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TARGETING CANCER CARE

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September 9, 2021

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1751-P
P.O. Box 8016
7500 Security Boulevard
Baltimore, MD 21244-8016

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

Medicare Program; CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-payment Medical Review Requirements.

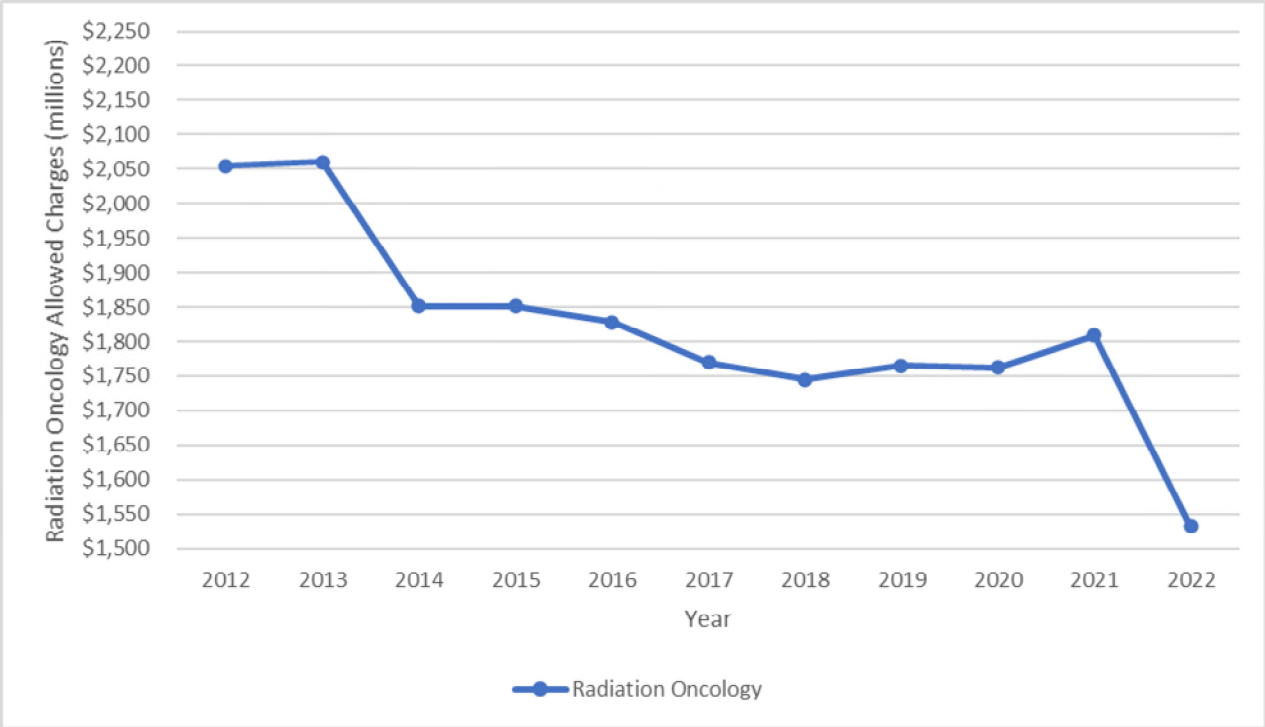
Dear Administrator Brooks-LaSure:

The American Society for Radiation Oncology (ASTRO)[1] appreciates the opportunity to provide written comments on the "Medicare Program; CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-payment Medical Review Requirements" published in the *Federal Register* as a proposed rule on July 23, 2021. ASTRO is very concerned about the financial implications this proposed payment rule will have on access to care for Medicare beneficiaries and radiation oncology practices across the country. Specifically, the cuts associated with the updates to clinical labor pricing and the expiration of the 2021 3.75% conversion factor increase have an incredibly onerous impact on community-based radiation oncology. **We urge the Agency to fully consider the impact of these draconian proposals on cancer treatment centers and patients and change course.**

The combined impact of these significant proposals means that payment for some radiation oncology services will be cut by as much as 23%. ASTRO is very disappointed in the Administration's proposal to implement these cuts, which could restrict access to care and prevent cancer patients from receiving high-value, high-quality radiation therapy close to home.

[1] ASTRO members are medical professionals practicing at hospitals and cancer treatment centers in the United States and around the globe. They make up the radiation treatment teams that are critical in the fight against cancer. These teams include radiation oncologists, medical physicists, medical dosimetrists, radiation therapists, oncology nurses, nutritionists, and social workers. They treat more than one million cancer patients each year. We believe this multi-disciplinary membership makes us uniquely qualified to provide input on the inherently complex issues related to Medicare payment policy and coding for radiation oncology services.

We do not understand how radiation oncology is expected to contribute to President Biden's important goal of "ending cancer as we know it" in light of these cuts. Furthermore, our members cannot withstand such drastic cuts on top of the crushing revenue declines associated with the global pandemic. The COVID-10 public health emergency (PHE) reduced radiation oncology practice revenues by 8% in 2020, and another wave of COVID-19 infections is leading hospitals to cancel elective procedures and shift radiation oncology staff, which will again result in drops in patient volumes and revenue. During the PHE, radiation therapy treatments have been interrupted or truncated prior to completion due to COVID infection and/or local quarantine requirements for patients, family caregivers, or clinic staff. The full extent of these unanticipated disruptions on clinical care is impossible to determine, and the payment cuts in the proposed rule only add to this unprecedented challenge. If finalized, these newly proposed cuts will result in a 25% decline in radiation oncology allowed charges over the last decade (see chart below).



** Assumes 2022 proposed rates are finalized*

The proposed rule updates the payment policies, payment rates, and quality provisions for services furnished under the Medicare Physician Fee Schedule (MPFS) effective January 1, 2022. In the following letter, ASTRO seeks to provide input on the policy change proposals that have a significant impact on the field of radiation oncology. Key issues addressed in this letter follow:

- Payment Rates for Radiation Oncology Services
- Clinical Labor Pricing Update
- Direct PE Inputs for Supply and Equipment Pricing – Year Four of Four-Year Phase-In

- Expiration of PHE Flexibilities for Direct Supervision Requirements
- Quality Payment Program Proposed Rule

Payment Rates for Radiation Oncology Services

In the 2022 proposed MPFS, CMS is proposing significant rate reductions for radiation oncology services. The 2022 Conversion Factor is proposed to be set at $33.58, a payment decrease of 0.14% over the original 2021 Conversion Factor update caused by the budget neutrality payment reduction. However, the 2021 Conversion Factor was actually set at $34.89 due to the Consolidated Appropriations Act, 2021 (CAA) provision that increased MPFS payment amounts for services furnished during CY 2021 by 3.75%. The expiration of this increased Conversion Factor means the entire MPFS faces an immediate 3.75% cut before taking into consideration the impact of the 2022 proposed rule.

In addition to the expiration of the 3.75% CAA Conversion Factor increase, CMS is proposing to reduce payments for radiation oncology services for 2022 by 5%. This reduction is primarily due to increases in clinical labor pricing for some specialties, which has the effect of lowering payments to specialties that use expensive equipment, such as radiation oncology, in the budget neutral environment for practice expense (PE).

If CMS implements the changes fully as proposed for 2022, radiation oncology will face a combined reduction of more than $140 million.[2] However, a more detailed analysis of the radiation oncology code set demonstrates that some services involved in the treatment of breast, prostate, lung, and other common cancers are more significantly impacted by the payment cuts than others. The chart below indicates that several high-volume radiation oncology codes will experience draconian cuts, some as much as 23%.

CPT Code	MOD/SOS	CPT Descriptor	2021 National Rate	2022 National Rate	2022 Impact
G6015		Radiation tx Delivery IMRT	$ 385.57	$ 336.52	-12.72%
77427		Radiation tx Management x5	$ 191.91	$ 190.43	-0.77%
77014		CT Scan for Therapy Guide	$ 126.31	$ 116.54	-7.74%
77301		Radiotherapy Dose Plan IMRT	$ 1,935.17	$ 1,677.56	-13.31%
G6012		Radiation Treatment Delivery	$ 264.84	$ 213.94	-19.22%
77014	26	CT Scan for Therapy Guide	$ 45.36	$ 44.33	-2.27%

[2] https://www.ama-assn.org/system/files/2022-pfs-qpp-proposed-rule.pdf

G6013		Radiation Treatment Delivery	$ 265.54	$ 214.27	-19.31%
77263		Radiation Therapy Planning	$ 169.93	$ 166.58	-1.97%
77373		SBRT Delivery	$ 1,172.06	$ 907.13	-22.60%
77301	26	Radiotherapy Dose Plan IMRT	$ 422.21	$ 415.11	-1.68%
77334	26	Radiation Treatment Aid(s)	$ 60.71	$ 59.78	-1.54%
77300		Radiation Therapy Dose Plan	$ 67.34	$ 63.14	-6.24%
G6002		Stereoscopic X-Ray Guidance	$ 77.11	$ 74.89	-2.88%
77336		Radiation Physics Consult	$ 82.70	$ 74.22	-10.25%
77338		Design Mlc Device for IMRT	$ 480.48	$ 450.37	-6.27%
77300	26	Radiation Therapy Dose Plan	$ 32.80	$ 32.24	-1.70%
77290		Set Radiation Therapy Field	$ 501.41	$ 424.51	-15.34%

When an update has a significant effect on the valuation of services, "[CMS has] occasionally implemented significant updates based on new data through a phased transition across several calendar years." As an alternative to an immediate change in clinical labor pricing, CMS is considering a 4-year transition to implement the updates, which "could smooth out the increases and decreases caused by the pricing update for affected stakeholders." By CMS's calculations, for radiation oncology, a phased approach to the clinical labor pricing updates changes the proposed rule's impact in 2022 to -2%. **Phasing in the clinical labor pricing updates does not fully address the impact these draconian payment cuts will have on practices, and we urge the Agency to work with ASTRO and other medical specialty societies on a more comprehensive solution (*see* Clinical Labor Pricing Update below).**

ASTRO is deeply concerned about the drastic payment cuts proposed for 2022, especially with the economic hardships of the COVID-19 PHE still being faced by radiation oncology practices. Furthermore, the 2022 Hospital Outpatient Prospective Payment System Proposed Rule included the proposed rule for the Radiation Oncology Alternative Payment Model, which would bring an additional $160 million in cuts to radiation oncology over 5 years. These cuts are simply untenable for many practices across the country, particularly in rural and underserved areas. The financial instability that these proposed payment cuts would cause will jeopardize access to safe and effective radiation therapy treatments for Medicare beneficiaries nationwide. This strain would be particularly acute among the office-based providers of radiation therapy services, for

whom all services are paid under the MPFS and who care for nearly 35% of all patients treated with radiation therapy. **ASTRO strongly urges CMS to reduce and, at minimum, phase in the proposed updates to clinical labor pricing to blunt the impact the proposed rule will have on radiation oncology.**

Clinical Labor Pricing Update

CMS is proposing to update the Clinical Labor Prices in conjunction with the final year of the supply and equipment pricing update. This addresses concerns that current wage rates are inadequate because they do not reflect current labor rate information, as well as concerns that updating the supply and equipment pricing without updating the clinical labor pricing creates distortions in the allocation of direct PE.

Our initial analysis shows updating the clinical labor rates is estimated to increase Medicare direct costs by 30%. Based on $11.5 billion in Medicare allowed direct costs, we estimate the "price tag" for updating the clinical labor rates in CY 2022 will be about $3.5 billion. By increasing the clinical labor pricing, physician services with high-cost supplies and equipment are disproportionately impacted by the budget neutrality component within the practice expense relative values.

In the proposed rule, CMS displayed the isolated anticipated effects of the clinical labor pricing update on specialty payment impacts in Table 6. CMS highlights in the text that specialties with a substantially lower or higher than average share of direct costs attributable to labor would experience significant declines or increases, respectively, if this proposal is finalized. The Agency goes on to say that the Table 6 impacts does not include complete impacts of all the policies the Agency is proposing for CY 2022, only the anticipated effect of the isolated clinical labor pricing update. The impacts published in Table 6 and Table 123 are misleading. For example, Table 123 shows radiation oncology at a -5% cut. In reality, the negative impact is much greater, with many radiation oncology services seeing reductions between -10% and -20%.

While ASTRO understands the impact tables are for illustrative purposes for aggregate impacts on specialties, and not meant to be code specific, ASTRO urges CMS to share actual impacts when they are so devastating to providers of office-based procedures with high supply and equipment costs. **CMS should publish a cost estimate for the clinical labor proposal, as well as impacts to illustrate how the proposal is actually impacting non-facility reimbursement rates for highly affected code families.**

The combined impact of steep reimbursement cuts and the continued pandemic risk the viability of many radiation oncology centers and their ability to provide lifesaving cancer treatment. **Therefore, we urge CMS to hold harmless the specialties that are bearing the brunt of this proposal and consider a more equitable way to update clinical labor pricing.**

Budget Neutrality

Section 1848(c)(2)(B)(ii)(II) of the Act requires that increases or decreases in RVUs may not cause the amount of expenditures for the year to differ by more than $20 million from what

expenditures would have been in the absence of these changes. If this threshold is exceeded, CMS makes adjustments to preserve budget neutrality. This $20 million "threshold" has been the same since the inception of the MPFS in 1992. **CMS should analyze the effects of implementing the clinical labor rates as they have proposed, after no change for 20 years, versus having implemented those updates more regularly. CMS should publish how the annual $20 million restriction on changes to expenditures played a role in the clinical labor updates. CMS should also consider all the ways budget neutrality can be accounted for in the practice expense methodology, as there are several steps in the formula where budget neutrality is applied.**

Scaling Factors

The direct scaling factor is proposed to decrease -24% from 0.5916 in 2021 to 0.4468 in 2022. The practice expense component of the MPFS comprises approximately 45% of the total physician payment, and that percentage is fixed. Therefore, an increase in the clinical labor rates results in a shift of RVUs that were previously directed to supplies and equipment. Stated another way, Medicare will now reimburse 44 cents on the dollar, instead of 59 cents on the dollar, for supply and equipment costs.

Radiation oncology is a technology-driven specialty, and that technology is some of the most expensive equipment used in the entire House of Medicine. However, the technology used in radiation oncology has tremendously improved in precision, efficacy, and efficiency over the years and should continue to do so, but steep cuts to payment rates is a stick in the spokes of this wheel of progress. These proposed policies will likely prevent Medicare beneficiaries from receiving modern, less invasive cancer treatments close to their homes. At minimum, practices will be forced to cut back on staff, services and equipment. At a time when the radiation oncology community is seeking resources and support to improve access and quality for rural and underserved populations, these polices represent a massive step backwards.

Unlike other fields of medicine where operating costs are flexible due to low fixed costs, radiation oncology operating costs are inflexible due to high fixed costs. Radiation oncologists make significant capital investments in expensive equipment, such as linear accelerators, for the delivery of radiation therapy, and those costs are fixed over the life of the equipment. If payments change drastically, there is no way to accommodate those shifts through operating expenses without cuts elsewhere, including staff and services offered. Additionally, the high costs of maintaining this equipment remain the same whether or not the equipment is used. Loans will need to be restructured to account for the drastic cuts proposed or bankruptcies will ensue. It is reckless for CMS to propose a policy that would result in such a wildly fluctuating shift in reimbursement. The Medicare system should provide stable and predictable reimbursement for care rendered to its beneficiaries. **CMS should explore options to adjust the scaling factor(s) to more appropriately reimburse for expenses incurred to treat their beneficiaries.**

Clinical Labor Rates – BLS Data

CMS believes it is important to update the clinical labor pricing to maintain relativity with the recent supply and equipment pricing updates. CMS is proposing to use the methodology

outlined in the CY 2002 PFS final rule, which draws primarily from United States Bureau of Labor Statistics (BLS) wage data. CMS believes that the BLS wage data continues to be the most accurate source to use as a basis for clinical labor pricing and this data will appropriately reflect changes in clinical labor resource inputs for purposes of setting PE RVUs under the PFS.

The clinical labor rates were last updated in CY 2002 using Bureau of Labor Statistics (BLS) data and other supplementary sources where BLS data were not available. In the proposal, 12 of the 32 staff types used "other sources," instead of BLS data for pricing. These 2002 "other sources" data were not readily available for public review. For CY 2022, 14 of the 32 staff types are being updated using a BLS crosswalk because an exact match was not available. **To maintain transparency, CMS should publish the 'other sources' wage data details. In addition, CMS should update specific clinical labor wage rates based on stakeholder comments and data.**

The table below lists the proposed updates to the clinical labor prices that are of particular interest to radiation oncology. **While ASTRO appreciates the increases in rates for these radiation oncology-related positions, we request that CMS change its methodology for determining wage data for medical physicists.** The Agency is proposing to use the 75th percentile of the average wage data for the Medical Physicist (L152A) clinical labor type because it believes this level would most closely fit with historical wage data for this clinical labor type. Furthermore, the available Bureau of Labor Statistics (BLS) wage data describes a more general category of physicist, which is paid at a lower rate than a Medical Physicist. The BLS data includes data for health physicists and not medical physicists, who are typically employed by radiation oncology practices. Health physicists focus on the evaluation and protection of human health from radiation, whereas medical physicists use radiation and other physics-based technologies for the diagnosis and treatment of disease. As a result, **ASTRO is concerned that the BLS data does not accurately estimate the wages and compensation of medical physicists and unfairly disadvantages radiation oncology practices**.

The American Association of Physicists in Medicine (AAPM) annually collects salary data on medical physicist wage and compensation data, and ASTRO recommends that CMS incorporate the AAPM 2020 medical physicist salary data in the 2022 clinical labor pricing update calculation. In the 2002 final rule, when clinical labor prices were last updated, CMS chose to use AAPM's survey data in lieu of BLS data because "[CMS] would not question the…assertion that the AAPM survey was more relevant to physicists working in radiation oncology than the survey [CMS] used to determine [its] proposed wage rate."[3]

Labor Code	Labor Description	Source	Current Rate Per Minute	Updated Rate Per Minute	% Change
L050C	Radiation Therapist	BLS 29-1124	0.50	1.00	100%

[3] https://www.govinfo.gov/content/pkg/FR-2001-11-01/html/01-27275.htm

L050D	Second Radiation Therapist for IMRT	BLS 29-1124	0.50	1.00	100%
L063A	Medical Dosimetrist	BLS 19-1040	0.63	1.07	70%
L107A	Medical Dosimetrist/Medical Physicist	L063A, L152A	1.08	1.45	35%
L152A	Medical Physicist	BLS 19-2012(75^{th} percentile)	1.52	1.80	18%

Data Elements in Wage Rates

The BLS data includes several data elements for consideration. In the clinical labor pricing update proposal, CMS utilizes the mean wage data to establish updated clinical labor rates, while the majority of the MPFS data inputs are based on the median. For example, when developing RUC recommendations (work and practice expense) the physician times, work RVUs, clinical staff times, and clinical staff types all use medians (i.e., "typical"). The BLS survey data also include wage rates for a variety of sites of service (e.g., hospitals, physician offices, farms) and wage data from a variety of industries. **We recommend the Agency utilize the median in its clinical labor pricing analysis to remain consistent with its other Medicare calculations.**

Fringe Benefit Multiplier

To account for employers' cost of providing fringe benefits, such as sick leave, CMS proposes to use the same benefits multiplier of 1.366 that was utilized in CY 2002. Using the fringe benefits multiplier rate from 20 years ago (2002) is not consistent with CMS's premise for updating the clinical labor pricing, which was to "maintain relativity with the recent supply and equipment pricing updates". BLS publishes benefits data routinely. **CMS should use a current fringe benefits multiplier.**

Timeline

Given the issues cited above, ASTRO believes the current clinical labor proposal requires additional analysis and modifications prior to implementation. There is further work to be done by both the Agency and stakeholders to ensure accurate data is used and appropriate methodological steps are taken for implementation. It is important to note that CY2022 will be the fourth and final transition year of the update to supply and equipment items—a proposal that also yielded significant shifts in payment rates. **CMS should fully consider stakeholders' serious concerns about the methodology and impact of the clinical labor price proposal and whether it would be more appropriate to publish an updated clinical labor proposal for the CY2023 regulatory cycle.**

Additionally, CMS has requested comment on whether to implement a four-year transition to the new clinical labor cost data. There is precedent for a phased transition for significant MPFS changes, across several calendar years. CMS utilized a 4-year transition for the market-based supply and equipment pricing update concluding in CY 2022. CMS also utilized a 4-year transition, starting in 2010, for the practice expense proposal. **CMS should use a 4-year transition to implement an updated clinical labor proposal, and given the above concerns**

about methodological flaws and severe impact, consider starting that transition in CY 2023. We also encourage the Agency to update clinical labor prices more frequently in the future, so as not to generate such drastic and destabilizing payment cuts caused by a 20-year gap.

Conversion Factor

For CY 2021, the MPFS Conversion Factor was set at $33.63, a 10.2% reduction to account for the shift in payment across all medical specialties due to modifications in the valuation of the evaluation and management codes. As part of COVID-19 relief in the 2021 Consolidated Appropriations Act (CAA), Congress averted this significant cut by increasing the Conversion Factor by 3.75% to $34.89.

In the proposed rule, the CY 2022 Conversion Factor is set at $33.58, which represents a decrease of $1.31, or more than 3%, from the 2021 MPFS Conversion Factor rate update of $34.89. While the CAA prohibited CMS from using the updated figure in future Conversion Factor updates, the proposed CY 2022 Conversion Factor is still a decrease from the original figure for CY 2021 and an extremely negative impact to practices still in the midst of the COVID-19 pandemic. **Therefore, we urge CMS to press Congress to act and provide a positive update to the Medicare Conversion Factor in 2022 and all future years.**

Direct PE Inputs for Supply and Equipment Pricing – Year Four of Four-Year Phase-In

In the 2019 MPFS final rule, CMS worked with market-research company StrategyGen to conduct an in-depth market research study to update the PFS direct PE inputs (DPEI) for supply and equipment pricing. CMS updated the Direct Practice Expense (PE) inputs for the pricing for over 2,000 supply and equipment items (1,300 supplies and 750 equipment items), including key equipment items related to radiation oncology. The changes in payment were significant, and to lessen the impact, CMS phased-in the new direct PE inputs over a four-year period. While we did not support the changes in radiation oncology supply and equipment items, we did appreciate the phased approach, which helped to mitigate some of the initially proposed reductions.

CY 2022 is the fourth and final year of the transition, which means that PE input pricing for the affected items in 2022 will be based on 100% of the new pricing. The chart below displays some of the significant price reductions for radiation therapy equipment.

	2020 Price	**2021 Price**	**2022 Proposed Price**
ED033 Treatment Planning System, IMRT (Corvus w-Peregrine 3D Monte Carlo)	$273,896	$235,571.50	$197,247
ER003 HDR Afterload System, Nucletron – Oldelft	$253,787	$193,181.09	$132,574.78

ER083 SRS System, SBRT, Six Systems, Average	$3,486,861	$3,230,291.38	$2,973,721.84

ASTRO appreciates CMS's efforts to acquire current pricing information, but we reiterate our prior concerns that the recommended prices are below industry standards. Given the high cost of these items and their substantial utilization in certain radiation oncology delivery codes, it is imperative that CMS accurately reflect the marketplace pricing. Undervaluing equipment inputs has the potential to create access to care issues and potentially reduce the utilization of services that provide high quality patient outcomes, and we encourage the Agency to work with the American Medical Association's (AMA) Relative Value Scale Update committee (RUC) Practice Expense Committee when reviewing the identified supply and equipment items CMS would like updated.

Expiration of PHE Flexibilities for Direct Supervision Requirements

Direct supervision requires the immediate availability of the supervising physician or other practitioner, but the professional need not be present in the same room during the service. Immediate availability has been interpreted to mean in-person, physical availability (not virtual). During the COVID-19 PHE, CMS changed the definition of "direct supervision" as it pertains to the supervision of diagnostic tests, physicians' services, and some hospital outpatient services to allow the supervising professional to be immediately available through virtual presence using real-time audio/video technology, instead of requiring their physical presence. In the 2021 MPFS final rule, CMS continued this policy through the end of the PHE for COVID-19 or December 31, 2021, whichever comes later.

In the 2022 MPFS proposed rule, CMS seeks information on whether this flexibility should be continued beyond the latter of the end of the PHE for COVID-19 or 2021. The Agency is specifically seeking input on whether this flexibility should potentially be made permanent, which would alter the definition of "direct supervision" to include immediate availability through the virtual presence of the supervising physician or practitioner using real-time, interactive audio/video communications technology. CMS is also seeking input on whether this policy change should be implemented without limitation after the PHE for COVID-19 or through a gradual sunset of the existing policy. Furthermore, the Agency is seeking comment on whether a revised policy should only apply to a subset of services, recognizing that it may be inappropriate to allow direct supervision without physician presence for some services, due to potential patient safety concerns.

ASTRO believes that direct supervision is the proper standard for delivery of radiation therapy and supports its continued use through real-time, interactive audio and video technology for the duration of the PHE. However, we do not support continued use of real-time, interactive audio and video technology once the PHE has concluded. Due to the irreversible nature of radiation therapy, it is critical that practices provide direct supervision to ensure the continued delivery of safe and high-quality radiation therapy services. Ideally. this supervision is provided in-person and on-site by the radiation oncologist. While ASTRO believes that a board-certified/board-eligible Radiation

Oncologist is the clinically appropriate physician to supervise radiation treatments, we recognize that some flexibility is necessary for those practices that deliver care to underserved populations who may experience access to care issues.

2022 Quality Payment Program Proposed rule

Merit-Based Incentive Payment System (MIPS)

For the 2022 performance year, CMS proposes the following changes to the MIPS performance category weights:

- Quality – 30% (10% decrease from the 2021 performance year)
- Improvement Activities – 15% (no change)
- Promoting Interoperability – 25% (no change)
- Cost – 30% (10% increase from the 2021 performance year)

By law, the Cost and Quality performance categories must be equally weighted at 30% beginning in the 2022 performance period. Also, as required by law, beginning with the 2022 performance year, the performance threshold must be either the mean or median of the final scores for all MIPS eligible clinicians for a prior period. The Agency is proposing to use the mean final score from the 2017 performance year, which would result in the performance threshold being set at 75 points, and an additional performance threshold would be set at 89 points for exceptional performance. The Agency notes that the 2022 performance year is the final year for an additional performance threshold or additional MIPS adjustment for exceptional performance. **ASTRO urges CMS to extend the exceptional performance threshold past the 2022 performance year.** The exceptional bonus is one way for radiation oncology practices to succeed in the program since the cost for compliance is so high because of dedicated staff time, system upgrades, and data collection and reporting mechanism implementation.

<u>Performance Category Reweighting</u>
CMS continues to provide Promoting Interoperability hardship exemptions for the 2022 performance period.

The Agency is proposing to no longer require an application for clinicians and small practices seeking to qualify for the small practice hardship exemption and reweighting. Instead, CMS is proposing to assign a weight of zero percent to the Promoting Interoperability performance category and redistribute its weight to another performance category (or categories) in the event no data is submitted for any of the measures for the Promoting Interoperability performance category. However, if data is submitted for a MIPS eligible clinician in a small practice, they would be scored on the Promoting Interoperability performance category like all other MIPS eligible clinicians. **ASTRO supports this proposal, believing that it will reduce administrative burdens for small practices.**

The Agency is seeking comment on potential options to increase small practice participation in the future. The major barrier to participation is the cost of updating technologies to ensure

compliance. Eligible clinicians do not have control over the EHR products issued by vendors and there is little incentive for vendors to upgrade their products. Additionally, when vendors are required to upgrade their products for MIPS participants to maintain compliance with federal regulations, it requires significant investment in those products. The cost of these upgrades is then passed directly on to clinicians. These excess charges are a financial burden for small and rural practices since CMS does not reimburse for these upgrades. **CMS must provide additional incentives for vendors to make necessary upgrades and ensure that the cost is not passed down to clinicians.**

Facility-Based Measurement

CMS is proposing, beginning with the 2022 performance year, that for facility-based clinicians and groups, the MIPS Quality and Cost performance category scores will be based on the facility-based measurement scoring methodology unless a clinician or group receives a higher MIPS final score through another MIPS submission. The Agency would calculate two final scores for clinicians and groups who are facility based. One score would be based on the performance and weights of the performance categories if facility-based measurement did not apply. The other score would be based on the application of facility-based measurement**. ASTRO supports this proposal because it not only aligns with other MIPS policies where the higher score is the score that is used, but it accommodates the complex nature of physician contracting and business agreements.**

Bonus Points

Complex Patients

CMS is proposing to continue to double the complex patient bonus for the 2021 and 2022 performance period. Clinicians, groups, virtual groups and APM Entities would be able to earn up to 10 bonus points (instead of 5) to account for the additional complexity of treating their patient population due to COVID-19. These bonus points (capped at 10 points) would be added to the final score.

The Agency is also proposing to revise the complex patient bonus beginning with the 2022 performance year by:

- Limiting the bonus to clinicians who have a median or higher value for at least one of the two risk indicators (HCC and dual proportion).
- Updating the formula to standardize the distribution of two risk indicators so that the policy can target clinicians who have a higher share of socially and/or medically complex patients.
- Increasing the bonus to a maximum of 10 points.

ASTRO supports the proposed changes to the complex patient bonus as we believe it will more accurately reflect the patient population being treated by radiation oncologists, and it will incentivize treating vulnerable populations due to the prevalence of more advanced stage disease and complex treatment requirements.

Quality Performance Category

The Agency is proposing to extend the CMS Web Interface as a collection and submission type in traditional MIPS for registered groups and virtual groups, and APM Entities with 25 or more clinicians through the 2022 performance period, sunsetting it with the 2023 performance period. **ASTRO supports the extension of the CMS Web Interface, giving clinicians additional time to transition to other collection and submission types.**

CMS is proposing to maintain the data completeness threshold at 70% of Medicare Part B patients for the 2021 and 2022 performance years, regardless of payer, with a minimum of 20 cases per measure. CMS is also proposing to increase the data completeness threshold to 80% for the 2023 performance period. **ASTRO supports the proposal to maintain the data completeness threshold at 70% for the 2021 and 2022 performance years.** The proposal will help maintain stability within the program. **We are concerned, however, about the proposal to increase the data completeness threshold to 80% for the 2023 performance period. Moving to digital quality measures (dQMs) requires new processes for implementation, which take time. Clinicians should not have to worry about new and increased requirements for implementing those new processes.**

The Agency is proposing to remove the Oncology: Medical and Radiation – Plan of Care for Pain [NQF #0383, Q144] from the radiation oncology measure set. CMS believes that this measure does not align with the Meaningful Measures Initiative as it splits a clinical process into individual quality measures. The agency plans to maintain Oncology: Medical and Radiation – Pain Intensity Quantified [NQF #384, Q143]. CMS recognizes that Plan of Care for Pain does not quantify the completion of a plan of care but includes the assessment of pain for patients undergoing cancer treatment. Further, CMS believes that Plan of Care for Pain is limited to those patients that were screened positive for pain, whether screened for pain or being voluntarily verbalized by the patient. CMS believes, as a stand-alone measure, it is not a true reflection of the quality of care being given, but only reflects care to a subpopulation of oncology patients with documented pain. To truly ensure quality of care for these patients, CMS believes that clinicians should engage all denominator eligible patients and perform this assessment to identify the presence of pain in patients undergoing cancer treatment.

ASTRO disagrees with the Agency's proposal to remove the Oncology: Medical and Radiation – Plan of Care for Pain measure. Ensuring that physicians are creating a plan of care for any pain is necessary. Patients with cancer can have multiple painful side effects and managing a patient's pain is key to their quality of life. This, and its paired measure, Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology (NQF #143), have been utilized since the Physician Quality Reporting System (PQRS) was initiated and are reliable quality measures. Both measures are capturable by electronic systems and are meaningful to the holistic care of patients. **We recommend that CMS retain the Plan of Care for Pain measure in MIPS, not only to maintain harmonization across quality reporting programs but also to maintain continuity between the paired measures.**

Additionally, the Oncology: Plan of Care for Pain quality measure is included in the proposed Oncology Care First Model and the Radiation Oncology Model. ASTRO finds it difficult to

understand why it is no longer feasible to implement a measure that has been in use for more than a decade in multiple programs and clinical settings. Removing the Plan of Care for Pain measure from MIPS means that it will not align with other reporting programs. Additionally, the National Quality Forum recently re-endorsed this measure, highlighting the importance of this measure from a pan-oncology panel and adding credence to the statements to its continuation.

Measures without a Benchmark
CMS is proposing to remove the 3-point floor for measures without a benchmark (except for small practices). These measures would receive 0 points, while small practices would continue to earn 3 points. This proposal would not apply to new measures in the first 2 performance periods available for reporting. **ASTRO opposes this proposal because it will disincentivize clinicians from reporting measures without a benchmark, while at the same time disincentivize measure stewards from developing new measures.** Further, we are concerned that even though this proposal would not apply to new measures in the first two performance periods, that will not be enough time for a measure to acquire enough data to be able to be benchmarked. **CMS continues to make measure development and implementation difficult with no clear rationale.**

Measure Bonus Points and End-to-End Electronic Reporting Bonus Points
CMS is proposing to remove bonus points for measures that meet end-to-end electronic reporting criteria. Additionally, the Agency is developing ways to encourage the use of CEHRT for electronic reporting without offering measure bonus points. As the program works to focus on the quality of care provided to beneficiaries, the Agency intends to score for performance on measures and not for reporting. Therefore, CMS is proposing to end measure bonus points for end-to-end electronic reporting beginning in the 2022 performance period. **Considering the transition to dQM reporting, ASTRO questions whether this proposal is counterintuitive given that dQMs incorporate new and additional data sources, thereby furthering interoperability. We believe that a bonus should be maintained during the transition to dQMs.**

Quality Scoring for Groups Reporting Medicare Part B Claims Measures
CMS recognizes that not all small practices that report Medicare Part B Claims measures intend to participate as a group. Therefore, the Agency is proposing to only calculate a group-level quality performance category score from Medicare Part B Claims measures if the small practice submitted data for another performance category as a group, thus indicating their intent to submit as a group. This proposal excludes those participating in MIPS as part of a virtual group because clinicians signal their intent to be scored as a virtual group through the virtual group election process. **ASTRO supports this proposal as it will alleviate confusion regarding group reporting.**

<u>Cost Performance Category</u>
CMS is proposing to increase the weight of the Cost category from 20% to 30% for the 2022 performance year. By law, the category must be weighted at 30% in the 2022 performance year. The Cost category continues to require a full calendar year reporting period.

The Agency is proposing to add the following five newly developed episode-based cost measures beginning with the 2022 performance period: Melanoma Resection, Colon and Rectal Resection, Sepsis, Diabetes, and Asthma/Chronic Obstructive Pulmonary Disease (COPD). In addition to the current cost measure development process, the Agency is proposing a process of external cost measure development by stakeholders, and a call for cost measures beginning in CY2022 for earliest adoption into the MIPS program by the 2024 performance period. **ASTRO requests clarification on this proposal. Specifically, we are looking for clarification on whether stakeholders will have access to needed data; whether the new measures will be subject to a comment period before implementation; and, how CMS will support stakeholders in the development of these cost measures.**

Improvement Activities Performance Category

Suspension and Removal of Activities

Currently, there is no existing policy to remove or suspend activities outside of the rulemaking process. The Agency is proposing that in the case of an improvement activity for which there is a reason to believe that the continued collection raises possible patient safety concerns or is obsolete, the improvement activity would be promptly suspended, and clinicians and the public would be notified through communication channels, such as listservs and web postings. The Agency would then propose to remove or modify the improvement activity as appropriate in the next rulemaking cycle. **ASTRO supports this proposal; however, we request clarification on what criteria the Agency would use to make these determinations.**

Criteria for Nominating a New Improvement Activity

CMS is proposing two new criteria for nominating new improvement activities:

- Improvement activities:
    - Should not duplicate other improvement activities in the Inventory.
    - Should drive improvements that go beyond standard clinical practice.

The Agency is also proposing that new improvement activities, must at minimum, meet the following criteria, including the two new criteria proposed above:

1. Relevance to an existing Improvement Activity subcategory (or a proposed new subcategory).
2. Importance of an activity toward achieving improved beneficiary health outcomes.
3. Feasible to implement, recognizing importance in minimizing burden, including, to the extent possible, for small practices, practices in rural areas, or in areas designated as geographic Health Professional Shortage Areas by the Health Resources and Services Administration.
4. Evidence supports that an activity has a high probability of contributing to improved beneficiary health outcomes.
5. Can be linked to existing and related MIPS Quality, Promoting Interoperability, and Cost Measures, as applicable and feasible.
6. CMS can validate the activity.

The Agency is also proposing the following optional factors that they may use to consider nominated activities:

1. Alignment with patient-centered medical homes.
2. Support for the patient's family or personal caregiver.
3. Responds to a public health emergency as determined by the Secretary.
4. Addresses improvement in practice to reduce health care disparities.
5. Focus on meaningful actions from the person and family's point of view.
6. Representative of activities that multiple individual MIPS eligible clinicians or groups could perform (for example, primary care, specialty care).

ASTRO supports the proposed criteria for improvement activities. We believe the new criteria will ensure high quality improvement activities.

The Agency is proposing the addition of the following activities:

1. Achieving Health Equity:
    a. Create and Implement an Anti-Racism Plan
    b. Implement Food Insecurity and Nutrition Risk Identification and Treatment Protocols
2. Behavioral and Mental Health
    a. Implementation of a Trauma-Informed Care (TIC) Approach to Clinical Practice
    b. Promoting Clinician Well-Being
3. Emergency Response and Preparedness
    a. Implementation of a Personal Protective Equipment (PPE) Plan
    b. Implementation of a Laboratory Preparedness Plan
4. Patient Safety and Practice Assessment
    a. Application of CDC's Training for Healthcare Providers on Lyme Disease

ASTRO supports the addition of the proposed improvement activities.

<u>Promoting Interoperability (PI) Performance Category</u>
CMS is proposing to apply automatic reweighting to clinical social workers and small practices beginning with the 2022 performance period. **ASTRO supports the automatic reweighting of the Promoting Interoperability performance category for clinical social workers and small practices.**

The Agency is proposing a new measure where MIPS eligible clinicians must attest to conducting an annual assessment of the High Priority Guide of the Safety Assurance Factors for EHR Resilience Guides (SAFER Guides). This measure would be required, but not scored, and would not affect the total number of points earned for the Promoting Interoperability performance category. **ASTRO supports the addition of this new measure and agrees with the Agency's proposal not to score this measure during implementation.**

Advancing to Digital Quality Measurement and the Use of Fast Healthcare Interoperability Resources (FHIR) in Physician Quality Programs and Additional Objectives Adopting FHIR-based API Standards Requests for Information

The Agency is soliciting comments on the transition to digital quality measurement and on its intention to align additional Promoting Interoperability performance category objectives with approaches utilizing HL7 FHIR standard Release 4-based API functionality, specifically targeting the Health Information Exchange, as well as the Public Health and Clinical Data Exchange objectives in the Promoting Interoperability performance category. **ASTRO supports the use of FHIR and FHIR-based APIs and commends the Agency for promoting one standard for everyone to work toward.**

The availability and use of data standards is key to interoperability, data transparency and liquidity. ASTRO is currently engaged in the Common Oncology Data Elements eXtension (CodeX) FHIR Accelerator and has recently completed work to standardize data elements necessary in the end of treatment summary, which promotes care coordination between the numerous clinicians required for holistic cancer treatment. Prior to this initiative, limited standards existed, outside of Digital Imaging and Communications in Medicine (DICOM), that could transfer data between non-radiation oncology systems. To date, the CodeX project has created four radiation therapy profiles, six extensions, and nine value sets, resulting in 322 new radiation oncology-specific data elements. These concepts have not only been added into the Minimal Coding Oncology Data Elements (mCODE) standard, but also have been approved for new Systemized Nomenclature of Medicine-Clinical Terms (SNOMED CT) codes.

Standards development and the framework for information transfer is vital in the move to value-based care; however, it is costly. **ASTRO recommends that CMS provide funding for the transition to provider FHIR-based APIs.** The infrastructure needed for this transition does not exist and must be developed. If CMS expects practices to have one, it will require significant resources (both financial, and staff time) to implement. Currently these tools do not exist so development time must be taken into consideration. Oncology vendors are just now looking into API solutions for their customers, despite the approaching timelines presented in the ONC and CMS Interoperability rules.

Utilizing this growing framework for data, measure stewards will need time and resources to test any re-specification needed to support the transition to dQM using FHIR, and new standards will need to be developed. Quality measure development and maintenance are costly and burdensome, and there is no reason to believe that dQMs will be cheaper to develop and test.

Closing the Health Equity Gap in CMS Clinician Quality Programs Request for Information
CMS is requesting information on revising several related CMS programs to make reporting of health disparities based on social risk factors, and race and ethnicity more comprehensive and actionable for hospitals, providers, and patients.

For purposes of the 2022 QPP proposed rule, CMS is using the definition of equity established in Executive Order 13985, issued on January 25, 2021, “the consistent and systematic fair, just, and

impartial treatment of all individuals, including individuals who belong to underserved communities that have been denied such treatment, such as Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality."

The CMS Equity Plan for Improving Quality in Medicare focuses on three core priority areas, which inform Agency policies and programs: 1) Increasing understanding and awareness of health disparities; 2) developing and disseminating solutions to achieve health equity; and 3) implementing sustainable actions to achieve health equity.

In the 2022 QPP proposed rule, CMS is seeking comment on two potential future expansions of the CMS Disparity Methods, including 1) stratification of quality measure results by race and ethnicity, and 2) improving demographic data collection.

ASTRO supports the stratification of quality measures results by race and ethnicity, but also encourages CMS to consider stratification by patient residency in rural versus urban locations. These indicators lend themselves to demonstrating whether a hospital or other healthcare settings may provide healthcare services to an underserved population that is at higher risk for experiencing healthcare disparities.

As for the collection of additional demographic data, the collection of a minimum set of demographic data elements such as race, ethnicity, sex, sexual orientation, gender identity, primary language, tribal membership, and disability status can be valuable to better understanding the patient population served. However, these indicators can be further enhanced through the collection of additional data points such as employment status, education level, insurance status, income level, and distance from provider, which may further inform whether a patient needs additional social and financial supports to ensure they are able to initiate and complete care. Distance is a critical determinant in whether a patient will start and complete their radiation treatments.

The collection of demographic data and stratification of quality measures can be used to better understand quality measures performance across different patient populations. It will allow for more granular analysis to determine whether interventions that are in place to improve quality are successful for some populations but not for others. Thus, informing the need for modifications or changes to quality measures metrics that can be designed to truly drive quality improvement across all patient populations.

Additionally, this data could be used to establish a Hospital Equity Score, but why stop there? Hospital Equity Scores can synthesize reported metrics to better inform decision making for addressing healthcare disparities, but it could be taken one step further and applied to patients seeking care in these facilities by ensuring that they have access to the social and financial supports necessary to access and complete medical treatment. **ASTRO supports the concept of developing beneficiary-specific equity scores that are established to identify those patient**

populations that require wrap around services, such as nutritional counseling, access to healthy food, transportation and housing. A health equity score can then be further used to tie community need to additional reimbursement that supports the delivery of specific services that are supportive of patients who experience health inequities.

While ASTRO is supportive of efforts to collect better data points for informing improved patient care and outcomes, we continue to urge the Agency to consider the burden—on practices and patients—associated with collecting this data. Not only are time and money needed to upgrade software and implement new programming, but also hospitals and other healthcare settings will require staff to collect data and manage the related programming. **CMS cannot meaningfully address the healthcare equity gap without investing in the resources and infrastructure necessary to reach our nation's most vulnerable populations.**

Many physicians are frustrated with the existing Certified Electronic Health Records Technology (CEHRT) requirements associated with the Promoting Interoperability programs. Clinicians do not have any control over the electronic health records (EHR) products issued by vendors, yet they are penalized for not achieving CEHRT status. More data submission requirements need a stronger reporting framework, more commonly applied standards, and changes to workflow, for which there is currently no funding. **CMS must provide funding assistance for these upgrades.** Additionally, these changes cannot be made overnight, they take time to implement. For example, the Cures Update Edition is set for 2023, yet only Cerner has made adequate upgrades to meet these new requirements. CMS needs to provide adequate time for vendors to prepare and implement upgrade requirements.

Additionally, vendors must be held accountable for the upgrades required to CEHRT systems to ensure improved care coordination and patient access. Hospitals and physicians should not shoulder the burden of meeting these requirements nor should they bear the cost associated with system upgrades. As previously stated, CMS needs to invest in the technological and social resources necessary to improve patient care across all populations. As COVID-19 has demonstrated, a "one-size-fits-all" approach has left many Americans behind. Therefore, the way to achieve health equity will be to target high risk populations with the social support and resources necessary to ensure they are able to achieve better health outcomes.

<u>COVID-19 Vaccination by Clinicians Measure Request for Information</u>
The Agency is seeking feedback on including the COVID-19 Vaccination Coverage Among Healthcare Personnel measure in MIPS. CMS believes it is important to assess whether clinicians are taking steps to limit the spread of COVID-19, and to help sustain the ability of U.S. hospitals to continue serving their communities throughout the COVID-19 PHE and beyond. **ASTRO supports the adoption of the COVID-19 Vaccination Coverage Among Healthcare Personnel measure.** The entire radiation oncology treatment team, not just physicians, have daily contact with patients over the course of treatment, which can last several weeks, and measuring vaccination status protects both patients and practice staff.

Clinical Notes Request for Information

The Agency is soliciting stakeholder feedback on changes it can make that will ensure that clinical notes are widely available to patients. **ASTRO urges caution with ensuring that clinical notes are widely available to patients, as inadvertent disclosure of a diagnosis could occur before a clinician has had a chance to discuss with a patient, causing anxiety and worry.**

Request for Information on a Patient Access Outcomes Measures

The Agency is seeking comments surrounding changes to the Promoting Interoperability performance category and related efforts, which could better target patient access outcomes related to the use of patient portals or third-party applications. The Promoting Interoperability performance category addresses patient access to key healthcare data as part of an overarching interoperability landscape. However, vital elements of data sharing are still in development and the Promoting Interoperability performance category should stay focused on these connectivity issues. Similar to previous comment letters stating that clinicians should not be held accountable for the functionality of a vendor's system, **ASTRO believes that clinicians also cannot be held accountable for patient awareness or engagement with electronic health data.** ASTRO supports the alignment of the performance category requirements with the Cures Act and USCDI requirements, but believes that these structures need to be developed, implemented, and tested before any additional patient-facing requirements are included. As stated above, ASTRO urges caution with clinical notes to avoid early disclosure of diagnosis or any other relevant information that might cause undue stress to a patient in the absence of a clinician.

MIPS Value Pathways (MVP)

CMS is proposing to further delay the implementation of MVP until the 2023 performance period. CMS believes this delay will provide practices the time they need to review requirements, update workflows, and prepare their systems as needed to report MVP. **ASTRO supports the delayed implementation of MVP, and we urge CMS to delay the implementation even further.** In addition to the challenges clinicians are still facing regarding the COVID-19 PHE, there has been little guidance regarding the development of MVP, and we believe it is unreasonable to expect specialties and other stakeholders to develop and be ready to implement MVP by 2025. Further, we think it is ambitious of CMS to believe that traditional MIPS can sunset by 2027 given the uncertain and murky guidance given regarding development of MVP to date.

Subgroups

The Agency is proposing to limit subgroup reporting only to clinicians reporting through MVP or APM Performance Pathway (APP) for the first year of subgroup implementation. Subgroup reporting would be voluntary for the 2023 and 2024 performance years. CMS defines subgroups as "a subset of a group which contains at least one MIPS eligible clinician and is identified by a combination of the group TIN, the subgroup identifier, and each eligible clinician's NPI." ASTRO questions the proposal limiting subgroup reporting to just MVP reporting. **We believe subgroup reporting should be available to all MIPS participants and recommends CMS include this option for MIPS participants. ASTRO believes that the inclusion of subgroups**

will be good for physician choice; however, we worry about the additional layers of complexity that would be added if the proposal is finalized.

To participate as a subgroup, each subgroup would be required to:

- Identify the MVP the subgroup will report, along with one population health measure included in the MVP and any outcomes-based administrative claims measure on which the subgroup intends to be scored, if available.
- Identify the clinicians in the subgroup by TIN/NPI.
- Provide a plain language name for the subgroup for purposes of public reporting.

Once registered, the subgroup would be assigned a unique subgroup identifier that would be separate from the individual NPI identifier, the group TIN identifier, and the MVP identifier.

Participation Options

CMS is proposing the following in the definition of an MVP Participant: individual clinicians, single specialty groups, multispecialty groups, subgroups, and APM Entities. Beginning with the 2025 performance year, the Agency is proposing that multispecialty groups would be required to form subgroups to report MVP. CMS did not indicate whether all specialties will have their own MVP, or how this will be operationalized. Nor did CMS indicate if subgroups must be made up of a single specialty. If, in fact, a subgroup can be made up of multiple specialties, then we question why CMS is requiring multispecialty groups to form subgroups for MVP reporting. **ASTRO requests clarification on this requirement. Further, ASTRO believes that requiring multispecialty groups to form subgroups by 2025 is an overly ambitious proposal.** The Agency's rationale is that this will give multispecialty groups time to become familiar with MVP; however, it is likely that subgroups within multispecialty groups will not have MVP by 2025. Additionally, multispecialty groups will have to develop the infrastructure, hire additional staff, and make necessary practice changes to support multiple submission types, all of which will take time. Given the proposed transition time, CMS must provide additional guidance so these practices and groups can begin the transition process. **ASTRO requests clarification on the following:**

- Does CMS anticipate all specialties having an MVP to report to by 2025?
- Will CMS be developing MVP or is the Agency leaving it up to specialties and other stakeholders?
- Does CMS expect development of overlapping MVP? If an MVP can be patient-, disease-, or specialty-focused, how does this decrease the options and increase comparability?
- Will there be a "generic" MVP for those specialties who do not have a specialty-specific MVP?
- Do single-specialty practices or groups have to report MVP? If CMS plans to transition these groups to MVP, when do they expect that to occur?

Reporting Requirements

CMS is proposing the following reporting requirements for MVP Participants and Subgroups:

- Foundational Layer (MVP agnostic)
    - Population Health Measures: MVP Participants and Subgroups would select one population health measure, the results of which would be added to the quality score.
    - Promoting Interoperability Performance Category:
        - MVP Participants would report on the same Promoting Interoperability measures required under traditional MIPS, unless they qualified for automatic reweighting or had an approved hardship exemption.
        - Subgroups submit Promoting Interoperability data at the group level, not the subgroup level
- Quality Performance Category
    - MVP Participant scoring policies would align with those used in traditional MIPS.
    - Subgroups would select four quality measures. One must be an outcome measure (or a high-priority measure if an outcome measure is not available or applicable).
- Improvement Activities Performance Category
    - MVP Participants would select four quality measures. One must be an outcome measure (or a high-priority measure if an outcome measure is not available or applicable).
    - Subgroups would select two medium-weighted improvement activities or one high-weighted improvement activity available for the MVP.
- Cost Performance Category
    - CMS would calculate performance exclusively on the cost measures that are included in the MVP using administrative claims data.

ASTRO supports the proposal that subgroups would report the Promoting Interoperability at the group level, not the subgroup level. We remain concerned about the inclusion of population health measures, as few exist and even fewer are relevant to specialties. How will this requirement be modified in the case where no population health measure exists?

Alternative Payment Models (APM)

Advanced APM

<u>Advanced APM Incentive Payment</u>

In the 2022 MPFS proposed rule, CMS is proposing a change to the APM Incentive Payment payee hierarchy that was established in 2021. This modification will allow CMS to expand its search at each step of the hierarchy, identifying potential payee TINs that are associated with the QP during the QP payment year. This proposed approach enables the Agency to make payments earlier in the year and reduces the number of QP NPIs that do not match with a payee TIN. Overall, this would reduce CMS' reliance on the public notice process to request more information. **ASTRO appreciates CMS' commitment to correctly identifying and paying earned bonuses to Advanced APM participants. We support the proposed modifications to**

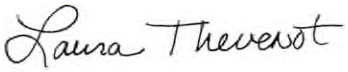
the existing payee hierarchy that will allow CMS to expediate payee identification and payment.

Alternative Payment Model Performance Pathway (APP)

In 2021, CMS established the Alternative Payment Model Performance Pathway (APP) under the MIPS program. The APP allows for the reporting of a single quality measure set with broad applicability. The APP establishes measures, which according to CMS address the highest priorities for quality measurement and improvement, while also reducing reporting burden, promoting alignment of measures and consolidation of reporting requirements across CMS programs. In the 2022 MPFS proposed rule, CMS recognizes that when the APP program was established in the 2021 MPFS final rule, it did not discuss how the other category weights would change given that APP participants are already meeting cost category requirements. The Agency sets forth proposed weighting modifications but does not address concerns that the APP has limited application and is not broadly applicable to unique specialties of care. **While ASTRO supports efforts to establish new pathways for participating in Alternative Payment Models, the APP seems to be designed more for primary care providers than specialty providers, based on the broad range of standardized quality measures. We urge CMS to further consider model development in collaboration with a variety of stakeholder groups.**

Thank you for the opportunity to comment on this proposed rule. We look forward to continued dialogue with CMS officials. Should you have any questions on the items addressed in this comment letter, please contact Adam Greathouse, Senior Manager, Health Policy, at (703) 839-7376 or Adam.Greathouse@astro.org.

Respectfully,



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