



Sound Policy. Quality Care.

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September 13, 2021

Chiquita Brooks-LaSure, JD  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1751-P  
P.O. Box 8016  
Baltimore, MD 21244-8016

**RE: 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 Alliance of Specialty Medicine (the “Alliance”) represents more than 100,000 specialty physicians across 14 specialty and subspecialty societies. The Alliance is deeply committed to improving access to specialty medical care through the advancement of sound health policy. On behalf of the undersigned members, we write in response to proposals outlined in the CY 2022 Medicare physician fee schedule (MPFS).

#### Conversion Factor

***The Alliance is deeply concerned about another steep cut in Medicare payments to physicians, especially as their costs have increased and their productivity is down, due to the COVID-19 public health emergency (PHE).***

In the rule, CMS estimates the CY 2022 conversion factor (CF) to be \$33.58, a decrease of \$1.31 from the CY 2021 CF of \$34.89. The reduction stems from a mandatory budget neutrality adjustment of -0.14 percent, the statutory 0.00 percent update specified in the Medicare Access and CHIP Reauthorization Act (MACRA), and the expiration of the 3.75 percent increase provided for CY 2021 under the Consolidated Appropriations Act, 2021 (CAA). Medicare physicians also face potential reductions in CY 2022 as a result of the Medicare and “Pay-As-You-Go” sequesters, 2.0 and 4.0 percent, respectively. In addition, we remind CMS that, despite Congressional intervention earlier this year, physicians realized a 3.3 percent reduction in their CY 2021 payments.

We recognize CMS’ lack of authority to address key challenges with the current Medicare physician payment system, namely budget-neutrality, and with respect to the threat of sequestration. Nevertheless, and when faced with staggering payment reductions, Medicare physicians will struggle to continue providing care and treatment to beneficiaries, hindering access to important specialty care. Almost every other Medicare provider will receive a positive payment update in CY 2022, while physicians face an unfair and inappropriate reduction that could force practice closures or consolidation – neither of which are desirable in the broader context of improving access or lowering costs.

***CMS must work with Congress on a long-term solution to the ongoing flaws in the physician payment methodology and ensure physicians receive fair and reasonable updates similar to their Medicare provider counterparts.*** Without a major course correction in the mechanism used to pay Medicare physicians, it will be nearly impossible for physicians – particularly those serving rural and underserved communities – to continue providing care to beneficiaries.

### Clinical Labor Pricing Update

In the rule, CMS proposes to update clinical labor pricing inputs as part of the practice expense relative value unit (PE RVU) calculation. These inputs have not been adjusted for nearly two decades, since 2002; we agree that CMS must use more current data to reflect increases in clinical labor rates.

Unfortunately, however, the result of this policy is steep cuts in key Medicare services – including drug infusions and key urologic procedures – despite the fact that the clinical labor rates associated with delivering these services have gone up. indeed, some Alliance specialties face reductions as high as 22.04 percent for certain PFS services they deliver.

As expressed above, the budget-neutral aspect of the PFS is extremely problematic. And, as evidenced by this proposal, many physicians will be paid less for services that cost them more to deliver. We recognize that CMS is limited when it comes to addressing the broader challenges of the PFS; however, ***we urge CMS to delay, for one-year, the implementation of the updated clinical labor inputs.*** This additional year would give the agency time to work with Congress on a longer-term solution to budget-neutral conundrum that has wreaked havoc on the Medicare physician payment system since its inception. ***In addition, CMS should phase-in the use of these data over a four-year transition, similar to the phase-in used for the other direct practice expense inputs (i.e., supply and equipment prices).*** CMS should also consider other options that would potentially mitigate the negative impact of these changes, as described by the American Medical Association (AMA) Relative Value System Update Committee (RUC).

### Payment for Medicare Telehealth Services and Other Non-Face-to-Face Services Involving Communications Technology

As a result of waivers and additional flexibilities offered during the PHE for COVID-19, specialists and their patients have come to realize the value of delivering and receiving health care virtually. Many of our members are making sizeable investments in virtual platforms and are hopeful that telehealth and other virtual care can remain a core component of their practice mix, including through legislative expansion of policies that would enable Medicare beneficiaries to continue to receive telehealth services regardless of where they are located in the country, including their homes. As we have previously noted, however, ***CMS should make clear that telehealth services must be provided consistent with applicable supervision requirements, state scope of practice and licensure, professional training, and all applicable state and local laws. Additionally, telehealth expansion efforts should emphasize and ensure broad access to specialists.***

Availability of audio-only telehealth services during the PHE has supported such access and enabled patients who cannot or who are not willing to utilize audio-visual telecommunications technology to continue to receive essential specialty medical care throughout the pandemic, as clinically appropriate – regardless of whether such patients have the financial resources, local broadband infrastructure, or technological wherewithal utilize more traditional audiovisual telehealth modalities. The Alliance was pleased to see that CMS recognizes its authority to allow use of audio-only technology for the delivery of Medicare telehealth services, as evidenced by CMS’ proposal to enable audio-only technology in the delivery of mental health services. ***We believe CMS should extend this authority to allow ongoing delivery of audio-only evaluation and management services following the PHE in order to facilitate***

***equitable access to care and enable delivery of care consistent with patient preferences, subject to physicians' professional judgment regarding the clinical appropriateness of audio-only care.***

We recognize that expansions of telehealth will present challenges, including around potential increases in utilization and spending, as well as increased program integrity risks. The Alliance is committed to assisting CMS as it works toward establishing policies that balance the value of ongoing access to medically necessary virtual care with CMS' financial stewardship and program integrity responsibilities.

### Evaluation and Management Services

CMS refers to its work over the last several years to update coding and payment for office and outpatient evaluation and management (E/M) services, and states that its proposals related to split/shared visits, critical care services, and teaching services, are part of that ongoing effort. As part of its critical care services proposal, CMS explains that it is "continuing to assess values for global surgery procedures, including in particular the number and level of preoperative and postoperative visits, which can include critical care services." Again, consistent with the recommendations by the AMA RUC, we encourage CMS to apply the increased E/M values to post-operative visits in the global surgery codes.

### Appropriate Use Criteria for Advanced Diagnostic Imaging

In accordance with the Protecting Access to Medicare Act (PAMA) of 2014, CMS implemented the Appropriate Use Criteria (AUC) for advanced diagnostic imaging program in January 2020, but has not, to date, enforced the penalties for non-compliance due to ongoing operational challenges. Under this program, ordering professionals at outpatient sites must consult appropriate use criteria (AUC) for every advanced diagnostic imaging order using a federally approved clinical decision support mechanism (CDSM) before a radiologist can furnish a scan.

The AUC program's effective date has been delayed numerous times due to its administrative complexity. In 2020, CMS launched an educational and operations testing period for the program during which it continued to pay claims whether or not they correctly included AUC consultation information. In 2020, in response to the COVID-19 PHE, the educational and operations testing period was extended through CY 2021, with the penalty phase set to start on January 1, 2022. In this rule, CMS proposes to begin the AUC payment penalty phase of the program on the later of January 1, 2023, or January 1 of the year after the year in which the PHE for COVID-19 ends.

**The Alliance continues to view the Imaging AUC program as duplicative and unnecessary, and we support legislative and regulatory efforts to further delay implementation of the mandatory AUC consultation and to further evaluate the utility of the program overall.** Our concerns continue to focus on the fact that:

- The AUC Program was enacted seven years ago, prior to MACRA. In that span of time, CMS has adopted numerous programs that address appropriate use of imaging, including the Quality Payment Program (QPP) and numerous alternative payment models (APMs) launched by the Center for Medicare and Medicaid Innovation (CMMI). These other initiatives make the AUC Program unnecessary or in need of re-thinking — particularly as CMS accelerates movement away from fee-for-service and towards bundled payment and other shared risk models;
- There are existing multiple, significant demands being placed on claims forms due to the QPP and other initiatives;
- The law is financially advantageous to CDSM developers at the expense of clinicians who order advanced diagnostic imaging tests;
- Not all applicable AUC will be available for consultation by the ordering professional because CDSM vendors can "pick and choose" among qualified AUC; and

- The program may ultimately be costlier to administer than the potential for savings and lacks a patient outcomes or quality component.

CMS has admitted on multiple occasions that the program is plagued by operational issues and other limitations that it does not have solutions to, including the statutory requirement that CMS collect all necessary information via the claims form. CMS also has been very candid that Congress did not understand the complexity of this law when it handed it over to CMS. These ongoing challenges recently caught the attention of Congress and resulted in language that was included in the House Labor, HHS, Education Appropriations Subcommittee [report](#) adopted in July. This language recognizes that in the more than seven years since Congress created the AUC program, it has not advanced beyond educational and operations testing. The language also requests a report within 180 days of enactment on implementation of the Imaging AUC program, including challenges and successes and a consideration of existing quality improvement programs and relevant APMs that may influence appropriate use of advanced diagnostic imaging.

## Quality Payment Program

### MIPS Value Pathways (MVP)

The Alliance supports CMS' desire to streamline MIPS reporting, to reduce clinician burden, to focus on metrics that are valuable to clinicians and patients, and to provide a glidepath to APM participation. However, we are concerned that the MVP framework is not enough of a departure from traditional MIPS and fails to resolve foundational issues that some Alliance member specialties contend have limited meaningful clinician engagement and hampered meaningful progress towards higher quality care. ***Given these ongoing concerns, which are detailed in the bullets below, the Alliance appreciates the delayed introduction of MVPs on a voluntary basis starting in 2023. We also believe it is premature to consider making MVPs mandatory by 2028, and urge CMS to instead continue working with stakeholders and Congress to fundamentally reform this program***

- **Siloed performance categories.** The current MVP framework lacks a cohesive, streamlined approach to holding physicians accountable for improving quality of care, leveraging technology, and reducing avoidable costs. ***To better streamline the program, CMS must take more concrete steps to break down the silos that currently result in four disjointed MIPS performance categories that each have a distinct set of measures, reporting requirements and scoring rules.*** Clinical actions captured by measures and activities should translate into credit across multiple performance categories to unify the program and minimize administrative burden. For example, CMS could work with stakeholders to identify Improvement Activities (IAs) that are inherently performed as part of a specific MVP and provide automatic credit for those IAs, similar to how MIPS APMs and patient-centered medical homes are now scored under the IA category. In another example, clinicians who engage in more robust activities such as reporting to and receiving feedback from a clinical data registry that interacts with CEHRT should receive credit under the Quality, IA, and Promoting Interoperability categories. Similarly, a clinician should be eligible for credit under both the Quality and PI categories for using an eCQM. The current siloed structure, which remains under the MVP framework, makes the program challenging to navigate, duplicative, and unnecessarily resource intensive. ***The Alliance requests that CMS provide a rationale for why it has not implemented these more cross-cutting strategies to date.***
- **Policies that discourage meaningful participation among specialists.** MIPS participation options, scoring rules, and QCDR policies continue to disincentivize the development and use of more clinically focused measures and participation pathways that align with clinical practice. Some Alliance members have reported that their specialty physician members, particularly

those who are associated with larger practices or institutions, have little control over MIPS participation options and are largely disconnected from the program. They have also noted that some specialists in smaller, independent practices who do have direct control over these decisions are increasingly faced with fewer relevant options due to measure removal policies and scoring caps that discourage the use of more focused measures. As a result, some specialty practices have little choice but to choose a reporting strategy that has the best chance of avoiding a penalty, regardless of its relevancy. This, in turn, results in wasted resources and useless performance data. For example, a recent search on Care Compare for a neurosurgeon associated with a large academic center produced a MIPS performance report that displays data on measures related to pneumococcal vaccines and breast and colorectal cancer screenings. We ask CMS, what value does this report provide for a patient searching for a quality neurosurgeon?

The Alliance appreciates that CMS' proposed subgroup reporting option attempts to address some of these disincentives, but as discussed in more detail below, if CMS simultaneously maintains policies that also disincentivize the development of more granular and patient-centric measures and the use of more relevant data collection mechanisms (i.e., QCDRs), then the subgroup reporting option will fail to have a positive impact on the program and will instead make it even more complex and burdensome.

As discussed in more detail below, there are currently few incentives for specialty societies to invest in more meaningful measures and for clinicians to report those measures, especially as CMS continues to raise the MIPS performance threshold each year. Unfortunately, the MVP framework does nothing to resolve these disincentives. ***As CMS implements the MVP framework and particularly as it considers the adoption of a sub-group reporting mechanism, as discussed below, it is critical that it incentivize the ongoing development and use of a diverse inventory of specialty- and sub-specialty specific measures that are meaningful to both physicians and their patients.***

In short, we are disappointed that CMS seems to be reverting to a one-size-fits-all approach to measurement. We strongly urge the agency to reverse course if it wishes to truly move the needle on quality and produce more meaningful data for patients. When CMS discusses the complexity of MIPS, it is quick to point out that clinicians are overwhelmed by the large inventory of measures. We dispute that assertion—the complexity that most overwhelms specialists has to do with the four separate performance categories, which each have their own reporting and scoring rules, as well as the nuanced requirements and goalposts that shift from year to year. The waning diversity of the MIPS measure inventory and program policies that fail to promote more specialized and impactful measures further contribute to our members feeling so disconnected from the program.

- **Inflexible approaches to Promoting Interoperability (PI).** The MVP framework does nothing to move beyond the one-size-fits-all approach to this category and continues to rely on measures that focus on the functionalities of CEHRT rather than true improvements in patient care. ***The Alliance urges CMS to use the MVP framework as an opportunity to provide clinicians with the flexibility to demonstrate meaningful use of EHRs in more innovative ways that account for differences in practice settings, patient populations, infrastructure, and experience with health information technology.*** To realize the full potential of EHRs, requirements under this category need to be less prescriptive and more diverse. Clinicians should have the opportunity to demonstrate the variety of ways that they are capturing, applying and sharing electronic data to improve patient care, including the implementation of practice improvements based on patient-generated electronic health data; the use of clinical registries that seamlessly incorporate EHR data; the use of clinical decision support tools; and the use of electronic platforms and apps that allow clinicians to better communicate with patients.

- **Ongoing gaps in cost measures.** Many of the proposed MVPs continue to rely on total cost of care measures, such as the Medicare Spending Per Beneficiary (MSPB) measure and the Total Per Capita Cost (TPCC) measure, because more focused episode-based cost measures are not yet available. While we appreciate CMS' interest in promoting team-based care and preparing clinicians for the more population-level measurement that occurs under APMs, the total cost of care measures hold specialists accountable for care that is often beyond their direct control and have ability to impact care coordination in a clinician-focused accountability program. The MSPB measure, in particular, was originally developed for hospital-level accountability, but when used under MIPS, results in very little actionable data for individual clinicians seeking to better manage resource use. ***As CMS continues to develop more focused episode-based cost measures, we strongly recommend that it refrain from using total cost of care measures other than for confidential feedback.***

At the same time, the current inventory of episode-based cost measures lack a direct association with existing quality measures, which limits CMS' ability to accurately evaluate the value of specialty care. This becomes even more evident as CMS attempts to assemble MVPs that are centered around a specific condition or specialty. For example, the Stroke MVP includes some quality measures that focus on surgery, but an episode-based cost measure that focuses on medical management of the stroke patient. As a result, the MVP will produce an incomplete and inaccurate assessment of value related to the individual surgeon or surgical practice, which is only responsible for a specific portion of the patient's stroke care. The end result is data that are not useful for either the surgeon or the patient.

***To address these limitations, we urge CMS to consider alternative ways to fill cost measure gaps,*** such as considering appropriateness of care measures that may have more of a direct association with quality and allowing for the development of cost measures that rely on more comprehensive sources of data in addition to claims, such as clinical registry data.

The Alliance appreciates CMS recognizing the need to fill ongoing gaps in cost measures by proposing to establish a process for the development of cost measures by stakeholders outside of the current development process, beginning in CY 2022. ***In order for this policy to result in meaningful progress, it is absolutely critical that cost measure development is specialty society-led to ensure adequate input from those with clinical and methodological expertise. CMS also must provide more comprehensive Medicare claims data and cost performance data to specialty-societies, as well as funding and technical support to help specialty societies identify and develop clinically appropriate cost measures.*** The current processes for obtaining Medicare claims data, such as through ResDAC, are time-consuming, expensive, and impractical. Additionally, the provision of more specialty-specific and condition-specific cost performance data would help specialty societies better understand and target remaining gaps in cost measures.

- **Inappropriate reliance on population health measures.** Although we appreciate the need for team-based approaches to care, population health measures hold specialists accountable for aspects of care that are outside of their direct control. While there may be a role for population health measures in an APM or in a facility-level quality program, these types of measures simply do not align with clinician-level accountability tied to fee-for-service payments. Population health measures are also outside of the intent of the MACRA legislation and seem to deviate from CMS' goals of incorporating the patient's voice, measuring clinical conditions and outcomes, and generating more actionable real-time feedback. ***If CMS insists on using these types of measures, then the resulting data should only be provided to clinicians as confidential feedback.***

- **Flawed performance assessment methodologies.** Under the MVP framework, CMS also would continue its flawed approach of setting benchmarks that lump all physicians together regardless of specialty, location, practice size, or patient population. This approach does not provide physicians or patients with meaningful or accurate information to distinguish between high quality or poor care.
- **Indeterminate glidepath to APMs.** CMS continually promotes MVPs as a way to prepare clinicians for APM participation. However, the current MVP framework does little to create a practical glidepath for most specialists to seamlessly transition to APMs. For example, under the Bundled Payments for Care Improvement-Advanced (BPCI-A) model, specialists are often required to report data on quality measures used under MIPS, such as the Perioperative Care: Selection of Prophylactic Antibiotics measure and the Advance Care Plan measure; yet the data for these measures must be reported separately under each program.

More importantly, as we've stated in multiple prior comments on the QPP, and in the context of the Medicare Shared Savings Program (MSSP), there are few – if any – APMs available for most specialists to “glide” into. Alliance member organizations have a long history of attempting to work with the Innovation Center and the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to establish specialty-specific APMs that address recognized challenges in the delivery and cost of care for certain conditions and procedures, yet these models have not been approved as Advanced APMs for purposes of QPP. Alliance members have also recommended a host of improvements to the MSSP to allow meaningful participation by a broader range of specialists in Medicare' Accountable Care Organizations (ACOs), to no avail.

***We strongly urge CMS to identify ways that it can better align the reporting requirements of these programs to not only minimize duplication and inefficiencies, but to help better prepare clinicians for greater involvement in these APMs. Similarly, we request that CMS work with stakeholders to identify additional opportunities to more closely align MIPS with other facility-level quality programs since many specialists are already contributing data to those programs and those programs more closely represent the shared accountability and team-based approaches of APMs. Finally, we strongly urge CMS to prioritize the establishment and recognition of specialty-focused APMs, thus providing a true glidepath for the vast majority of specialists to engage in APMs, if they so choose.***

- **Ongoing lack of transparency and consultation of relevant clinical stakeholders.** Finally, we are concerned about the inconsistent and incomplete manner in which CMS has conducted MVP development with stakeholders to date. For example, neurosurgeons were not consulted during the development of the Stroke MVP, despite the significant contributions of this specialty to the treatment of stroke patients in the acute care setting. ***To ensure more complete participation and input from relevant clinical stakeholders, we recommend that CMS establish a formal process to ensure transparency and early involvement of all relevant specialty societies in the development of MVPs.*** For instance, CMS could publish a list of MVPs under consideration on the QPP website along with the MVP developer to contact for coordination. ***It is also critical that CMS adopt a formal criterion to ensure that MVP development is clinician-led, and that it provide clear and timely feedback about why a candidate MVP submission might not have been proposed for implementation.***

### **Subgroup Reporting**

As part of the MVP framework, CMS also proposes a subgroup reporting option that would be voluntary for the 2023 and 2024 performance years. However, starting in 2025, if a multispecialty group would like to report MVPs, they could only do so if they form subgroups. CMS anticipates that at a future time,

when subgroup reporting is mandatory, there will need to be criteria to determine which specialty is a primary specialty of clinicians and potential limits around how clinicians can participate and be assessed as subgroups. One consideration is to limit clinicians in multi-specialty groups to participate through single-specialty subgroups. However, at this time, CMS is not putting limitations on which specialty will be considered the primary specialty for purposes of subgroup reporting.

As noted earlier, the Alliance agrees with the goal of providing clinicians the ability to report measures and activities that are most meaningful to their practice. As noted earlier, current program policies encourage large multispecialty groups and institutions to report on measures that are not relevant or meaningful to all specialists in those groups. At the same time, specialty societies that have invested in the development of better measures, including through QCDRs, have not been able to keep up with the resources required to maintain those measures, have been forced to water down measures to the point of it not being worth the investment, and have faced program disincentives for groups and facilities to invest in those registries. As a result, specialists lack MIPS results that can lead to data-driven improvements in quality, while their patients are denied the granularity of data needed to make informed healthcare decisions. ***While we believe that subgroup reporting has the potential to produce more clinically relevant, actionable and valuable data, it can only do so if paired with policies that simultaneously incentivize the development and use of more meaningful measures and more focused reporting mechanisms. Otherwise, subgroup reporting will only add another layer of complexity and administrative burden to an already unworkable program.***

We are also concerned that there are currently too many unanswered questions about the subgroup reporting option. For example, would subgroup reporting preserve the efficiencies of group-level reporting where the group is only required to report on patients applicable to a specific measure, even if that means that some clinicians in the group will not be captured by the measure denominator? Or, is the expectation that every clinician in the subgroup has to contribute to the measure denominator? ***It is critical that CMS recognize that even a subgroup with relative homogeneity, there will be times when someone does not see the same exact type of patients as his/her colleagues or perform the same exact type of care.*** We also seek clarification from CMS on what would happen in a situation where a 20 clinician TIN forms a subgroup with 18 clinicians. What are the obligations of the 2 other clinicians if CMS were to make subgroup reporting mandatory for multi-specialty practices participating through the MVP pathway? Would those two clinicians be required to form their own subgroup, and if so, would they have to report through an MVP? Or, could they report as individuals, and if so, could they opt to report through traditional MIPS? Discussions with CMS have seemed to indicate that the group practice would still be required to report at the group level (i.e., capturing all relevant clinicians in the group, including those reporting as a subgroup) in order to capture the two clinicians who are not in the subgroup. ***The Alliance would need clarity on these and other issues before it can make a determination about the feasibility of subgroup reporting. However, we strongly advise against duplicative reporting requirements, as described above, which deviate from CMS' goal to streamline MIPS participation.***

***Given these unresolved issues, and concerns about the potential administrative burden that subgroup reporting could create for multi-specialty practices, the Alliance opposes CMS' proposal to mandate that multispecialty groups that report MVPs form subgroups starting in 2025.*** It is premature for CMS to finalize this requirement at a time when full interoperability is not yet a reality and many practices still rely on manual quality data entry; alignment of measures between settings, programs, and APMs is still weak; and CMS policies do not yet support the development and use of more meaningful measures.

***We also advise against requiring subgroups to be single specialty since there may be instances where it is more appropriate to build an MVP around a condition, where team-based care may be appropriate. This policy could also disenfranchise clinician types whose primary specialty designation***

*is related to their clinical degree and not to the specific type of care they provide (such as PAs, NPs, hospitalists, etc.). CMS should provide group practices with the flexibility to decide the most clinically appropriate way to organize its clinicians into subgroups for purposes of MIPS value-based assessments.*

*Finally, we request that CMS consider the feasibility of allowing clinicians to also report via subgroups under traditional MIPS.* CMS is only proposing 7 MVPs for 2023, which means that it could be awhile until the majority of clinicians—particularly specialists— have the opportunity to participate through the MVP pathway.

## Traditional MIPS

### **MIPS Performance Threshold**

Under statute, CMS must compute a performance threshold with respect to which the final scores of MIPS eligible clinicians are compared for purposes of determining the MIPS payment adjustment factors for a year. Starting with the 2022 performance year/2024 payment year, the performance threshold for a year must be either the mean or median (as selected by CMS and which may be reassessed every 3 years) of the final scores for all MIPS eligible clinicians for a prior period specified by CMS. In this rule, CMS proposes to use the 2019 MIPS payment year as the prior period and the rounded mean final score of 75 points as the year six performance threshold, which is consistent with CMS' annual performance threshold increases if 15 points for year two to five of the program. ***The Alliance appreciates CMS' attempt to propose a performance threshold that represents the lowest possible value it could select based on historical performance. However, we strongly urge CMS to consider ways that it can take advantage of authority under the Extreme and Uncontrollable Circumstances Hardship exception policy or the COVID-19 Public Health Emergency (PHE) and instead maintain a performance threshold of 60 points to account for ongoing strains to the healthcare system.*** In the rule, CMS estimates that that the proportion of clinicians receiving a positive or neutral payment adjustment would decrease from 91.7% to 67.5% if the performance threshold were increased to this level. Subjecting so many MIPS eligible clinicians to potential cuts in 2024 would be insensitive to the impact that the PHE has had on medical practice and the other substantial Medicare cuts that physicians face in the coming years. ***If CMS finalizes a higher MIPS performance threshold against our recommendation, then we request that it at least ensure that other MIPS scoring policies (e.g., high priority measure bonus points and scoring floors for measures with no benchmarks), which it clearly has the authority to tweak, account for the challenges that will result from an increased performance threshold, particularly during a PHE.*** These policies are discussed in more detail below.

### **MIPS Performance Category Weights**

In accordance with statute, CMS also proposes to decrease the weight of the Quality category to 30% and increase the weight of the Cost category to 30% for 2022. Similar to the MIPS performance threshold, ***we strongly urge CMS to consider ways that it can take advantage of authority under the Extreme and Uncontrollable Circumstances Hardship exception policy or the COVID-19 Public Health Emergency (PHE) to maintain the weights of these categories for 2022. Given ongoing concerns with the Cost category measures and the impact that COVID-19-related disruptions have had on cost data over the past few years, we recommend that CMS assign a weight of 15% to the Cost category, consistent with how it was weighted prior to the PHE in 2019, but at a minimum, we would like it maintained at 20%.***

### **Quality Category Policies**

#### *Scoring*

In regards to scoring policies, CMS proposes to further disincentivize specialty-specific measures by proposing to assign measures that lack a benchmark 0 points, rather than 3 points, which will result in

even fewer clinicians selecting historically unused measures and the near term removal of these measures from the program. While we appreciate CMS proposing a 5-point floor for “new” measures during their first 2 years in the program, beginning with the CY 2022 performance period, this proposal is too little, too late now that the performance threshold is so high. It also does nothing to address the numerous measures that have been in the program for many years now, but continue to lack a benchmark and are at risk for removal. There is simply no incentive to report on these measures since they would put clinicians at a major scoring disadvantage, especially as CMS continues to raise the MIPS performance threshold each year. ***Instead of allocating 0 points for measures with no benchmarks, CMS should provide credit to clinicians who take the time to report on more focused measures and contribute to the building of performance benchmarks. We also encourage CMS to consider either raising the floor for reporting on new measures (e.g. to a minimum of 7 points) or to simply suppress such measure to account for what is now a considerably high performance threshold.*** As expressed earlier, addressing these and other policies to encourage the ongoing development and use of a diverse inventory of specialty-specific measures is especially critical in the context of implementation of MVPs and subgroup reporting.

CMS also proposes to also end its policy of offering bonus points for reporting additional outcome and high priority measures and for end-to-end electronic reporting of quality measures, beginning with the 2022 performance period/2024 MIPS payment year. ***The Alliance also strongly opposes this proposal and encourages CMS to maintain these bonus points to help ensure that clinicians who make a concerted effort to comply with the program have a chance of crossing what is now a high MIPS performance threshold.***

***In light of COVID-19, we reiterate our request from last year that CMS suspend topped out measure scoring caps for 2022. In general, the Alliance continues to oppose policies that result in capped scoring or the elimination of topped out measures.*** Current determinations of topped out performance may not be accurate due to shifting program requirements from year to year and COVID-19-related disruptions in care. They also might only reflect the performance of a portion of clinicians who self-select the measure because of expected high performance, rather than true performance across all eligible clinicians.

***Additionally, high performance on one reporting option should not automatically trigger its removal. CMS should instead consider performance across reporting options before proposing to remove a measure to ensure its reflective of all clinical care.*** We remind CMS that high performance rates do not necessarily mean that a measure is no longer meaningful to patients and clinicians and should stopped being tracked. In fact, removal of such measures could lead to serious unintended consequences if declining performance becomes difficult to track over time.

***In general, we request greater transparency from CMS when it comes to measure removal decisions.*** To date, measure removal decisions have not been applied consistently across measures and CMS seems to favor preserving its own measures while removing other measures that meet the same criteria. CMS also should consider the impact the measure removal could have on specific specialties in terms of measure gaps. ***Since specialty society measure development has slowed down considerably due to strained resources as a result of the PHE, we request that CMS temporarily refrain from removing measures at this time to ensure all specialties have a sufficient number of measures to report to avoid a penalty.***

#### *Data Completeness*

In this rule, CMS also proposes to maintain the data completeness criteria threshold of at least 70% for the 2022 MIPS performance period, but to increase it to at least 80% for the 2023 MIPS performance period. ***Until reporting is more seamlessly integrated across providers and settings, the Alliance***

**opposes CMS' proposal to increase the threshold.** Specialists sometimes do not have direct control over EHR systems and revisions to accommodate new measure requirements may take time to design and implement. Additionally, sub-regulatory guidance is usually not available until late in the performance year, which could result in a change in reporting strategy that makes it challenging to satisfy data completeness requirements. Furthermore, no other CMS quality programs at the hospital or health plan level rely on sample sizes as high as MIPS. **Similar to benchmarking, we request that CMS consider setting different data completeness thresholds for different types of measures.** For example, clinicians may find it challenging to even satisfy a 50% data completeness threshold for patient-reported outcome measures. Setting a lower threshold for these types of measures would incentivize the development and use of such measures.

#### *Quality Measure Performance Benchmarks*

For purposes of setting 2022 quality measure performance benchmarks, CMS had intended to rely on 2020 historic performance, but due to COVID disruptions is proposing to relying on 2022 performance period benchmarks. CMS also seeks comment on using a different historic baseline other than the 2020 performance year, such as calendar year 2019. **The Alliance supports the use of 2022 performance year benchmarks since they rely on the most current data available. However, we would also support CMS providing clinicians with historic benchmarks based on 2019 performance data and using the score that is most favorable for each measure.** This hybrid policy would promote the use of timely data while also providing clinicians with a performance target going into the performance year.

#### **Cost Category**

As discussed in the MVP section of our comments, we continue to have general concerns about the current inventory of cost measures. **The Alliance opposes the ongoing use of the total cost of care measures for clinician-level accountability since they hold specialists accountable for care that is often beyond their direct control and provide very little actionable data for individual clinicians seeking to better manage resource use. As CMS continues to develop more focused episode-based cost measures, and potentially other types of cost measures, we strongly recommend that it refrain from using total cost of care measures other than for confidential feedback.**

We appreciate the work that has been done to date to develop episode-based cost measures, but we have concerns about the failure of many of these measures to align directly with what is being measured on the quality side and the limitations of cost measures that are based solely on claims data. **As stated earlier, we urge CMS to consider alternative ways to fill cost measure gaps, such as considering appropriateness of care measures that may have more of a direct association with quality. We also urge CMS to support the development of cost measures that rely on alternative sources of data, such as clinical registry data, while also providing more comprehensive access to claims data and specialty-specific cost performance data.**

**Finally, we request that CMS exclude Part B and Part D prescription drug costs from MIPS cost measures.** In general, the inclusion of medications often penalizes physicians for costs over which they have no control.

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We appreciate the opportunity to comment on these important issues and welcomes opportunity to meet with you to discuss them in more detail. Should you have any questions or wish to schedule a meeting, please contact us at [info@specialtydocs.org](mailto:info@specialtydocs.org).

Sincerely,

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