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October 1, 2020

Ms. Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1693-P
P.O. Box 8013
7500 Security Boulevard
Baltimore, MD 21244-8013

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

Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2021

Dear Administrator Verma:

The American Society for Radiation Oncology (ASTRO)[1] appreciates the opportunity to provide written comments on the "Medicare Program: CY 2021 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; etc." published in the *Federal Register* as a proposed rule on August 17, 2020. ASTRO is very concerned about the financial implications this payment rule will have on radiation oncology practices across the country, as they continue to treat cancer patients during what will likely be an extended public health emergency (PHE). Specifically, the cuts associated with the changes to the Evaluation and Management (E/M) code set add insult to injury for radiation oncology clinics, as many struggle with revenue declines of 20-30 percent due to the COVID-19 PHE. While ASTRO appreciates the Agency's efforts to reduce the physician burden related to E/M documentation and the willingness to work with the medical community through the AMA CPT/RUC process to update the E/M codes, the anticipated cuts in reimbursement to offset these changes in RVUs for 2021 are devastating. ASTRO members cannot withstand such drastic cuts, on top of the crushing revenue declines associated with the global pandemic.

The proposed rule updates the payment policies and payment rates for services furnished under the Medicare Physician Fee Schedule (MPFS) and modifies requirements associated with the Quality Payment Program (QPP) effective January 1, 2021. In the following letter, ASTRO

[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.

seeks to provide input on the policy change proposals that have a significant impact the field of radiation oncology. Key issues addressed in this letter follow:

- Payment Rates for Radiation Oncology Services
- Proton Beam Treatment Delivery (CPT codes 77520, 77522, 77523, and 77525)
- 2021 Office/Outpatient Evaluation and Management (E/M) Visits
- Practice Expense Methodology
- Telehealth and Other Services Involving Communications Technology
- Continuation of Payment for Audio-only Visits
- Direct Supervision by Interactive Telecommunications Technology
- Proposed Changes to Scope of Practice for Diagnostic Tests
- MIPS Scoring Methodology
- MIPS Value Pathways (MVP)
- Advanced APMs
- Alternative Payment Model Performance Pathway (APP)
- MIPS APMs

Payment Rates for Radiation Oncology Services

In the 2021 proposed MPFS, CMS is proposing significant rate reductions for radiation oncology services.

The 2021 Conversion Factor is proposed to be set at $32.26, a payment decrease of $3.83, nearly -11 percent, from the 2020 Conversion Factor rate update of $36.09. The steep reduction in the Conversion Factor is necessary to meet the statutorily mandated budget neutrality requirement, which is driven by the need to offset increases in payments for Evaluation and Management (E/M) services that were finalized in the 2020 MPFS Final Rule and effective January 1, 2021.

Although CMS proposes RVU increases for several key radiation oncology codes in the 2021 MPFS proposed rule, the significant reduction in the Conversion Factor largely offsets those proposed increases.

According to Table 90 of the 2021 MPFS proposed rule, the impact on radiation oncology is a combined reduction of 6 percent. However, a more comprehensive analysis of the radiation oncology code set demonstrates that some codes are more significantly impacted by the payment cuts than others. The chart below indicates that several key radiation oncology codes will experience cuts of as much as 12 percent.

CPT Code	MOD/SOS	CPT Descriptor	2020 National Rate	2021 Estimated National Rate	2021 Impact
77334	26	Radiation treatment aid(s)	$ 63	$ 55	-12%
77014	26	Ct scan for therapy guide	$ 46	$ 41	-11%
77300	26	Radiation therapy dose plan	$ 34	$ 30	-11%
77301	26	Radiotherapy dose plan IMRT	$ 433	$ 387	-11%
77427		Radiation tx management x5	$ 196	$ 176	-10%
77263		Radiation therapy planning	$ 174	$ 156	-10%
77338		Design MLC device for IMRT	$ 497	$ 448	-10%
77373		SBRT delivery	$ 1,231	$ 1,110	-10%
77300		Radiation therapy dose plan	$ 68	$ 63	-8%
77290		Set radiation therapy field	$ 508	$ 473	-7%
77301		Radiotherapy dose plan IMRT	$ 1,949	$ 1,819	-7%

ASTRO is deeply concerned about the steep E/M-driven payment cuts proposed for 2021. Due to the COVID-19 PHE, many radiation oncology practices already face a myriad of economic hardships. Radiation oncologists have reported significant revenue losses upwards of 30 percent due to the pandemic. **ASTRO is concerned that the financial instability created by the COVID-19 PHE will be exacerbated by the budget neutrality requirement when CMS implements the widely supported Medicare E/M office visit payment policy in 2021. Furthermore, the imminent financial strain on radiation oncology practices could jeopardize access to safe and effective radiation therapy treatments for Medicare beneficiaries across the country. 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 percent of all patients treated with radiation therapy. In light of these concerns, ASTRO strongly urges CMS to use its authority under the PHE to waive the budget neutrality requirement resulting from the implementation of the new Medicare office visit E/M codes.**

Proton Beam Treatment Delivery (CPT codes 77520, 77522, 77523, and 77525)

In April 2018, the AMA RUC's Relativity Assessment Workgroup (RAW) identified CPT code 77522 (Proton treatment delivery; simple, with compensation) and CPT code 77523 (Proton treatment delivery; intermediate) as contractor-priced Category I CPT codes with 2017 estimated Medicare utilization of over 10,000 services. The RAW agreed with ASTRO's recommendation to maintain contractor pricing for the family of proton services; however, the full RUC did not agree and required the specialty society to conduct a practice expense survey to evaluate proton direct practice expenses to set national reimbursement rates for proton services.

The AMA's practice expense committee reviewed the proton survey results in great detail at the April 2019 RUC meeting. The practice expense subcommittee and subsequently the full RUC approved ASTRO's recommendations and forwarded them to the Agency to establish national reimbursement rates for proton services.

In the 2021 MPFS proposed rule, CMS rejected the RUC's proton recommendations and is proposing to maintain contractor pricing for proton services instead of establishing national reimbursement rates. According to CMS, the costs associated with the Proton Treatment Vault (ER115) and the Proton Treatment Delivery System (ER116) were extraordinarily high and would have far surpassed pricing for the SRS system, Linac (ER082) which is currently the highest equipment price in the CMS database, valued at $4,233,825. CMS expressed concern that establishing proton equipment pricing at a rate significantly higher than anything else in the CMS equipment database could distort relativity within the fee schedule.

ASTRO supports the RUC's direct practice expense recommendations for proton services. Concurrently, ASTRO applauds the Agency for carefully considering the unintended consequences of pricing high equipment cost items using the current CMS methodology. ASTRO agrees with CMS' assertion that contractor pricing will allow proton therapy providers to adapt quickly to shifts in the market-based costs associated with the proton treatment equipment. ASTRO looks forward to our continued work with CMS on issues related to proton service reimbursement.

2021 Office/Outpatient Evaluation and Management (E/M) Visits

In the 2020 MPFS Final Rule, CMS finalized modifications to the E/M codes, including creating five levels of coding for established patients, reducing the number of levels to four for new patients, and revising the code definitions. The finalized changes will allow clinicians to choose the E/M visit level based on either medical decision-making or time and require the collection of medical history and exam **only** when medically appropriate. CMS also adopted the AMA's RUC-recommended payment rates and finalized payments based on each code descriptor to pay for each level of service, rather than utilizing a "blended rate" for E/M code levels 2 through 4 that was finalized in the 2019 MPFS Final Rule. These changes are scheduled to begin January 1, 2021.

Total Time

In the 2020 MPFS final rule, the RUC recommended, and CMS accepted the use of survey total median times for the new E/M codes. However, in the 2021 MPFS proposed rule, CMS has changed its position and is proposing to use total time (sum of pre/intra/post) instead. The Agency does not believe that comments received on the topic sufficiently address why the use of survey total median times for the new E/M codes were more appropriate then total time – sum of the parts. Robust comments were submitted to the Agency, outlining how the RUC survey data were collected and analyzed (3 days prior, 7 days post, etc.) and why, in this instance, the sum of the parts does not equal the total time. **ASTRO urges CMS to implement the use of survey**

median total times instead of sum of the parts total time, as it more appropriately reflects the strong physician survey data.

Global Periods

This proposed rule does not include a new proposal to apply the office visit increases to the visits bundled into global payments. This creates a two-tiered system for evaluation and management services that does not recognize that physicians are performing follow-up care with their patients. The RAND study, which CMS uses to defend its position, is flawed in that it does not recognize that physicians are seeing patients for follow-up care. This work should be accounted for in the global payments. **ASTRO urges CMS to apply the RUC recommended values to the visits bundled into global payments.**

HCPCS code GPC1X

In the 2020 MPFS, CMS finalized HCPCS code GPC1X - *Visit complexity inherent to evaluation and management associated with primary medical care services that serve as the continuing focal point for all needed health care services (Add-on code, list separately in addition to an evaluation and management visit)* to better describe the work associated with visits that are part of ongoing, comprehensive primary care and/or visits that are part of ongoing care related to a patient's single, serious, or complex chronic condition.

CMS is moving forward with the implementation of HCPCS code GPCIX. The Agency received numerous requests seeking clarification on the intended use of GPC1X code and the medical community expressed grave concerns that the projected utilization numbers were too high. In the 2021 MPFS proposed rule, not only did the Agency not provide the requested detail explaining the utilization numbers, its estimates in this proposed rule are even higher than those included in the 2020 MPFS.

CMS is soliciting public comments on additional, more specific information regarding what aspects of the definition of HCPCS add-on code GPC1X are unclear, how the Agency might address those concerns, and refine the utilization assumptions for the code. **ASTRO believes many aspects GPC1X remain unclear and not well defined and clarification regarding the application of GPC1X is necessary before we can provide meaningful comments. We urge CMS to postpone the implementation of GPC1X so that the services can be considered through the CPT/RUC process to better establish the use of the code. Additionally, we ask that the Agency remove the estimated utilization numbers in the 2021 formulas.**

Prolonged Office/Outpatient E/M Visits (CPT code 99XXX)

In the 2021 MPFS, CMS is proposing the application of CPT Code 99XXX in combination with either 99205 or 99215 (Level 5 – Office E/M Visit or Outpatient E/M Visit) when the actual time of the reporting physician or Non-Physician Provider (NPP) exceeds the maximum allotted time by at least 15 minutes on the date of service. The allotted time for 99205 is 85 minutes and the allotted time for 99915 is 70 minutes; therefore, the Prolonged Office/Outpatient E/M Visit code

could be used for visits that exceed those allotted time by 15 minutes. **ASTRO expects radiation oncologists to bill 99XXX given the complexity of most radiation oncology patients.**

Practice Expense (PE) Methodology

Payments made under the fee schedule reflect physician work, professional liability insurance, and practice expense (PE) components. The current PE methodology for setting rates relies in part on data collected in the Physician Practice Information (PPI) Survey. In the current system, PE is broken into *direct* and *indirect* components. Direct PE includes non-physician clinical labor, disposable medical supplies, and medical equipment that are typically used to provide a service. Indirect PE relates to such expenses as administration, rent, and other forms of overhead that cannot be attributed to any specific service.

CMS has stated that it is interested in refining the PE methodology and updating the data used to make payments under the MPFS. In addition, the Agency states *that potential refinements could improve payment accuracy and strengthen Medicare*. While those goals are laudable, the data/results included in the *Practice Expense Methodology and Data Collection Research and Analysis Interim Phase II Report (RAND)* are alarming. Table 7.3 *Impact of Using Outpatient Prospective Payment System–Based Relative Values for Total Practice Expense Relative Value Units, by Specialty* illustrates wild shifts in potential impacts to specialties (i.e. interventional radiology -23%, radiology -15%, radiation oncology -19% and vascular surgery -27%). A fundamental key in the report was using hospital outpatient costs as the basis to re-establish PE RVUs. The Agency has received numerous comments over the years from stakeholders identifying egregious flaws in the outpatient cost data. Often hospitals use APC payments to quantify their costs, which is a circular methodology and highlights the unreliability of those data.

In the 2021 proposed MPFS, CMS states that the Agency would like to "obtain[ing] the data as soon as practicable". **ASTRO, along with the specialty society community, implores the Agency to work closely with stakeholders to analyze alternatives and/or modifications to the PE methodology. While CMS notes that it is interested in hosting a Town Hall meeting at a date to be determined, it is critical to the success of the project that the Agency make informed decisions from the information collected from broad stakeholder representation at those Town Hall meetings, as well as Technical Expert Panels (TEP). Holding these types of activities in name only is disingenuous and will lead to uninformed policy.**

There is discussion in this proposed rule, as well as within the AMA, to conduct another Physician Practice Information Survey (PPIS) to update physician and practice costs. If a new PPIS is to be conducted, it is imperative that the Agency and the AMA work closely with specialties to conduct concurrent supplemental surveys due to the complicated nature of their specialties to determine the most cost effective and thorough way to update their practice costs. Additionally, in this time of devastating cuts in reimbursement to practices due to the global pandemic, specialty societies will need assistance in covering the costs to conduct supplemental

surveys.

Telehealth and Other Services Involving Communications Technology

Expanded flexibilities for telehealth services were issued through COVID-19 waivers established in several interim final rules issued in March 2020. These flexibilities remain in effect as HHS recently extended the PHE declaration. In the 2021 MPFS proposed rule, the Agency is seeking public input on expanding the number of telehealth services available to Medicare beneficiaries.

In response to the PHE for the COVID-19 pandemic, CMS undertook emergency rulemaking to add a number of services to the Medicare telehealth services list on an interim basis for the duration of the PHE, including the on-treatment visit (OTV) portion of CPT Code 77427. CMS is seeking comments on whether the Agency should include CPT code 77427 on the telehealth list on a permanent basis but is proposing to remove 77427 from the telehealth list for 2021. CMS also is proposing to permanently keep several codes that radiation oncologists typically bill on the Medicare telehealth list, including the prolonged office and outpatient E/M visit code.

ASTRO believes America's cancer patients have benefited from the expansion of telehealth during the COVID-19 PHE. Interim waivers introduced early in the pandemic have allowed radiation oncologists to provide much needed services to patients via telehealth while mitigating the risk of the spread of the virus, particularly for initial consults and follow-up care.

In March, 2020, cases of COVID-19 were growing exponentially, at the same time many radiation oncology practices were struggling to secure appropriate PPE, modifying patient schedules to ensure social distancing, and establishing new patient intake protocols while continuing to deliver cancer treatments. CMS swiftly introduced unprecedented telehealth waivers and expansions in response to the declaration of the COVID-19 PHE. At that time ASTRO urged CMS to exercise non-enforcement of in-person, face-to-face interactions that are typically required as part of the weekly OTV associated with CPT code 77427. At the onset of the pandemic, many hospitals and clinics were plagued by issues that made face-to-face interactions unsafe for both physicians and patients. CMS recognized ASTRO's concerns and undertook emergency rulemaking to add CPT code 77427 on the approved telehealth list on an interim basis for the duration of the PHE, permitting radiation oncologists to conduct face-to-face OTV interactions using approved virtual real-time audio video communication technologies.

Face-to-face engagement between radiation oncologists, clinical treatment teams, and patients under treatment is the ideal and most appropriate way to manage care. Since March, radiation oncology practices have established protocols and precautions to ensure patients and providers are better protected from COVID-19 exposure. Radiation oncology practices have been able to secure access to PPE supplies, initiated new patient screening and intake protocols, and have a better understanding of how to conduct face-to-face visits with greater precautions. Finally, given that both the patient and the radiation oncologist are present in the clinic, to receive and supervise treatment, respectively, face-to-face visits are logistically feasible.

ASTRO appreciates the Agency's commitment to telehealth expansion both during and at the conclusion of the PHE. While appropriate to protect patients and radiation oncologists from infection spread during the COVID-19 PHE, ASTRO believes that the use of telehealth for the face-to-face portion of the OTV (CPT code 77427) is not appropriate after the conclusion of the PHE. The physical examination is an integral part of cancer patients' treatment management during the course of radiation therapy to ensure quality of care. While exceptions and flexibilities may be needed to address rural, underserved, and low-income communities, ASTRO believes that it is best practice for the radiation oncologist to conduct the face-to-face portion of the weekly management code in-person.

Continuation of Payment for Audio-only Visits

CMS established separate payment for audio-only telephone E/M services (CPT codes 99441, 99442, and 99443) during the PHE, and cross-walked payment rates for these services from office/outpatient E/M codes. CMS received feedback from stakeholders that the use of audio-only services was more prevalent than expected, especially because many beneficiaries were not utilizing video-enabled communication technology from their homes. Since the statute requires telehealth services to have a two-way, audio/video communication technology, CMS states that it does not have the authority to extend this flexibility beyond the PHE. In the 2021 MPFS proposed rule, CMS recognizes the value of audio-only services, and the Agency is seeking comments on whether it should develop coding and payment for a service similar to the existing virtual check-in codes but for a longer period of time and with an accordingly higher value. CMS is also seeking comment on whether separate payment for such telephone-only services should be a provisional policy to remain in effect until a year or some other period after the end of the PHE or if it should be a permanent PFS payment policy.

ASTRO appreciates the Agency's continued support of telehealth evidenced by its recognition of the value of audio-only services. Cancer patients have benefited from the use of audio only codes, particularly for those who lack access to audio/video capable devices. ASTRO agrees with CMS that the prevalent use of audio-only codes necessitates their continued separate reimbursement, particularly during the COVID-19 PHE.

Direct Supervision by Interactive Telecommunications Technology

For the duration of the COVID-19 PHE, CMS adopted an interim final policy revising the definition of direct supervision to include virtual presence of the supervising physician or practitioner using interactive audio/video real-time communications technology. In the 2021 MPFS proposed rule, CMS is proposing to allow direct supervision to be provided using real-time, interactive audio and video technology (excluding telephone that does not also include video) through the end of the PHE or December 31, 2021, whichever comes later.

This allows for the continued use of virtual presence of the supervising physician or practitioner using interactive audio/video real-time communications technology recognizing that in some cases, the physical proximity of the physician or practitioner might present additional infection

exposure to the patient and/or practitioner. According to CMS, individual practitioners are in the best position to make decisions about how to meet the requirement to provide appropriate direct supervision based on their clinical judgement in certain circumstances.

Furthermore, CMS plans to collect additional input on services and circumstances for which this policy may be appropriate on a permanent basis. Specifically, the Agency is seeking information from commenters regarding whether there should be any "guardrails" in effect as it finalizes this policy and what risks this policy might introduce to beneficiaries as they receive care from practitioners that would supervise care virtually in this way. In addition to comments regarding patient safety/clinical appropriateness, CMS is seeking comment on potential concerns around induced utilization and fraud, waste, and abuse and how those concerns might be addressed.

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. 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.

Proposed Changes in Scope of Practice for Diagnostic Tests

In the 2021 MPFS proposed rule, CMS is proposing changes related to the scope of practice for physician fee schedule services that would allow Nurse Practitioners (NPs), certified Clinical Nurse Specialists (CNSs), Physician Assistants (PAs), and Certified Nurse Midwives (CNMs) to provide the appropriate level of supervision assigned to diagnostic tests, to the extent authorized under State law and scope of practice. In accordance with statute, these non-physician providers (NPPs) would be working either under physician supervision or in collaboration with a physician. According to CMS, this flexibility is designed to increase the capacity and availability of practitioners who can supervise diagnostic tests, which would alleviate some of the demand on physicians as the only source to perform this specific function. In order to pursue this modification, the Agency indicates that it would need to better understand the scope of practice for the different types of auxiliary staff who could potentially provide these tests under the supervision of a non-physician practitioner.

According to the proposed rule, CMS is seeking to review state scope of practice laws and licensure requirements, as well as facility specific supervision policies to determine whether additional flexibilities can be granted for the supervision of diagnostic tests. This review potentially applies to existing diagnostic imaging tests associated with image guided radiation therapy (IGRT).

Section 410.32(b)(3) of the Code of Federal Regulations, Title 42 defines three different levels of

physician supervision required for the various diagnostic imaging tests used in IGRT. The IGRT codes assigned to a given level are provided in parentheses below.

- General Supervision: The procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. (76950 or G6001[2] - *Ultrasonic guidance for placement of radiation therapy fields*)
- Direct Supervision: The physician must be present and immediately available to furnish assistance and direction throughout the performance of the procedure. The physician does not need to be present in the room when the procedure is performed. (77014 - *Computed tomography guidance for placement of radiation therapy fields* and 77421 or G6002[3] - *Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy*[4])
- Personal Supervision: The physician must be in attendance in the room during the performance of the procedure. (76965 - *Ultrasonic guidance for interstitial radioelement application*).

ASTRO believes that NPs, PAs, and other non-physician members of the radiation oncology treatment team can play an important role in the ongoing management of patients receiving radiation therapy. These individuals can assist the radiation oncologist in the recognition and documentation of treatment-related symptoms and advise or prescribe interventions to mitigate acute or chronic treatment-related toxicity. Many practices comply with APEx Accreditation Standards that define specific staff roles and responsibilities, including supervision requirements associated with the delivery of specific modalities of treatment to ensure patient safety:

> *Standard 6: Safe Staffing Plan*
> *The radiation oncology practice (ROP) establishes, measures and maintains staffing requirements for safe operations in clinical radiation therapy.*
>
> > *6.1 - Staffing levels and requirements:*
> > *6.1.1 - The ROP has documentation of staffing requirements for each professional discipline that is derived from measurable criteria.*
> > *6.1.2 - The documentation specifies the number of each professional discipline required to be on-site, directly involved in patient care or available remotely during operating and non-operating hours.*
> > *6.1.3 - Coverage requirements include a qualified Radiation Oncologist to be on-call 24 hours a day and seven days a week to address patient needs and/or emergency treatments.*
> > *6.1.4 - There is a documented plan for coverage during planned and unplanned absences of professional staff.*

[2] Medicare deleted CPT 76950 in 2015 and replaced it with G6001
[3] Medicare deleted CPT 77421 in 2015 and replaced it with G6002
[4] The level of supervision for 77421 was changed from personal to direct, effective for services on or after January 1, 2009 in the July Update to the 2009 Medicare Physician Fee Schedule Database (Transmittal 1748, Change Request 6484, May 29, 2009)

Additionally, practices also adhere to *Safety is No Accident* for additional guidance regarding certification requirements that ensure radiation oncologists, physicists and other members of the radiation oncology team are adequately trained and educated on the complexities of radiation treatment delivery.[5]

The supervising physician or non-physician practitioner must have within his or her state scope of practice and hospital-granted privileges the ability to perform the service or procedure that he or she supervises.[6] As it specifically pertains to radiation therapy services, many states (as well as hospital privilege guidelines) are likely to limit a non-physician practitioner's scope of practice such that he or she would not be able to serve as a supervisor.

Additionally, due to the irreversible nature of radiation therapy, to protect patients and to ensure the continued delivery of safe and high-quality radiation therapy services it is ASTRO's opinion that the existing supervision levels associated with IGRT services (i.e., codes G6001 (previously 76950), 77014, G6002 (previously 77421), and 76965) should remain in place and require the physician's presence and participation as currently described in the CFR.

2021 Quality Payment Program (QPP) Proposed Rule

Recognizing the impact of the COVID-19 Public Health Emergency (PHE), CMS continues to consider the extraordinary health system stresses by providing burden relief and delaying key proposals to future performance years.

CMS has implemented several policies in response to the PHE for the 2020 performance year, including :

- Clinicians, groups and virtual groups may submit an Extreme and Uncontrollable Circumstances application requesting reweighting of one or more MIPS performance categories due to the current PHE. The deadline to submit is December 31, 2020 at 8pm ET. Approved applications will reweight performance categories to 0%. Data submission will void approved applications on a category-by-category basis.
- A new high-weighted COVID-19 clinical trials (IA_ERP_3) improvement activity for the 2020 performance period to provide an opportunity for clinicians to receive credit in MIPS. A clinician may participate in a COVID clinical trial and have those data entered into a data platform for that study; or a clinician participating in the care of COVID-19 patients may submit clinical COVID-19 patient data to a clinical data registry for purposes of future study.

ASTRO appreciates the Agency providing flexibilities for the 2020 performance year due to the current PHE and delaying key proposals for future performance years. **However, we believe**

[5] "Safety is No Accident" American Society for Radiation Oncology, 2019
[6] Medicare Benefit Policy Manual, Chapter 6, Section 20.5.2

that clinicians will face similar circumstances during the 2021 performance year, and therefore we recommend that CMS extend these flexibilities through at least the end of the 2021 performance year.

Merit-based Incentive Payment System (MIPS)

MIPS Scoring Methodology

CMS is proposing a 50-point performance threshold for the 2021 performance year, rather than the 60 points finalized in the 2020 Final Rule. **ASTRO supports the Agency's proposal to change the performance threshold to 50, instead of the 60 finalized in the 2020 Final Rule.** The Agency is not proposing any changes to the exceptional performance threshold, currently set at 85 points for the 2021 performance year. ASTRO remains concerned that an 85 point performance threshold will adversely affect small and rural practices and lead to consolidation, which may limit patient access to vital cancer treatments. However, we understand the need to increase the requirements for the program, even though CMS data show that small practices receive more negative payment adjustments than larger practices. **ASTRO therefore recommends that the Agency provide more bonus opportunities for small and rural practices.**

Performance Category Reweighting

CMS continues to provide Promoting Interoperability hardship exemptions for the 2021 performance period. In a case where the Promoting Interoperability category is reweighted to zero, the Agency proposes reweighting the Quality category to 75 percent and the Improvement Activities category to 25 percent. Further, the Agency is proposing that where the Quality category is reweighted to zero, the Promoting Interoperability category would receive 75 percent and the Improvement Activities category 25 percent. **ASTRO is disappointed that the Agency is not proposing to equally redistribute the weights between both the Quality and the Improvement Activities categories, or the Promoting Interoperability and Improvement Activities categories.** We continue to believe redistributing weights to Improvement Activities more accurately weights that category, which is the one performance category that we believe has the power to transform a practice and drive true quality improvement. Quality measures only track what a physician is doing, while Improvement Activities effect the entire care team.

Establishing Separate Performance Periods for Administrative Claims Measures under the Quality Performance Category

The Agency is proposing to modify the definition of the performance period for the Quality and Cost performance categories as follows: Beginning with the 2021 MIPS performance year, the performance period for the Quality and Cost performance categories is the full calendar year (January 1 through December 31) that occurs 2 years prior to the applicable MIPS payment year, except as otherwise specified for administrative claims-based measures in the MIPS final list of quality measures. This would establish a separate performance period for administrative claims

measures under the Quality performance category. **ASTRO opposes this recommendation as it is adding more complexity to an already complex program.** We believe it is confusing for clinicians to have different performance periods under the same category in the same program. In trying to make the program more successful, if finalized, this proposal would add to clinician burden. **We therefore recommend that the Agency not finalize this proposal.**

Bonus Points - Complex Patients

CMS proposes to double the complex patient bonus for the 2020 performance period only. 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. **ASTRO agrees with the rationale for increasing the complex patient bonus for the 2020 performance year, and recommends the Agency extend the increase through the 2021 performance year.**

Quality Performance Category

CMS is proposing to use the performance period rather than historical benchmarks to score quality measures for the 2021 performance period. The Agency is concerned they may not have a representative sample of historic data for the 2019 performance year because of the PHE, which could skew benchmarking results. For the 2021 performance year, the Agency is proposing to apply a 3-point floor for each measure that can be reliably scored against the benchmark. Given the use of performance period benchmarks for 2020, CMS also proposed an update to the scoring policy for topped-out measures. The 7-measure achievement 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. **ASTRO thanks CMS for recognizing that the PHE has had, and will likely continue to have, dramatic effects on performance reporting during this unprecedented time.**

In addition, CMS is proposing to add two new administrative claims measures; Hospital-Wide, 30 day, All-Cause Unplanned Readmission (HWR) Rate for the MIPS Eligible Clinician Groups and the Risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) for MIPS Eligible Clinicians.

- Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups.
    - 200 case minimum
    - 1-year measurement period
    - Only applies to groups and virtual groups with 16 or more clinicians that meet the case minimum

Though unlikely, based on the case minimum, the Hospital-Wide, All-Cause Unplanned Readmission claims measure could apply to large radiation oncology or multidisciplinary groups. However, we worry that the attribution methodology will unfairly target radiation oncologists,

who do not perform primary care services. The Agency finalized specialty exclusions under the Total Per Capita Cost (TPCC) Measure in the 2020 Final Rule. These exclusions ensure that the TPCC measure is more accurately applied to clinicians who provide primary care services. Under the TPCC, attributed episodes of care are excluded if they are performed by clinicians who (i) frequently perform non-primary care services (for example, global surgery, chemotherapy, anesthesia, radiation therapy) or (ii) are in specialties unlikely to be responsible for providing primary care to a beneficiary (for example, podiatry, dermatology, optometry, ophthalmology). **We therefore recommend that CMS apply the same specialty exclusions to the Hospital-Wide, All-Cause Unplanned Readmission claims measure.**

Cost Performance Category

CMS is proposing to increase the weight of the Cost category from 15 to 20 percent for the 2021 performance year, and 30 percent for the 2022 performance year. By law, the category must be weighted at 30 percent in the 2022 performance year. The Cost category continues to require a full calendar year reporting period. Due to the Public Health Emergency and the increase in use of telehealth services, CMS is proposing to update existing measure specifications to include telehealth services that are directly applicable to existing episode-based cost measures and the total per capita cost measure. **ASTRO supports this proposal and suggests that CMS retain the specialty exclusions for the TPCC Measure finalized in the 2020 Final Rule.**

Improvement Activities Performance Category

CMS is retaining the weight for Improvement Activities performance at 15 percent, based on a selection of medium and high weighted activities. The Agency is also retaining the 90-day minimum performance period, as well as the simple attestation reporting requirement. CMS is proposing 1 new element to the criteria for nomination of new improvement activities beginning with the 2021 performance period and future years: include activities which can be linked to existing and related MIPS quality and cost measures, as applicable and feasible. The Agency believes that when possible, it is important to establish a strong linkage between Quality, Cost, and Improvement Activities. **In general, ASTRO supports this new element, however, we recommend that CMS defer this requirement until the MIPS Value Pathways (MVP) (see discussion below) have been finalized, implemented, and assessed.**

Promoting Interoperability (PI) Performance Category

The Agency proposes to retain the Query of Prescription Drug Monitoring Program measure as an optional measure and proposes to make it worth 10 bonus points.

For the 2021 performance year, CMS is proposing to change the name of the Support Electronic Referral Loops by Receiving and Incorporating Health Information to Support Electronic Referral Loops by Receiving and *Reconciling* Health Information to better reflect specific actions required by the measure's numerator and denominator.

CMS is also proposing to add an optional Health Information Exchange (HIE) Bi-Directional Exchange measure. As proposed, clinicians may either report the two existing measures and associated exclusions OR may choose to report the new measure. CMS proposes that the HIE Bi-Directional Exchange measure would be worth 40 points. The measure would be reported through attestation.

CMS believes that HIEs allow for the sharing of health information among clinicians, hospitals, care coordinators, labs, radiology centers, and other healthcare providers through secure, electronic means so that healthcare providers can have the benefit of the most recent information available from other providers. **ASTRO supports this proposal and believes it will promote adoption of standards and Office of the National Coordinator for Health Information Technology (ONC) requirements by vendors because of client requests.**

Certified Electronic Health Record Technology (CEHRT)

CMS is continuing the requirement that eligible clinicians use 2015 Edition CEHRT for 2020. In May 2020, the Office of the National Coordinator for Health Information Technology (ONC) finalized additional updates to the 2015 Edition in the 21st Century Cures Act Final Rule, including an e-prescribing standard required for alignment with other CMS programs.

The 21st Century Cures Act final rule finalized updates to a number of certification criteria which are currently associated with objectives and measures under the Promoting Interoperability Program, as well as criteria that are included in the 2015 Edition Base EHR[7] definition. In general, ONC finalized that health IT developers have until May 2, 2022 to make technology certified to these updated criteria available to their customers. During this time, developers are expected to continue supporting technology certified to the prior version of certification criteria for use by their customers.

In general, health IT developers have up to 24 months from May 1, 2020 to make technology certified to the updated criteria available to their customers, plus the additional three-month period during which ONC will exercise enforcement discretion around compliance dates finalized in the 21st Century Cures Act final rule in response to the COVID-19 PHE. As a result, where the 21st Century Cures Act final rule requires health IT developers to make technology meeting new and updated certification criteria available by May 2, 2022, developers taking advantage of enforcement discretion would be permitted to delay making updated certified technology available until August 2, 2022. After this date, technology that has not been updated in accordance with the 2015 Edition Cures Update will no longer be considered certified.

Health IT developers are expected to continue supporting technology certified to the prior

[7] *2015 Edition Base EHR* means an electronic record of health-related information on an individual that: (1) Includes patient demographic and clinical health information, such as medical history and problem lists; (2) Has the capacity: (i) To provide clinical decision support; (ii) To support physician order entry; (iii) To capture and query information relevant to health care quality; (iv) To exchange electronic health information with, and integrate such information from other sources; and (3) Has been certified to the certification criteria adopted by the Secretary.

version of the certification criteria for use by their customers prior to implementing updates, and healthcare providers participating in QPP may use such technology for the purposes of these programs while working with health IT developers to implement updates in a manner that best meets their needs.

As we have mentioned in previous comment letters, eligible clinicians do not have control over the EHR products issued by vendors and penalizing providers for not achieving any level of CEHRT status must be avoided. **ASTRO believes that CMS and ONC must issue clear direction to vendors, so a complete and timely upgrade of EHR products are available by the 2022 deadline to increase care coordination and patient access. The onus on updating required software should rest solely on the vendor, not the clinician.** Additionally, when vendors are required to upgrade their products to maintain compliance with federal regulations, it requires significant investment in the products. However, these costs are often passed on directly to physicians. **As we have mentioned previously in other comment letters, we are concerned that vendors will use every new, regulatorily-required update or module as an opportunity to generate additional charges and fees for their products.** These excess charges are a financial burden for many practices, especially for small and rural practices, which often find these costs prohibitive.

Extreme and Uncontrollable Circumstances Reweighting Application

Beginning with the 2020 performance period, CMS proposes to allow APM Entities to submit an application to request reweighting of all MIPS performance categories. If the application were approved, the APM Entity group would receive a score equal to the performance threshold even if data is submitted. This is different than the policy for individuals, groups, and virtual groups, which remain the same. **ASTRO is supportive of efforts to implement flexibilities within the scoring methodology to recognize extreme and uncontrollable circumstances.**

MIPS Value Pathways (MVP)

Due to the current PHE, CMS is delaying the implementation of MVP until the 2022 performance period, or later. **ASTRO supports the delayed implementation of MVP until the 2022 performance period or later.** However, we request clarification on the following: Since the MVP approval process must go through the rulemaking process, will the submission template and standard application process be available during 2021 so potential MVP will appear in the 2022 proposed rule? Or will the template and application be included in the 2022 proposed rule, with the first approvals in the 2023 rule? **Finally, since the Agency has indicated that MVP is a stepping stone between MIPS participation and APM participation, we believe that the development criteria for MVP should not be more onerous than that for an APM.**

Alternative Payment Models (APM)

Advanced APMs

Qualified APM Participant (QP)

In the 2017 QPP final rule, CMS established Qualified APM Participant (QP) status requirements that allowed for the determination of QP status first at the APM Entity Level, after which the Agency would make further QP determinations at the individual level for Eligible Clinicians who are either participating in multiple Advanced APM Entities or are included on an Affiliated Practitioner List that is used for QP determination. The QP determination Threshold Score calculations are aggregated using data for all Eligible Clinicians participating in an APM Entity on each snapshot date (March 31, June 30, August 31, and December 31) during the QP Performance Period. If the APM Entity's Threshold Score meets the relevant QP threshold then all individual eligible clinicians in that APM Entity would receive the same QP determination.

CMS includes "attribution eligible beneficiaries" in the denominator of the patient count and payment amount methods used to calculate the QP Threshold Scores. Beneficiaries may only be counted once in the numerator and denominator for a single APM Entity but may also be counted in other APM Entity calculations. The calculation involves the ratio of payment amounts or patient counts for "attributed beneficiaries" to the payment amounts or patient counts for "attribution eligible beneficiaries." If the ratio meets or exceeds the relevant QP thresholds, the Eligible Clinician will have attained QP status for the year.

The Agency has come to recognize that this policy disadvantages some APM Entities, as it includes "attribution eligible beneficiaries" in the denominator of the calculation that could not be included in the numerator as "attributed beneficiaries". For example, beneficiaries prospectively attributed to an ACO are not available to be attributed to other APMs, thus limiting the number of "attribution-eligible beneficiaries".

CMS is proposing to modify the policy to specify that beneficiaries who have been prospectively attributed to an APM Entity for a QP Performance Period will be excluded from the attribution-eligible beneficiary count for any other APM Entity that is participating in an APM where that beneficiary would be ineligible to be added to the APM Entity's attributed beneficiary list. This removes the prospectively attributed beneficiaries from the denominators when calculating Threshold Scores for APM Entities or individual Eligible Clinicians in Advanced APMs denominator when calculating the QP threshold score. **ASTRO supports efforts to ensure that Eligible Clinicians are given every opportunity to participate in Advanced APMs as QPs. The modification that CMS proposes excludes those beneficiaries who have been prospectively attributed to an APM entity from the total count of attribution eligible beneficiaries in the denominator used to calculate QP status. ASTRO urges CMS to consider further modifications that recognize mid-year implementation for APMs. Currently, a model implemented on July 1 would only have one month (August) included in the QP determination. We urge CMS to establish a March 31 snapshot date for APMs that are implemented mid-year in the previous performance year. This will ensure that**

more Eligible Clinicians meet the QP threshold required for the Advanced APM incentive payment.

Finally, CMS is also proposing to establish a QP determination review process that will allow Eligible Clinicians to bring to the Agency's attention any potential clerical errors or necessary corrections, if warranted. The review process will align with the existing MIPS targeted review process. An Eligible Clinician or APM Entity may request targeted review of a QP or Partial QP determination only if they believe, in good faith, that, due to a CMS clerical error, an Eligible Clinician was omitted from a Participation List used for QP determinations. **ASTRO supports the establishment of a QP determination review process for Eligible Clinicians who believe their QP status determination is inaccurate.**

Partial QP Participant

CMS is anticipating that there will be a greater number of Eligible Clinicians who are determined to be Partial Qualified APM Participants or Partial QPs in the 2021 QP Performance Period in comparison to the 2020 QP Performance Period, due to increases in the QP thresholds. Beginning with the 2021 QP Performance Period, the QP payment amount threshold increases from 50 percent to 75 percent, while the QP patient threshold increases from 35 percent to 50 percent. Partial QPs who do not elect to participate in MIPS as MIPS Eligible Clinicians are excluded from MIPS, and thus, not subject to the MIPS reporting requirements or payment adjustments. CMS is seeking comment on whether it would be less burdensome for Partial QPs if the Agency were to allow an APM Entity to make the Partial QP election on behalf of all of the individual Eligible Clinicians associated with the APM Entity, rather than requiring each Eligible Clinician to make the election individually. Additionally, the Agency seeks feedback on how to address potentially conflicting elections between entities.

ASTRO has long expressed concern that the QP Thresholds set by the Medicare Access and CHIP Reauthorization Act (MACRA) do not adequately recognize the limited number of available Advanced APMs. As anticipated, this results in a greater number of Eligible Clinicians who do not meet the QP thresholds and are thus considered Partial QPs. These Eligible Clinicians deemed as Partial QPs are participating in an APM and therefore putting a nominal amount of their revenue at risk, as prescribed by MACRA. However, due to their Partial QP status, they can either participate in MIPS, which puts them at risk for potential reductions in payment based on comparisons with other Eligible Clinicians who are not putting payment at risk, or not participating in MIPS all together. Either way these Eligible Clinicians are subject to reduced reimbursement due to the nominal risk requirement associated with their APM participation, but unable to recognize the Advanced APM incentive payment due to their Partial QP status. **ASTRO supports CMS' proposal that would allow the APM Entity to make the Partial QP MIPS election on behalf of the Eligible Clinician; however, there should be some mechanism to ensure that the Eligible Clinician has given the APM Entity permission to make that election. Additionally, we urge the Agency to consider other ways that Partial QPs can be rewarded for participating in Advanced APMs.**

Advanced APM Incentive Payment

CMS is clarifying the 5 percent APM Incentive Payment is based on the *paid amount* of applicable claims for covered professional services. The Agency points out that it would not be appropriate to calculate the APM Incentive Payment based on amounts that were allowed, but not actually paid by Medicare. CMS also reasserts its opinion that certain payments, including MIPS payment adjustments, will not be included when calculating the APM Incentive Payment amount.

Distribution of the APM Incentive Payment is made to the TIN affiliated with an APM Entity. If Eligible Clinicians become a QP through participation in multiple Advanced APMs, the Agency will divide the APM Incentive Payment proportionally, based on payments for covered professional services during the performance period. CMS has found that Eligible Clinicians may change TINs, APM Entities, or make other changes that impact their relationship with the Medicare program. Due to the two-year time lapse between the end of the performance period and the issuance of the APM Incentive Payment, these changes make it difficult for CMS to ensure that the APM Incentive Payment is received by the appropriate TIN. The Agency is proposing to modify its approach to identifying the TIN(s) to which it makes APM Incentive Payments. This new approach would allow CMS to review a QP's relationship with their TIN(s) over time, as well as consider the relationship the TIN(s) have with the APM Entity or Entities through which the Eligible Clinician earned QP status, or other APM Entities the QP may have joined in the interim. CMS believes this approach will reduce the burden on the payee TIN(s) who under the current structure must find QPs that are no longer affiliated with them.

Additionally, CMS is proposing a hierarchy for recipient TIN affiliation identification when making the APM Incentive Payment. The Agency believes this will help it make the APM Incentive Payment in a more timely and efficient manner. The first step of the hierarchy requires the identification of any TIN associated with the QP that, during the QP Performance Period, is associated with an APM Entity through which the Eligible Clinician achieved QP status. If CMS is unable to identify one or more TINs with which the QP has a current affiliation, then the Agency will move on to successive steps of the hierarchy until it identifies one or more TINs with which the QP has an affiliation. If more than one TIN is identified, then CMS will divide the APM Incentive Payment proportionally between the TINs based on the relative paid amount for Part B covered professional services. If CMS is unable to identify a TIN associated with a QP, then the Agency will attempt to contact the QP via public notice.

The Agency is proposing a cutoff date of November 1 of each payment year or 60 days from the day on which the Agency made the initial round of APM Incentive Payments, whichever is later, as a point in time after which the Agency will no longer accept new help desk requests from QPs or their representatives who have not received payment. After that time, any claims by a QP to an APM Incentive Payment will be forfeited.

ASTRO appreciates that CMS is seeking ways to ensure that Advanced APM incentive payments are making their way to QPs in an efficient manner. However, the application of a November 1 or 60 day cut off period for QPs to claim their incentive payment or risk forfeit is too short, particularly given the amount of lag time CMS has to determine the

amount and issue it to QPs. ASTRO urges the Agency to extend the payment claim period to at least a year, so that QPs have adequate time to collect the payments they have earned.

COVID-19 Public Health Emergency (PHE) Advanced APM Determination and QP Determinations

CMS anticipates that the COVID-19 PHE will result in changes to existing APMs. The Agency may publish regulations or amend existing APM Participation Agreements to address issues resulting from the COVID-19 PHE. That said, CMS is modifying the existing Advanced APM determination structure in the 2021 MPFS proposed rule. CMS will not reconsider the Advanced APM determinations of APMs which have already been evaluated and determined to meet Advanced APM criteria for 2020. Furthermore, the Agency plans to evaluate all APMs in future years with the understanding that any revisions to the Participation Agreement or governing regulation in response to the COVID-19 PHE will not be considered to the extent that they would prevent the APM from meeting Advanced APM criteria.

The Agency also understands that the COVID-19 PHE may lead to an earlier end date for certain APMs based on amendments to the APM's governing documentation, such as the Participation Agreement. This would not revoke the QP status of Eligible Clinician participants in Advanced APMs.

ASTRO appreciates CMS' recognition of the impact that COVID-19 in the 2021 MPFS proposed rule on existing Advanced Alternative Payment Models. It is unfortunate that the Agency did not extend this same courtesy to the RO Model, which was released as a final rule on September 18. As described in ASTRO's July 22, 2020 letter, the RO Model needs to be modified to account for the impact of COVID-19 on mandatory participation, quality reporting, the trend factor and case mix methodology. When the model was proposed in July 2019, COVID-19 was not considered by the Agency nor the radiation oncology community. Much has changed over the past several months, and while ASTRO strongly supports efforts to continue the transition from fee-for-service payments to value based payment, it cannot be done without considering the ongoing impact of COVID-19 on radiation oncology practices. The fact that CMS introduced the mandatory model in September with a January 1, 2021 start date is very concerning given everything that the radiation oncology community has experienced as a result of the PHE. ASTRO requests a delay in the RO Model start date until July 1, 2021, depending on any extension of the PHE, and a reduction in payment cuts in the model.

Alternative Payment Model Performance Pathway (APP)

CMS is proposing to establish an Alternative Payment Model Performance Pathway (APP) under the MIPS program, effective January 1, 2021. The new, voluntary APP would be available to MIPS eligible clinicians identified on the Participation List or Affiliated Practitioner List of any APM Entity participating in any MIPS APM on any of the snapshot dates (March 21, June 30, August 31 or December 31) during a performance period, as well as participants in the CMS Shared Savings Program ACOs.

Individual MIPS Eligible Clinicians who are participants in MIPS APMs may report through the APP at the individual level. Groups and APM Entities may report through the APP on behalf of their constituent MIPS Eligible Clinicians; however, the final score earned by the group through the APP would be applied only to those MIPS Eligible Clinicians who appear on a MIPS APM's Participation List or Affiliated Practitioner List on one or more snapshot dates. The final score applied to each individual MIPS eligible clinical would be the highest available score for that clinician or a Virtual Group score, if applicable.

The APP allows for the reporting of a single quality measure set with broad applicability. Participants would receive an Improvement Activities Category credit and the Cost Category will be waived. The APP establishes six 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. The table below describes the measures included in the Proposed APM Performance Pathway program:

TABLE 36: Measures included in the Proposed APM Performance Pathway Measure Set

Measure #	Measure Title	Collection Type	Submitter Type	Meaningful Measure Area
Quality ID#: 321	CAHPS for MIPS	CAHPS for MIPS Survey	Third Party Intermediary	Patient's Experience
Quality ID#: 001	Diabetes: Hemoglobin A1c (HbA1c) Poor Control	eCQM/MIPS CQM	APM Entity/Third Party Intermediary	Mgt. of Chronic Conditions
Quality ID#: 134	Preventive Care and Screening: Screening for Depression and Follow-up Plan	eCQM/MIPS CQM	APM Entity/Third Party Intermediary	Treatment of Mental Health
Quality ID#:236	Controlling High Blood Pressure	eCQM/MIPS CQM	APM Entity/Third Party Intermediary	Mgt. of Chronic Conditions
Measure # TBD	Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups	Administrative Claims	N/A	Admissions & Readmissions
Measure # TBD	Risk Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions for ACOs	Administrative Claims	N/A	Admissions & Readmissions

For those MIPS Eligible Clinicians, groups or APM Entities for whom a given quality measure is unavailable due to the size of the available patient population or who are otherwise unable to meet the minimum case threshold for a measure, CMS proposes to remove the measure(s) from the quality performance category score. Furthermore, the Agency is proposing not to apply the quality measure scoring cap in the event that a measure in the APP measure set is determined to be topped out. Because the measure set is fixed, CMS does not believe it is appropriate to limit the maximum quality performance category available to them.

CMS proposes waiving the Cost Performance Category for APP because APM Entities in the MIPS APMs are already subject to cost performance assessment. Additionally, CMS is

proposing to establish a baseline score for each MIPS APM based on the Improvement Activity requirements of the particular MIPS APM. The Agency would review the MIPS APM's requirements in relation to activities specified under the generally applicable MIPS Improvement Activities Performance Category and assign for each MIPS APM an Improvement Activities Performance Category score that is applicable to all MIPS Eligible Clinicians reporting through the APP. Finally, CMS is proposing that the Promoting Interoperability Performance Category score be reported and calculated for APP participants just as it is for regular MIPS participants.

CMS is proposing to reweight the MIPS Performance Categories as follows for APP participants:

- Quality 50%
- Cost 0%
- Promoting Interoperability 30%
- Improvement Activities 20%

Finally, CMS is proposing that scoring for Eligible Clinicians reporting to MIPS through the APP would follow the same methodology as established for MIPS generally. That includes scoring each performance category and multiplying each performance category score by the applicable performance category weight, and then calculating the sum of each weighted performance category score and apply any applicable adjustments.

While ASTRO supports efforts to establish new pathways for participating in Alternative Payment Models, the APP seems as though it is designed more for primary care providers than specialty providers based on the broad range of standardized quality measures. Additionally, it continues to stratify and complicate an already complicated payment program.

MIPS APMs

APM Scoring Standard

The APM Scoring Standard was designed to encourage greater participation in APMs, as well as to reduce reporting burden for participants in MIPS APMs by eliminating the need for MIPS Eligible Clinicians to submit data for both MIPS and their respective APMs. As the program has matured, CMS has recognized that the APM Scoring Standard is infeasible to fully implement due to its complexity and inflexibility in adapting to changes in APM participation and design. The Scoring Standard has become an additional burden for APM Entities and their participant MIPS Eligible Clinicians. The Agency is proposing to eliminate the APM scoring Standard for the 2021 performance year to allow MIPS APM participants to participate in MIPS as individuals, groups, Virtual Groups, or APM entities. This will allow participants to report through any MIPS reporting and scoring pathway, including the newly formed APP.

Due to this proposal, CMS will no longer depend on the availability of quality data reported directly to the APM Entity, as is required under the existing APM Scoring Standard. This discontinues the requirement that MIPS APMs be in operation and collecting quality data for the

duration of the performance period. The Agency does not believe that there is a substantial risk of the MIPS final scores being inappropriately influenced by MIPS Eligible Clinicians moving in to or out of APM Entities late in the performance year. Therefore, MIPS Eligible Clinicians identified on either a Participation List or Affiliated Practitioner list would only need to appear as a MIPS APM participant on any one of the four snap shot dates (March 31, June 30, August 31 or December 31) in order to be considered participants in an APM Entity.

CMS stated in the RO Model final rule that it anticipates up to 18 percent of model participants will be designated as MIPS APMs. ASTRO disagrees with CMS' assumption and believes that providers who are selected to participate in the RO Model will necessarily meet these QP thresholds as a result of two characteristics of the proposed model: first, the proposed model mandates participation by the selected providers. And second, the proposed model is intended by CMS to be, and is, an Advanced APM. Given these two characteristics of the model, most if not all, of the RO participants' Medicare patients will be seen through an Advanced APM entity. Thus, the RO participants will satisfy the requirements to be a QP and therefore should be eligible for the APM incentive payment.

RO Model participants who are deemed MIPS APMs, due to the QP threshold requirements, would be better served by the existing APM Scoring Standard because they are participating in every aspect of the Model. The MACRA designated QP thresholds are unrelated to the model construct and this particular group of MIPS APM participants are not interested in participating in MIPS given their requirement to participate in the RO Model. The Agency states in the proposed rule that the elimination of the APM Scoring Standard allows MIPS APM participants to participate in MIPS as individuals, groups, Virtual Groups, or APM entities. Additionally, it would allow participants to report through any MIPS reporting and scoring pathway, including the newly formed APP. This is not a desirable solution for radiation oncology practices participating in the RO Model. By doing this, CMS is creating a situation in which these practices are further penalized because they cannot meet the QP standards by forcing them to have one foot in MIPS and the other in an Advanced APM. **ASTRO urges the Agency to ensure that all RO Model participants are deemed QP, so that they may recognize the benefits of the Advanced APM incentive payment. This is particularly important given that practices are compelled to participate in the model. Additionally, provisions should be put in place to align the RO Model Advanced APM scoring methodology across all practices regardless of whether they meet the QP threshold or not.**

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 Bryan Hull, Assistant Director of Health Policy, at (703) 839-7376 or Bryan.Hull@astro.org.

Respectfully,

Laura I. Thevenot
Chief Executive Officer