataract and Refractive Surgery
American Society of Echocardiography
American Society of Plastic Surgeons
American Society of Retina Specialists
American Urological Association
Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons
North American Spine Society