



Physicians Caring for Texans

Oct. 5, 2020

The Honorable Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1734-P  
PO Box 8016  
Baltimore, MD 21244-8016

*Re: Medicare Program; CY 2021 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies of Proposed Rulemaking (CMS-1734-P, RIN 0938-AU10)*

Submitted via Federal eRulemaking Portal at [www.regulations.gov](http://www.regulations.gov)

Dear Administrator Verma:

On behalf of our more than 53,000 Texas physicians and medical student members, the Texas Medical Association (TMA) appreciates the opportunity to provide feedback in response to the 2021 proposed Medicare Physician Fee Schedule as published in the Aug. 17, 2020, *Federal Register*.

TMA is the largest state medical society in the nation and is committed to improving the health of all Texans. In partnership with 110 county medical societies, TMA physicians have been setting high professional and ethical standards since 1853. It is the mission of TMA to stand up for Texas physicians by providing distinctive solutions to the challenges they encounter in the care of patients.

In summary, TMA:

- Supports the Centers for Medicare & Medicaid Services' (CMS') changes in the Physician Fee Schedule to recognize the unduly low payments for physician office visits. However, CMS also must work with Congress to stop penalizing doctors with the current budget-neutral methodology.
- Remains concerned about the constantly changing and moving target under the Quality Payment Program, which is harmful for physician practices.
- Appreciates the work CMS did within the public health emergency to expand telehealth services for Medicare beneficiaries, especially through payment parity and originating-site restriction waivers. TMA strongly advocates for the agency to maintain payment parity for telemedicine visits and to work with Congress to change how telehealth services are regulated for seniors and Medicare-eligible individuals with disabilities.

- Urges CMS to not expand the scope of practice for nonphysician health care professionals beyond their licensure, education, and training.
- Emphatically asks CMS not to impose penalties on physicians for noncompliance with electronic prescription of controlled substances.
- Implores CMS to insist health information exchange and electronic health record vendors assume all the connections needed for seamless bidirectional exchange. Such information exchanges should happen effortlessly for physicians.

The COVID-19 public health emergency has financially devastated physician practices and health systems. A [TMA Practice Viability Survey](#) conducted in May 2020 asked physicians how the pandemic has affected their practice revenue. Sixty-three percent of the respondents reported their revenue had decreased by 51% to 100%.

TMA recognizes and appreciates the 1135 waivers the secretary of the U.S. Department of Health and Humans Services issued that provided the much-needed flexibilities that benefited physicians and their patients. The road to recovery from the public health emergency will be long, and TMA asks CMS to consider TMA's comments through the lens of practices struggling to stay afloat during what continues to be times of uncertainty.

TMA stands ready to provide you and others within the agency our policy expertise and any additional assistance you may find useful. Feel free to contact me by email at [president@texmed.org](mailto:president@texmed.org).

Wishing you and your team good health.

Sincerely,



Diana L. Fite, MD  
President  
Texas Medical Association

Attachment

## **COMMENTS OF THE TEXAS MEDICAL ASSOCIATION**

*Re: Medicare Program; CY 2021 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies of Proposed Rulemaking (CMS-1734-P, RIN 0938-AU10)*

### **II.D Telehealth and Other Services Involving Communications Technology**

#### *Summary*

The Centers for Medicare & Medicaid Services (CMS) proposes to permanently designate communication technology-based service (CTBS) codes G2061-G2063 (Qualified nonphysician health care professional online assessment and management, for an established patient) as billable by nonphysician practitioners (NPPs) – licensed clinical social workers, clinical psychologists, physical therapists (PTs), occupational therapists (OTs), and speech language pathologists (SLPs) – consistent with their scope of practice.

Additionally, CMS proposes to create two new Healthcare Common Procedural Coding System (HCPCS) codes to be billed by NPPs, consistent with their scope of practice:

- G20X0 – Remote assessment of recorded video and/or images submitted by an established patient, and
- G20X2 – Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient.

CMS proposes to designate HCPCS codes G20X0, G20X2, G2061, G2062, and G2063 as “sometimes therapy” services. When billed by private-practice PTs, OTs, or SLPs, the codes would need to include the corresponding GO, GP, or GN therapy modifier to indicate the service was furnished as therapy under an OT, PT, or SLP plan of care.

CMS proposes to clarify that when a CTBS originates from a related evaluation and management (E&M) service within seven days by the same physician, the CTBS is bundled into the E&M service and not separately billable.

CMS is clarifying that consent for all CTBS can be documented by the billing practitioner and auxiliary staff under general supervision.

CMS proposes to add seven service types to the Medicare telehealth services list on a Category 1 basis – services similar to professional consultations, office visits, and office psychiatry services. Codes to be added:

- GPC1X – Visit complexity associated with certain office/outpatient E&Ms
- 99XXX – Prolonged services
- 90583 – Group psychotherapy
- 96121 – Neurobehavioral status exam
- 99483 – Care planning for patients with cognitive impairment
- 99334/99335 – Domiciliary, rest home, or custodial care services
- 99347/99348 – Home visits

CMS proposes to create a new category of criteria – Category 3 – for adding services to the Medicare telehealth list on a temporary basis through the end of the calendar year in which the PHE ends. Codes to be added:

- 99336/99337 – Domiciliary, rest home, or care services, established patients
- 99350 – Home visits, established patients
- 99281/99282/99283 – Emergency department visits
- 99315/99316 – Nursing facilities discharge day management
- 96130/96131/96132/96133 – Psychological and neuropsychological testing

#### *TMA Response*

Since the COVID-19 PHE, TMA has seen rapid adoption of telehealth. During a TMA tele-town hall hosted in April 2020, 74% of physicians participating in the call indicated they had started using telemedicine since March 1.

**TMA appreciates the work CMS did within the public health emergency to expand telehealth services for Medicare beneficiaries, especially through payment parity and originating-site-restriction waivers.** This work helped ensure patients had access to the care they needed in a timely fashion while helping to mitigate concerns of increased spread of a virus through in-person visits. CMS also did well to recognize that physicians apply the same amount of decisionmaking and often used more resources to provide telemedicine services to Medicare beneficiaries both through audio-visual technology and audio-only technology. Because of the success of these temporary changes, the agency has considered expanding the services in the Category 1 list and create a Category 3 list of telehealth services.

CMS has proposed to add nine codes to the Category 1 list of telehealth services. These services are similar to services already on the Category 1 list and therefore the reason they are proposed additions. **TMA agrees with this logic and supports CMS’ proposal to add these nine codes to the Category 1 list.**

CMS has proposed to create a Category 3 list of telehealth services. This list would be for services added to the telehealth list during the PHE, and CMS would allow them to continue through the end of the year in which the PHE ends. This is helpful to physicians who provide these services to patients. It allows them to plan their transition and ensure any gaps of care are minimized. If CMS finalizes its proposal and does not allow the continuation of Category 3 services, at the very least the psychological and neuropsychological testing, as well as physical and occupational therapy (added for the PHE) should remain active. In certain cases, these are part of a covered service (e.g., the psychological therapy services), and in others there is a significant benefit to patients with access issues due to ambulation and transportation challenges.

TMA agrees with CMS’ assessment to remove outdated technology and use the more up-to-date definition of “multimedia communications equipment that includes at a minimum, audio and video equipment permitting two-way, real-time interactive communication.”

CMS did well to recognize the struggles seniors and Medicare-eligible individuals with disabilities have in using the required audio-visual technology for telemedicine visits. Many do not own the technology, and others do not have any knowledge of or experience in using or learning how to use their technology for telemedicine visits. Significant portions of Texas are classified as rural.

Medicare patients in these areas do not have broadband internet access, which prevents them from using the required audio-visual technology for telemedicine visits. The agency's decision to allow audio-only calls to be on the telehealth service list greatly increased access to medical care for these seniors. Once the PHE has expired, nothing will change for these patients. If these services are not continued, Medicare patients' access to care will abate, and the health of this population will continue to degrade.

The services provided through the audio-only telephone E&M services (99441-99443) have been critical to seniors' access to care during the PHE in more than one way. Patients who cannot access the required audio-visual technology were able to access care via an audio-only visit. Additionally, physician practices that focused on serving Medicare patients and rural patients were able to stay in business when they were unable to see patients in person. If these businesses had closed, access to care for these patient populations would have been permanently lost. Even though many physician offices have reopened, Medicare patients' transportation struggles have not changed. Removing the audio-only visits at the end of the PHE will remove access to their physicians and the complex care they need. While some physician visits should remain in-person visits, this is not the case for all of them. TMA urges CMS to continue making the audio-only telephone E&M services covered services after the PHE expires. The audio-only duration should mirror those of the audio-visual visits.

However, CMS must not stop there. **TMA strongly urges CMS to work with Congress to change how telehealth services are regulated for seniors and Medicare-eligible individuals with disabilities.** Outside of the current PHE for COVID-19, Medicare patients must travel to an "originating site" to receive care from a "distant site." With the exception of some substance use disorder treatment, the patient's home cannot act as the originating site. This is a problem for patients who have complex chronic conditions that need frequent monitoring and follow-up with physicians. These same patients often struggle with transportation or live in rural areas where access to care is already limited. TMA resolutely urges CMS to engage Congress in expanding telemedicine care to Medicare patients. It would be an absolute tragedy to offer these medical services to patients during the PHE and then remove them at the end of the emergency period. While CMS cannot remove the originating site requirement on its own, the agency can work with Congress to do so. CMS must strongly urge Congress to remove this medical care barrier that is imposed on one of America's most vulnerable populations.

CMS also increased payment for telemedicine visits to ensure payment parity with in-person office visits. TMA appreciates this positive response to advocacy for the duration of the PHE. To ensure access to care remained as robust as possible, physicians rapidly deployed telemedicine solutions. Their staff assisted seniors navigating these solutions to ensure they received the appropriate level of care. While telemedicine visits can help reduce patient exposure to a highly infectious virus and is more convenient, it doesn't mean the cost to deliver care has decreased. Therefore, payment must not decrease, either.

Concern has been expressed that making telehealth payment parity permanent will add to the cost of the care. The evidence coming out of research conducted during the pandemic simply does not support this. Telehealth has improved access to care; many patients defer care that could be handled more easily via telehealth thus preventing expensive emergency department visits or inpatient hospital stays. Physicians have reported that telemedicine visits many times last longer than in-person visits. And the standard of care is maintained throughout the visit. Physicians are acutely

aware of what types of visits can be handled digitally versus in person and should be able to make those decisions in the best interest of their patients.

CMS made changes to how physicians may provide direct supervision to nonphysician practitioners via interactive, audio-visual, real-time communications technology during the PHE. This change was instrumental in ensuring patients had access to care. NPPs were able to provide services while being appropriately supervised to ensure care quality. TMA supports the proposal to extend this form of direct supervision through the end of the year in which the PHE expires. When used appropriately, virtual supervision greatly increases patient access to care without negatively impacting patient safety.

**TMA strongly advocates for the agency to maintain payment parity for all telemedicine visits regardless of AAPM participation.**

A recommendation came out of MedPAC's September meeting that the Medicare telehealth waivers should continue as permanent but only for physicians participating in advanced alternative payment model (AAPM). **TMA strongly advises CMS NOT to accept this recommendation but rather seek to make the waivers permanent for the benefit of all Medicare beneficiaries.** This most vulnerable population has now experienced the convenience of receiving the same standard of care for nonacute care via telemedicine from the comfort of their own home. There is no reason not to allow this to continue for the convenience and safety of Medicare beneficiaries, no matter what the payment model of their physician. Cutting off telemedicine care to these patients because the physician doesn't participate in an AAPM is inexplicable to patients who can no longer get the care they have been receiving and would seriously damage patient-physician relationships by driving patients to physicians they do not know and who are unfamiliar with their needs. We appreciate the desire to move to AAPMs but not at the expense of patient care.

## II.E Care Management Services and Remote Physiologic Monitoring Services

### *Summary*

CMS proposes to allow auxiliary personnel to furnish services described by remote patient monitoring (RPM) Current Procedural Terminology (CPT) codes 99453 and 99454 under the general supervision of the billing physician or practitioner.

After the PHE, CMS will revert to requiring that these services be furnished to established patients and that 16 days of data be collected within 30 days to meet the requirements for CPT codes 99453 and 99454.

CMS also clarifies that RPM CPT codes 99453, 99454, 99091, 99457, and 99458 can be billed only by physicians or NPPs who are eligible to bill for Medicare E&M services and that these services can be furnished to patients with acute conditions in addition to patients with chronic conditions.

- 99453 – Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate)
- 99454 – Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days
- 99091 – Collection and interpretation of physiologic data digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified

by education, training, licensure/regulation requiring a minimum of 30 minutes of time, each 30 days

- 99457 – Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes
- 99458 – Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes

CMS proposes to permanently allow consent to be obtained at the time the RPM service is furnished.

#### *TMA Response*

TMA supports extending RPM services that can continue to support the provision of high-quality care by physicians. However, it is important to have guardrails to ensure these services continue to be provided by appropriately trained clinicians with clinical expertise and are not outsourced to third-party vendors with no clinical background. **We urge CMS to not expand the scope for nonphysician health care professionals beyond their licensure, education, and training.**

### II.F Refinements to Values for Certain Services to Reflect Revisions to Payment for Office/Outpatient Evaluation and Management (E/M) Visits and Promote Payment Stability during the COVID-19 Pandemic

#### *Summary*

CMS proposes to permanently eliminate the limitation that “telephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications system,” allowing the use of smart phones and other devices in furnishing telehealth services. CMS states it will no longer recognize audio-only visit codes as covered services after the end of the PHE. CMS is unable to waive the requirement that telehealth services be furnished using interactive telecommunications systems that include two-way, audio-visual communication technology.

CMS seeks input on whether to develop coding/payment for a service similar to virtual check-in but for a longer unit of time, and the appropriate interval for such services. It also seeks input on whether separate payment for telephone-only services should be a provisional policy that remains in effect for a duration of time after the end of the PHE or whether it should be a permanent policy beyond the PHE.

CMS proposes to extend the policy that direct supervision can be satisfied by the virtual presence of the supervising physician/practitioner using interactive, audio-video, real-time communications technology to the later end of the calendar year in which the PHE ends or Dec. 31, 2021. CMS is clarifying that services that may be billed incident-to may be furnished via telehealth incident to a physician’s service and under direct supervision.

CMS is clarifying that if audio-visual technology is used to furnish a service when the beneficiary and practitioner are in the same setting, the service should be billed as if it was furnished in person.

#### *TMA Response*

We ask CMS to consider TMA’s comments through the lens of practices struggling to stay afloat during what continues to be times of uncertainty.

We appreciate that CMS is continuing with the policy revision finalized in the calendar year 2020 physician fee schedule rule. Last year, the agency followed TMA's urging to work with the American Medical Association/Specialty Society RVS Update Committee (RUC) to make much-needed changes without harming physician practices. This include retaining the five payment levels associated with the five levels of visit complexity. As a way to relieve some of the administrative burden CMS (as well as other payers) established for billing purposes, the agency has reduced its billing documentation requirements and increased flexibility. It is good to give physicians the option of using total time (time spent face to face with patients as well as time spent working on the case) or medical decisionmaking.

Additionally, TMA appreciates that CMS finalized the GPC1X HCPCS add-on code for physicians to use when they treat patients with a single serious or complex chronic condition, along with CPT add-on code 99XXX for prolonged visits when time is used to support billing documentation. This helps ensure physicians are not penalized when they spend additional time caring for patients.

**TMA supports CMS' changes to recognize the unduly low payments for office visits. However, CMS also must work with Congress to stop penalizing doctors with the current budget-neutral methodology.** The system is designed where when one specialty is paid appropriately for medical services rendered, others must be penalized. For office visits to be paid appropriately, payment for other services was decreased. Even more importantly, the conversion factor was decreased by almost 11%. This action causes great harm to physicians and to access to care for Medicare patients. CMS has consistently instituted systems that add significant cost and administrative burden to physicians. To ensure access to care for seniors, one of our more vulnerable populations, physician payments must increase and not decrease.

## II.G Scopes of Practice and Related Issues

### *Summary*

CMS proposes policies in response to President Trump's Executive Order 13890, Protecting and Improving Medicare for Our Nation's Seniors. The agency proposes flexibilities to increase capacity and improve access to care for seniors. Specifically, CMS proposes to amend the regulations on a permanent basis to specify that:

- Supervision of diagnostic psychological and neuropsychological testing services can be done by nurse practitioners, certified nurse specialists, physician assistants (PAs), or certified nurse-midwives to the extent they are authorized to perform the tests under applicable state law and scope of practice.
- Diagnostic tests performed by PAs in accordance with their scope of practice and state law do not require the specified level of supervision assigned to individual tests.
- The requirement for a general level of physician supervision for diagnostic tests performed by a PA is removed.
- Pharmacists may provide services incident to the services of the billing physician or nonphysician practitioner if payment for the services is not made under the Medicare Part D benefit. This includes providing the services incident to the services of the billing physician or NPP and in accordance with the pharmacist's state scope of practice and applicable state law. Pharmacists fall within the regulatory definition of auxiliary personnel.
- Therapists can delegate performance of maintenance therapy services to an occupational therapist assistant or physical therapy assistant for outpatient occupational and physical therapy

services in Part B settings beginning Jan. 1, 2021. CMS clarifies that the broad policy principle that allows billing clinicians to review and verify documentation added to the medical record for their services by other members of the medical team also applies to therapists.

*TMA Response*

Unfortunately, this path is a slippery slope toward harm and is based on flawed logic. CMS states unnecessary increased utilization would be offset by lower payment rates. This stance is counter to a desire to ensure quality and value in medicine for patients.

Earlier in the proposed rule, CMS stated it was concerned with virtual supervision because it could be insufficient, i.e., not only could the supervised provider miss a diagnosis or symptoms needing immediate intervention but also the physician may miss this if the physician was not physically present to supervise or did not see the patient in person. The proposed scope-of-practice changes contradict these concerns.

Access to care is a legitimate concern. CMS and nonphysician practitioners are not the only ones concerned about this problem. Physicians are deeply concerned about this. Texas has a considerable geographic area that is deemed rural and has underserved populations. Physicians serve and care for patients in these areas. They truly understand the need to increase access to care. However, they also recognize the best care is delivered in a team model. Just like a CEO is the leader of a company, the administrator is the leader of CMS, and the secretary is the leader of Department of Health and Human Services, physicians are the leaders of medical teams. Medical teams provide the best care quality and value to patients. Nonphysician practitioners are able to work within their scope under the leadership of a physician. Such teams improve access to care while maintaining care quality.

**TMA strongly urges CMS not to expand payment for independent nonphysicians and pressure inappropriate scope-of-practice expansion through these proposed rules. TMA encourages all advanced nurse practitioners and physician assistants to work within their respective licensed scope of practice, limited further by their education, training, and experience, under appropriate physician delegation and supervision, in a team approach.** This is how access can be expanded. Nonphysician practitioners are essential members of a dynamic team. CMS has already recognized that these teams must be led by physicians to ensure quality of care.

G.1b. Supervision of Residents in Teaching Settings Through Audio/Video Real-Time Communications Technology

*Summary*

At the end of March, CMS issued an interim final rule (IFC) that allowed teaching physicians to supervise residents via audio-video, real-time communications technology. In the time since the interim rule's release, teaching physicians found using such technology for observation and teaching to be effective. Academic medical centers (AMC) and graduate medical education programs both have guardrails, requirements, and protections. They ensure standard of care is met for patients and medical education standards are met for students. These standards are met no matter if the patient is a Medicare patient or not.

*TMA Response*

TMA understands CMS' concern with allowing this method of teaching to continue. However, over the past six months, teaching physicians and residents have found this tool not only to be efficient

but also, most importantly, effective. Physicians, AMCs, and their staff all are concerned about patient safety. To that end, their mission is to provide patients and teach residents quality patient care.

It is important for physicians, residents, and AMCs to take advantage of the technology advances. This change helps reduce barriers to medical education. CMS has repeatedly declared reducing administrative burdens and barriers is a top priority. Here is an opportunity to follow through on such declarations.

**TMA urges the agency to make permanent the temporary rule allowing teaching physicians to supervise residents through audio-video, real-time communications technology.**

In the March 31 IFC, CMS permitted residents to separately bill for inpatient services unrelated to their approved GME program. Currently multiple requirements must be met before a resident can moonlight. A resident must complete at least one year of residency, meet all licensure requirements, and meet the AMC's requirements before moonlighting. Additionally, the AMC may restrict the amount of moonlighting as well as the type of services provided based on the resident's skills. This has not changed with the IFC. These requirements must be met no matter how residents bill.

Moonlighting allows resident physicians to gain more experience and pay down some of their massive student debt, helps AMCs with staffing challenges, and improves patient access to care. Currently there is overlap in accountability for care quality and standards. Not only are AMCs responsible for care quality of the medical education program but also the individual resident is held responsible for care delivered. Access to care is expanded and also the level of quality is maintained because the care is delivered by a physician. CMS made a good choice in allowing residents to bill separately for moonlighting inpatient care they provide. Moonlighting is one of those proverbial win-win-win scenarios.

**Therefore, TMA recommends CMS make permanent allowing residents moonlighting in the inpatient setting to bill separately.**

III.F Medicaid Promoting Interoperability Program Requirements for Eligible Professionals (EPs)

*Summary*

CMS proposes to again require that Medicaid EPs report on any six electronic clinical quality measures (eCQMs) relevant to their scope of practice. In addition, as in 2020, Medicaid EPs are required to report on at least one outcome measure or other relevant high-priority measure. CMS notes that Medicaid EPs must report by Oct. 31, 2021, as statutorily, Medicaid must make all Medicaid Promoting Interoperability Program payments on or before Dec. 31, 2021.

*TMA Response*

TMA appreciates that CMS is not proposing changes to the Medicaid Promoting Interoperability Program for 2021, the last year of the program. TMA notes the reporting end date of Oct. 31, 2021, so that states can issue all Medicaid Promoting Interoperability Program payments on or before Dec. 31, 2021. **TMA encourages CMS and states to remind program participants of this deadline when it approaches so physicians and other practitioners do not inadvertently miss the reporting deadline.**

III.G Medicare Shared Savings Program

*Summary of APM Performance Pathway for Shared Savings Program ACOs*

Effective performance year 2021, CMS proposes to replace the current alternative payment model (APM) quality performance standard with the proposed APM performance pathway (APP) under the Quality Payment Program (QPP). Consequently, all Medicare Shared Savings Program (MSSP) accountable care organizations (ACOs) would report one set of quality metrics to satisfy reporting requirements under the Merit-Based Incentive Payment System (MIPS) and the MSSP. Required measures for ACOs will be reduced from 23 to six. Three measures reported by the ACO would be (1) A1c Poor Control (>9%), (2) Screening for Depression and Follow-Up Plan, and (3) Controlling High Blood Pressure. ACOs would continue to work with an approved vendor to field a Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, but all 10 questions would be scored as a single measure. Two additional measures would be extracted via administrative claims data: (1) 30-Day All-Cause Unplanned Readmission Rate and (2) All-Cause Unplanned Admissions for Patients With Multiple Chronic Conditions. Under MIPS, ACO participants would continue to receive full credit for the performance improvement category as a result of their ACO activities and would not be assessed for cost and utilization performance. The proposed APP framework would therefore be 50% for quality performance, 30% for promoting interoperability, 20% for improvement activities, and 0% for cost. If an ACO fails to report on any of the three APP measures or field a CAHPS survey, the ACO would not meet the standard to earn shared savings and/or would owe maximum losses if applicable. On the MIPS side, if the ACO fails to report APP measures on behalf of its ACO participants, physicians could report outside the ACO and still receive a MIPS quality performance score calculated at the ACO participant level. If the ACO participant elects to report outside the ACO, regular MIPS scoring rules would apply, and he or she would not be afforded the benefits offered to MSSP participants.

Effective Jan. 1, 2021, CMS proposes to remove the CMS Web Interface currently used by ACOs as a reporting option. Instead, ACOs would report quality measures via a submission type that aligns with MIPS: direct, log-in and upload, or third-party intermediary. Quality benchmarks reflect the method of data submission.

CMS proposes to increase the quality performance standard for all ACOs from the 30th to the 40th percentile across all MIPS performance category scores.

*TMA Response on APM Performance Pathway for Shared Savings Program ACOs*

TMA agrees that the measure set chosen within the APP is adequate to address the high-priority and high-prevalence chronic conditions among Medicare beneficiaries. Moreover, it significantly reduces the data collection, audit, and reporting burdens currently placed on ACOs in the MSSP.

TMA believes 2021 implementation does not afford MSSP ACOs enough time to investigate and implement new quality-reporting options. Note that this includes education and communication with ACO participants (and their administrative staffs).

While TMA acknowledges that CMS must continue to raise the bar in terms of quality performance, increasing the performance standard for ACOs in their first reporting period places an undue burden on ACO participants as they adjust to the rigors of value-based care. In addition to meeting quality standards, ACO participants are learning to impact overutilization and assist beneficiaries and their families in making smart decisions about cost-effective care decisions. We recommend that CMS keep in place the pay-for-reporting model for first-year ACOs.

*Summary of Use of ACO Quality Performance in Determining Shared Savings and Losses*

For 2021 and beyond, CMS proposes to eliminate the quality performance sliding scale for shared savings, allowing ACOs to earn savings at the maximum sharing rate according to the applicable financial model. If the ACO fails to meet the proposed quality standard, it is ineligible to share in savings. CMS also proposes modifications to loss calculations for Track 2 and the ENHANCED track so that an ACO's quality score will be taken into consideration as long as the loss rate stays within the minimum and maximum range.

*TMA Response on Use of ACO Quality Performance in Determining Shared Savings and Losses*  
**TMA supports these modifications that will simplify financial calculations.**

*Summary of Compliance with the Quality Performance Standard*

CMS proposes to specify how it will address continued noncompliance with the quality performance standard. Effective Jan. 1, 2021, ACOs exhibiting a pattern of failing to comply with the quality standard will be terminated from the program. This applies to ACOs that do not meet the standard for two consecutive performance years within an agreement period, or for three performance years within an agreement period regardless if they are in consecutive order. Termination will occur for renewing or reentering ACOs if they fail to meet the quality standard for two consecutive performance years across two agreement periods. Termination for failure to meet the quality standard would subject an ACO to the early termination payment consequences. This means the ACO is liable for a prorated share of any losses for the performance year in which the termination becomes effective.

*TMA Response on Compliance with the Quality Performance Standard*

Although TMA understands the importance of quality in the value-based care proposition, it is unreasonable to implement these standards at the same time CMS is implementing new quality standards. COVID-19 further disadvantages ACOs striving for compliance. **We recommend delaying quality compliance provisions until performance year 2022.**

*Summary of Updating the Process Used to Validate ACO Quality Data Reporting*

To align MSSP quality reporting under the proposed APP framework, CMS proposes that MIPS validate data submitted by ACOs for the three measures in the APP framework. The MIPS data validation and audit varies based on the submission method selected by the ACO.

*TMA Response on Updating the Process Used to Validate ACO Quality Data Reporting*

**TMA agrees with this alignment but believes that 2021 implementation does not afford MSSP ACOs enough time to investigate and implement new quality reporting options.** Note that this includes education and communication with ACO participants (and their administrative staffs).

*Summary of Changes to Extreme and Uncontrollable Circumstances Policy for PY 2021*

CMS proposes to increase the quality reporting standard from the 30th to the 40th percentile. However, due to the extreme and uncontrollable circumstances brought about by COVID-19, CMS proposes that ACOs be credited with the higher of an ACO's MIPS quality performance category score or the 40th percentile of the MIPS quality performance category score. If the ACO is unable to report quality data and meet case minimum requirements, the quality score would default to the 40th percentile MIPS quality performance score. Because the CMS Web Interface will be discontinued in 2021, CMS proposes to determine the percentage of the ACO's beneficiaries impacted by extreme and uncontrollable circumstances based on the fourth-quarter list of assigned beneficiaries.

*TMA Response on Changes to Extreme and Uncontrollable Circumstances Policy for PY 2021*  
**While TMA appreciates the flexibility of CMS in this unprecedented time, we ask that implementation of the new 40th percentile quality measure and reporting options be delayed until performance year 2022.**

*Summary of Revisions to the Definition of Primary Care Services Used in Beneficiary Assignment*  
Beneficiaries are assigned to an ACO based on their utilization of primary care services provided by a physician who is an ACO professional along with all services furnished by a rural health clinic or federally qualified health center.

CMS proposes updates to the list of primary care services used to for beneficiary assignment. Changes reflect codes for (1) online digital evaluation and management services for established patients, (2) assessment and care planning for patients with cognitive impairment, (3) chronic care management, (4) noncomplex chronic care management, (5) principal care management for specialists, and (6) psychiatric collaborative care. CMS specifically did not include place of service modifiers that would allow skilled nursing facilities and other institutions to establish plurality of care.

*TMA Response on Revisions to the Definition of Primary Care Services Used in Beneficiary Assignment*

**TMA applauds CMS for recognizing the importance of establishing a medical home for Medicare beneficiaries.** Changes made to the definition of primary care services support patient management by local physicians who have established relationships with Medicare beneficiaries and their families, rather than by institutions.

*Summary of Reducing the Amount of Repayment Mechanisms for Eligible ACOs*

Effective January 2022, for renewing ACOs that wish to maintain their existing repayment mechanism (RM), CMS proposes to discontinue the policy that requires the ACO to maintain its existing RM amount if it is higher than the RM amount calculated for the agreement period. The regulation will be revised to specify that CMS will determine the RM amount for an ACO applying to renew its participation for an agreement period only according to the methodology currently specified. A renewing ACO that wishes to use its existing RM to would be required to have an RM amount equal to the lesser of (1) 1% of the total per-capita Medicare Parts A and B fee-for-service (FFS) expenditures to the ACO's assigned beneficiaries, based on expenditures for the most recent calendar year for which 12 months of data are available, or (2) 2% of the total Medicare Parts A and B FFS revenue of its ACO participants, based on revenue for the most recent calendar year for which 12 months of data are available.

*TMA Response on Reducing the Amount of Repayment Mechanisms for Eligible ACOs*

TMA commends CMS for addressing the unintended consequences of ACOs having to maintaining a higher-than-required repayment mechanism as they transition to new agreement periods.

### III.I Modifications to Quality Reporting Requirements and Comment Solicitation on Modifications to the Extreme and Uncontrollable Circumstances Policy for Performance Year 2020

#### *Summary*

In the first quarter of 2020, CMS made some extreme circumstances and hardship waivers due to the pandemic and PHE. The agency recognized collecting and reporting data for the MSSP present a hardship and burden. Because of this and because physicians were focused 100% on treating patients with a novel virus, physicians received a waiver for 2019 reporting.

*TMA Response*

TMA appreciated CMS recognizing the burden it has placed on physicians and waiving these requirements during the pandemic.

However, these waivers must continue at least through 2021. Texas physicians followed the Centers for Disease Control and Prevention's (CDC's) guidance and temporarily closed their practice if it was not deemed "essential." This created a monumental stress on practices, causing many to close permanently. Practices that remained opened suffered significant operational obstacles and financial instability in caring for their patients.

III.K Requirement for Electronic Prescribing for Controlled Substances for a Covered Part D Drug under a Prescription Drug Plan or an MA-PD plan

*Summary*

While electronic prescribing has increased in general, CMS recognizes a sharper increase in 2020 as older adults and people with chronic conditions at elevated from COVID-19 practice social distancing. CMS proposes to add a requirement that all prescribers conduct electronic prescribing of Schedule II, III, IV, and V controlled substances using the NCPDP SCRIPT 2017071 standard by Jan. 1, 2022, except in circumstances in which the secretary waives the requirement. CMS also proposes that prescribers must use the NCPDP SCRIPT 2017071 standard because they are already required to use this standard when conducting e-prescribing for covered Part D drugs for Part D-eligible individuals.

*TMA Response*

TMA agrees it is important to control prescriber access through improved identity controls and authentication protocols. TMA recently submitted comments to the U.S. Drug Enforcement Administration about how the process can be improved and less burdensome to physicians.

TMA disagrees with the single workflow for electronic prescribing for controlled substances (EPCS). Physicians can delegate the order entry of noncontrolled substances but cannot with controlled substances. There are instances where EPCS does demand a modified workflow.

Regarding the waivers, CMS should consider an additional waiver related to volume. Physicians who prescribe fewer than 100 controlled substances a year should be exempt from the EPCS mandate. EPCS systems are too costly for physicians writing so few prescriptions. If CMS does not allow a waiver related to volume, physicians who prescribe so few prescriptions may stop writing them for controlled substances altogether, and this could inadvertently create patient suffering and harm.

Additionally, CMS should consider removing the waivers' one-year restriction. A physician who is unable to e-prescribe controlled substances due to economic hardship or technical limitations may not have relief from those barriers after one year. CMS could consider an annual review or waiver application as a mechanism to monitor the EPCS environment and adoption rates.

TMA has heard from physicians who prescribe compounded medications that qualify as controlled substances but are unable to use e-prescribing for the compounded medication because it is not available on the prescribing software's picklist. CMS should clarify or use compounding as an

example if the waiver “A prescription cannot be transmitted electronically under the most recently implemented version of the NCPDP SCRIPT Standard” applies. If CMS doesn’t, a waiver should be added for prescribers who need to prescribe compounded medications for appropriate patient care.

CMS solicited comments on whether penalties should be imposed for noncompliance. **TMA emphatically asks CMS NOT to impose penalties for noncompliance.** Penalties have unintended consequences such as limiting access to care or physicians not prescribing needed medications to patients. CMS needs to understand why a small minority of controlled-substance prescribers do not use EPCS. It likely will be linked to volume. Those who regularly prescribe controlled substances probably have already upgraded their software to accommodate EPCS.

TMA agrees with the proposal to postpone the EPCS requirement by one year to Jan. 1, 2022. Physicians may have reserved funds to upgrade their systems to meet the mandate but were significantly affected by the COVID-19 PHE. TMA encourages CMS to continue to monitor the viability of practices due to the financial devastation from COVID-19, particularly small and rural primary care practices that regularly operate on thin profit margins.

### III.M Updates to Certified Electronic Health Record Technology due to the 21st Century Cures Act Final Rule

#### *Summary*

CMS proposes that the technology used by health care practitioners to satisfy the definitions of Certified Electronic Health Record Technology (CEHRT) must be certified under the Office of the National Coordinator (ONC) Health IT Certification Program in accordance with the updated 2015 Edition of Health IT Certification Criteria as finalized in the 21st Century Cures Act final rule. This includes technology used to meet the 2015 Edition Base EHR definition at 45 CFR §170.102, technology certified to the criteria necessary to be a meaningful EHR user under the Promoting Interoperability Programs, and technology certified to the criteria necessary to report on applicable objectives and measures specified for the MIPS promoting interoperability performance category. Health care practitioners participating in the Promoting Interoperability Programs or QPP would be required to use only technology considered certified under the ONC Health IT Certification Program according to the timelines established in the Cures Act final rule.

#### *TMA Response*

While TMA understands that technology advancements must be reflected in the software and digital tools used in health care, the burdens should not fall to the physician users. CMS suggests that “practitioners could work with their health IT developers to plan for implementing CEHRT that meets the 2015 Edition Cures Update as soon as health IT developers make updated technology available.” We think that this innocent-sounding phrase perpetuates the myth that individual physicians have a significant say in how EHRs are designed and developed. The sentence should instead read, “Health IT developers should work closely with their physician customers to ensure the upgraded technology works safely and efficiently and that the upgrades and testing are conducted appropriately to ensure uninterrupted and safe patient care.”

CMS and ONC should carefully monitor the move from 2014 to 2015 CEHRT to prevent any unintended consequences due to vendor noncompliance, which places physicians in a no-win predicament. Physicians pay heavily for EHRs including annual licensing and maintenance fees.

CMS and ONC also should monitor for any price gouging when health IT developers release upgraded technology.

#### IV.A. CY 2021 Updates to the Quality Payment Program

##### *Overall TMA Concerns*

CMS has made its customary annual review and proposed changes to the Quality Payment Program. Even during a pandemic and PHE, CMS has chosen to make significant changes to the multiple complex aspects of this program. The QPP has changed multiple times since its original implementation. Each “improvement” the agency makes further complicates the program and significantly increases the burden on physicians. This year is no exception. CMS has chosen to continue on its path with “improvements.”

CMS would do well to continue recognizing the struggle physicians are under and how it continues even if policymakers lose interest or decide to focus on other topics their constituents desire. Physicians and their practices do not have this option. They still struggle to procure an appropriate amount of personal protective equipment to safely treat all patients. Additionally, since so many practices are financial unstable right now, many do not have the necessary staffing levels to compensate for the workload when one or more staff members become ill. Expecting physicians to meet and report on arbitrary measures that do not truly measure care quality during these difficult times is indeed misguided.

TMA has long called on CMS to be transparent with any programs, systems, data collection, and data reporting. Yet CMS continues with its opaque reporting and statistical manipulation that does not tell a true, objective, balanced, and transparent story of the effects this program has on physicians.

##### *Summary of MIPS Value Pathways*

CMS proposes to postpone the start of the MIPS Value Pathway (MVP) option to the 2022 performance year. Additionally, CMS proposes the following updates to the MVP guiding principles (with changes shown in italics):

1. MVPs should consist of limited, *connected complementary* sets of measures and activities that are meaningful to clinicians, which will reduce clinician burden, align scoring, and lead to sufficient comparative data.
2. MVPs should include measures and activities that would result in providing comparative performance data that is valuable to patients and caregivers in evaluating clinician performance and making choices about their care; *MVPs will enhance this comparative performance data as they allow subgroup reporting that comprehensively reflects the services provided by multispecialty groups.*
3. MVPs should include measures *selected using the Meaningful Measures approach and, wherever possible, the patient voice must be included,* to encourage performance improvements in high priority areas.
4. MVPs should reduce barriers to APM participation by including measures that are part of APMs where feasible, and by linking cost and quality measurement.
5. MVPs should support the transition to digital quality measures.

CMS proposes that, beginning with the 2022 performance period, stakeholders developing candidate MVPs would be required to include patients as a part of the development process

(incorporating patients and/or patient representatives through means that may include, but are not limited to, technical expert panels or an advisory committee).

CMS outlines the MVP candidate proposal/approval process, which would allow applicants to submit applications (to be made available on the QPP Resource Library) on a rolling basis. MVPs chosen for consideration would be announced through the rulemaking process; therefore, candidates will not know if an MVP candidate is under consideration until after publication of a proposed rule.

*TMA Response on MIPS Value Pathways*

CMS is focused on moving physicians to its risk-based systems in advanced alternative payment models and has established MVPs. Since the agency implemented a flawed system in 2020, it proposed changes to the system 2021. However, the agency still misses the point. If the structure of a system is damaging to physicians, then adding to this does not improve it. This agency has repeatedly professed how its focus on physician burden reduction has improved the way physicians practice medicine and care quality. Yet, with the changes it makes, CMS continues to increase physician burden and even require additional infrastructure investment. In nonpandemic times, this is unacceptable. However, physicians are still struggling to treat patients in a pandemic. They expect to be doing so for a significant portion of 2021 as well. Making changes to a system whose foundation is defective but not changing the foundation creates an increasingly unstable system.

TMA and other physician groups have supplied CMS with feedback and suggestions. Nevertheless, the agency continues on its own path, leaving physician practices destroyed in its wake. Physicians are struggling to keep practices viable during the pandemic, having temporarily closed them under CDC guidance though they still have financial obligations. CMS' choice to increase burden and harm to physicians and their practices at this time is untenable.

*Summary of APM Performance Pathway (APP); MIPS APM Scoring Standard*

CMS proposes to establish the APP as a replacement to the current MIPS APM scoring method. The APP consists of a fixed set of measures for the quality performance category. Cost performance would be weighted to 0%, similar to other APMs; improvement activities scores would be assigned automatically based on the requirements of the MIPS APM (and its use of MIPS improvement activities), with all APM participants reporting through the APP in 2021 earning a score of 100%. Promoting interoperability requirements and scoring would remain the same.

APP may be reported by the individual eligible clinician (EC), group (tax identification number [TIN]), or APM entity (on behalf of its constituent MIPS ECs). APP reporting can be applicable only to MIPS ECs identified on the participation list or affiliated practitioner list of any APM entity.

CMS also proposes that quality measure scoring caps would not apply to measures in the APP set. Since the set is fixed, CMS believes it is not appropriate to limit the maximum quality performance score available. Rather, CMS would consider amending the measure set in future rulemaking.

CMS is seeking general input on the measure set, as well as on the proposal to exempt quality measure scoring cap requirements.

*TMA Response on APM Performance Pathway (APP); MIPS APM Scoring Standard*

We support the general flexibilities outlined for the new APP reporting track. Specifically, we support new proposed flexibilities that allow ECs on both the participation list or affiliated practitioner list to report through the track, as well as flexibilities that allow APP reporting by the individual EC, group, or APM entity.

**However, TMA is concerned about the constantly changing and moving target under the QPP.** It is difficult, time-consuming (taking away from valuable patient time), and administratively burdensome for physicians and practices to keep up with the drastic changes and restructured framework for QPP participation.

#### *Summary of Changes to the MIPS Quality Category*

CMS proposes to:

- Add two new administrative claims outcomes measures for MIPS ECs: (1) Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the MIPS EC Groups and (2) Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA); and
- Modify existing specialty sets and propose new specialty sets, and remove 14 MIPS quality measures (two that are extremely topped out, one that is duplicative to another current measure, one that is duplicative to a newly proposed measure, two that do not align with the Meaningful Measures initiative, five that are no longer stewarded or maintained, one that does not meet current clinical guidelines, and two that are under the topped out lifecycle).

CMS proposes the changes related to the CAHPS for MIPS survey to address the increased use of telehealth care during COVID-19. CMS proposes to revise the definition of “primary care services” used in the MIPS assignment methodology for the 2021 CAHPS for MIPS survey and for any subsequent performance year to include the following additions:

- CPT codes 99421, 99422, and 99423 (codes for online digital E&M services [e-visits]); 99441, 99442, and 99443 (codes for telephone E&M services); and 96160 and 96161 (codes for administration of health risk assessment), and
- HCPCS codes G2010 (code for remote evaluation of patient video/images) and G2012 (code for virtual check-in).

#### *TMA Response on Changes to the MIPS Quality Category*

**TMA supports CMS’ efforts to improve meaningful measurement within the quality performance category; however we do not support the continuous and evolving changes to the measures list in general.** Continuous changes to quality measures often require immediate changes to workflow and data collection operations that are administratively burdensome. This administrative transition often hinders the patient-physician interaction. Furthermore, the immediate infrastructural changes needed to adjust to certain new quality reporting requirements often expose physicians to immediate upfront costs.

#### *Summary of Changes to the MIPS Cost Category*

CMS proposes to add the costs associated with telehealth services to the previously established cost measures. Notably, CMS states that it does not consider this addition an alteration to the original intent of the cost measures and does not believe this captures a new category of cost.

#### *TMA Response on Changes to the MIPS Cost Category*

CMS has chosen to continue using the flawed metrics of total per-capita cost and Medicare spending per beneficiary. TMA has repeatedly advised CMS how detrimental these metrics are to physicians who care for patients in disadvantaged populations. These metrics do not consider social determinants of health and penalize physicians for costs outside their control. Even though these metrics are not-risk adjusted for social determinants of health, the agency continues to choose penalizing physicians for serving these patients rather than developing an appropriate metric.

The cost score weighs 15% for the 2020 performance year. CMS proposes to increase it to 30% for the 2021 performance year. In spite of the flaws of these measurements and the fact that physicians are struggling to remain viable and ensure Americans have access to care, the agency has chosen to penalize physicians with an increase in the weight of the cost category.

Despite the harm to practice viability and how they may be penalized, physicians continued to treat patients during the pandemic and PHE. Many of their patients do not have adequate access to care. The PHE further constrained such inadequate access, thereby increasing the probability the cost measures will penalize physicians.

**TMA strongly advocates for CMS to develop appropriate cost measures that are risk-adjusted for social determinants of health and do not penalize physicians for caring for disadvantaged populations. TMA also advocates for the cost score weight to remain at 15% for the 2021 performance year.**

**TMA understands the rationale for including telehealth costs within cost performance category measures; however, we urge CMS to consider hardship exemptions (from such telehealth cost attribution) and/or scoring bonuses that help adjust for the significant upfront investments required of small and independent physician practices to upstand and scale telehealth platforms during the COVID-19 PHE.**

#### *Summary of Changes to the MIPS Improvement Activities Category*

CMS proposes specific and technical alterations to the following two improvement activities: Engagement of Patient Through Implementation of Improvements in Patient Portal and Comprehensive Eye Exams.

#### *TMA Response on Changes to the MIPS Improvement Activities Category*

Physicians are scientists. Like scientists in basic research, they are focused on data, discovery, and finding ways to improve the way they practice medicine. Physicians and specialty societies have sent numerous ideas for improvement activities for the MIPS program. However, CMS not only continues to reject these improvement activities but also does not provide any substantive critique to give physicians feedback and guidance. Physicians who deliver care are the best experts to design improvement activities that actually deliver positive change or improvement.

As a physician-led association, TMA knows the importance of not just the physician's voice but also the practicing physician's voice. It is why TMA's model of standing up for physicians in the care of patients has worked so well throughout history. It is unacceptable that CMS solicits physician input and then irrationally rejects all such input.

**TMA strongly urges CMS to heed physician and specialty society recommendations for improvement activities. CMS should work closely with these stakeholders to ensure improvement activities are appropriate and improve care.**

*Summary of Changes to the MIPS Promoting Interoperability Category*

CMS proposes to retain the Query of Prescription Drug Monitoring Program (PDMP) measure as an optional measure and make it worth 10 bonus points.

CMS proposes to add the following new measure under the health information exchange (HIE) objective beginning with the performance period in 2021: Health Information Exchange (HIE) Bi-Directional Exchange.

This would be reported by attestation and would require a yes/no response to the following statements:

1. I participate in an HIE in order to enable secure, bi-directional exchange to occur for every patient encounter, transition or referral, and record stored or maintained in the EHR during the performance period.
2. The HIE that I participate in is capable of exchanging information across a broad network of unaffiliated exchange partners including those using disparate EHRs, and does not engage in exclusionary behavior when determining exchange partners.
3. I use the functions of CEHRT for this measure, which may include technology certified to criteria at 45 CFR 170.315(b)(1), (b)(2), (g)(8), or (g)(10).

*TMA Response on Changes to the MIPS Promoting Interoperability Category*

TMA agrees with the CMS proposal to make the query of PDMP an optional measure under the electronic prescribing objective valued at 10 points versus the previous five points. CMS correctly surmised that the capabilities of PDMP integration varies greatly by geography and by EHR. This measure should remain a yes-no measure versus a performance measure.

In the current measure titled Support Electronic Referral Loops by Receiving and Incorporating Health Information, TMA agrees with replacing the word “incorporating” with “reconciling” as that better reflects the action physicians and other clinicians take to meet the measure. However, it should be noted that “reconciling” may be impossible with certain patient data, so “attempting to reconcile” would be preferable. We can foresee an auditor denying points for a physician who could not reconcile the patient’s data, and we don’t want that to happen.

The requirement that “bi-directional engagement occurs for all patients and all records” is naïve. Newborn babies, for example, don’t have information in an HIE, and it’s a waste of resources for the system to send a query regarding them. (Yes, their mother may have HIE information, but she frequently gets care in the same hospital system where she delivers.) Similarly, if a physician has a close relationship with a patient and provides all of his or her care (e.g., at a nursing home where the patient can’t go elsewhere), querying the HIE is a waste of time and money. Clearly physicians will access these systems if they are free and provide good data. But to put a requirement that physicians must check the HIE and reconcile in “all” encounters reflects a lack of understanding of the variations of practices.

The second part of the first attestation is confusing: “and record stored or maintained in the EHR during the performance period.” EHRs interact with HIEs in different ways. Some bring a complete record to the EHR and store it. Others bring selected data (via the FHIR standard, for example). If this phrase means the EHR must store whatever the HIE delivers, this is cumbersome. Where will

the data be stored? Is every vendor allowed to decide what is maintained and what is not? Using paper records as an example, physicians usually would extract the data they need for current care and the remainder was either returned to the patient or kept in a file room. Adding an HIE record for every encounter will rapidly create huge files that probably will impact system performance. We need more guidance before we can accept the second part of the first question.

Regarding the reconciliation of data, there is little published literature on how well this works and what is required to make it more effective. From the experiences of some of our physicians, this is a very unwieldy process. For example, if a physician decides not to bring over certain problems of the patient because the physician feels his or her own record better describes the patient's situation, the HIE continues to send the undesired data with each repeat visit, and the EHR requests the physician to repeat hitting the "ignore" button. The same happens when a physician believes a patient does not have a penicillin allergy, but the HIE has received an allergy notification from somewhere. There needs to be the ability to tag data as "previously ignored so please do not send it again."

Another issue physicians will face with this rule is that of HIE patient mismatches. If a patient has been mismatched and has erroneous data, there is no way to stop it from coming except to not query the HIE for that patient. This is primitive and dangerous and needs to be fixed.

Regarding engagement in bidirectional exchange through health information exchange, TMA appreciates CMS adding a new optional exchange measure that could be used in lieu of the other two exchange measures. CMS solicit comments on a few areas:

CMS Question. Do the attestation statements reflect appropriate expectations about information exchange capability for eligible clinicians that engage with HIEs capable of facilitating widespread exchange with other health care providers?

TMA believes the attestation statements need significant revision. Physicians should not have to attest to the capabilities of their HIE. There are great variances within HIE capabilities, and physicians have no way of knowing all of them when selecting an HIE. In fact, the local public HIE may be the only option a physician has. If CMS wants physicians to participate in HIEs that have certain functionality, then CMS should provide a list of eligible HIEs physicians can choose from that meet CMS' desired criteria. With a CMS list the EHR could report what HIE it uses, automatically compare with the CMS list, and answer the question for the physician. We want to minimize burden, not add to it. Please remove Question 2 of the attestation statement.

If Question 2 is not dropped, the HIE needs to indemnify the physician if the claim is found to be false. The recent experiences with eClinicalWorks and other EHR vendors require us to consider that an HIE might overpromise, particularly if it is experiencing financial difficulty. Physicians should not be held liable for this through loss of points or any other punitive action, as there will be enough cost just in switching HIEs.

CMS Question. How should CMS effectively identify those HIEs that can support the widespread exchange with other health care providers?

CMS can seek this information in a variety of ways. CMS can survey the HIEs or work with the eHealth Initiative or the Strategic Health Information Exchange Collaborative, a national

collaborative representing HIEs and their strategic business and technology partners. Additionally, CMS could engage with the Sequoia Project, which is the recognized coordinating entity named by ONC to create the nation's single on-ramp for HIE.

**CMS seems to ignore EHR-based HIEs such as Epic's CareEverywhere. TMA would like CMS to state clearly whether this meets the requirement of Question 2.**

CMS Question. How are eligible clinicians currently using CEHRT to exchange information with HIEs, and do the proposed attestation statements allow for different ways health care providers are connecting with HIEs utilizing certified Health IT capabilities?

In this proposed rule, CMS cited data from the "State of Interoperability" report which stated that among the reporting HIEs, 76% reported that independent physician practices or practice groups contributed data to the HIE, and 89% reported that providers viewed data in the HIE. CMS did not have data stating the percentage of independent physicians contributing or viewing data. CMS needs to better understand the barriers independent physicians face when trying to connect to an HIE. The root of the problem stems from proprietary EHRs that are not required to use a standardized interface when connecting EHRs to the HIE. EHR vendors charge physicians exorbitant fees to build the interface and then costly monthly fees to maintain the interface. The value to physicians is simply not there when their current workflow allows them to get needed patient data from patients and community sources such as pharmacies, labs, hospitals, and physician colleagues.

It is time that CMS take a hard look at why more than a decade after the HITECH Act and \$564 million expended on HIEs, there is still neither high uptake nor demand. The uptake should not be on the backs of physicians. **HIEs and EHR vendors should work out all the connections needed for seamless bidirectional exchange, and it should happen effortlessly for physicians.** CMS could take a lesson from how Appriss, the PDMP vendor for more than 42 states, built the interface with the vendors so that when installed, physicians would automatically have access to the PDMP link when launching a prescription. The physician did not have to reach out to Appriss and the EHR vendor and negotiate and pay for building an interface. The same should happen with HIEs. When a physician opens a patient record in the EHR, there should be a prominent button or link inviting the physician to check the HIE. When the physician closes the note, there should be a pop-up inviting the physician to send updated information to the HIE. There should not be additional fees or effort on the physician's behalf to have this functionality.

#### *Summary of MIPS Final Score Methodology*

CMS proposes the following category weights for the 2023 MIPS payment year:

- Quality = 40%
- Cost = 20%
- Improvement activities = 15%
- Promoting interoperability = 25%

CMS proposes the following category weights for the 2024 MIPS payment year:

- Quality = 30%
- Cost = 30%
- Improvement activities = 15%
- Promoting interoperability = 25%

CMS proposes to reduce the finalized MIPS performance threshold, which determines positive/negative payment adjustments, from 60 to 50 for the 2021 performance year (the 2023 payment year).

#### *TMA Response on MIPS Final Score Methodology*

CMS has suggested it would lower the performance threshold to 50 points (instead of 60 points). While this is appreciated, it is absurd that the agency would make any changes to a performance threshold while physicians continue to care for patients in a pandemic. This event is not like a natural disaster where there is a short, definitive time of active disaster. The pandemic has stretched across 2020 and is expected to considerably impact 2021. Considering this, increasing the performance threshold by any amount would increase the disastrous affects this pandemic has had on physicians and their practices.

MIPS has already proven to be harmful to rural and small practices. By the agency's own calculations in Table 93 of the proposed rule, small practices are harmed with this program. About 32% of qualified participants in practices of less than 25 will be penalized. This is in contrast to the 12.5% of qualified participants in practices with more than 25 that will be penalized. This program continues to penalize small, independent practices. Increasing the performance threshold during a pandemic is wrong.

#### **TMA advocates for maintaining the 2020 performance threshold of 45 points.**

#### *Summary of Third-Party Intermediaries*

CMS proposes to allow third-party intermediaries (TPIs) that support the quality, performance improvement, and improvement activities performance categories to also support reporting for MVPs. Additionally, qualified registries and health IT vendors may play a role in APP reporting, as three quality measures in the measure set are CQMs and/or eCQMs.

CMS proposes to add the following new criteria for the approval of TPIs:

1. The entity must demonstrate compliance with the requirements for any prior MIPS performance period for which it was approved as a TPI, and
2. The entity must not have provided inaccurate information to clinicians regarding QPP requirements.

Furthermore, CMS is proposing to mandate that third-party intermediaries attend and complete training and support sessions as specified by CMS.

CMS proposes to codify in federal regulation requirements that, beginning with the 2023 MIPS payment year, as a condition of approval qualified clinical data registries and qualified registries would be responsible for conducting annual data validation audits (with specific obligations), as well as targeted audits (with specific obligations) if deficiencies are identified through data

validation. (The specific requirements and details of each audit would be further defined in federal regulation.)

*TMA Response on Third-Party Intermediaries*

TMA generally supports policies that require additional oversight of TPIs that demonstrate noncompliance. **However, we caution CMS from instilling unnecessary data validation audits/requirements, as such actions often yield burdensome administrative requirements for physician practices downstream.**

*Summary of APM Incentive Payment Distribution*

CMS proposes a revised approach to identifying TIN(s) associated with ECs that achieve qualifying APM participant (QP) status for purposes of the APM incentive payment. Specifically, the approach would involve the following updated hierarchy.

1. Any TIN associated with the QP that, during the QP performance period, is associated with an APM entity through which the EC achieved QP status;
2. Any TIN associated with the QP that, during the APM incentive payment base period, is associated with an APM entity through which the EC achieved QP status;
3. Any TIN associated with the QP that, during the APM incentive payment base period, is associated with an APM entity participating in an advanced APM through which the EC had achieved QP status;
4. Any TIN associated with the QP that, during the APM incentive payment base period, participated in an APM entity in an advanced APM;
5. Any TIN associated with the QP that, during the APM incentive payment base period, participated with an APM entity in any track of the APM through which the EC achieved QP status;
6. Any TIN associated with the QP that, during the APM incentive payment base period, participated with an APM entity in an APM other than an advanced APM;
7. Any TIN associated with the QP that submitted a claim for covered professional services furnished by the QP during the APM incentive payment base period, even if such TIN has no relationship to any APM entity or APM; then
8. If CMS has not identified any TIN associated with the QP to which it can make the APM incentive payment, CMS will attempt to contact the QP via a public notice to request its Medicare payment information. The QPs identified in the public notice, or any other eligible clinicians who believe that they are entitled to an APM incentive payment must notify CMS of their claim as directed in the public notice by Nov. 1 of the payment year, or 60 days after CMS announces that initial payments for the year have been made, whichever is later. After that time, any claims by a QP to an APM incentive payment will be forfeited for such payment year.

*TMA Response on APM Incentive Payment Distribution*

CMS has intently focused on assisting physicians in moving from MIPS to advanced alternative payment models. However, TMA is concerned that the agency is pushing physicians to accept risk in a program that is not balanced and fair to all physicians. Unfortunately, CMS has focused on creating programs that penalize small practices and using those penalties to reward large practices. In addition to this already unfavorable design, CMS has proposed to increase the performance threshold for qualified participants. This increase puts practices in a position with unattainable goals. TMA recognizes that CMS may not be able to fully control all aspects of threshold and performance-setting. However, CMS must do all it can to maintain current performance metrics. Additionally, the agency must work with Congress to make any necessary changes to the statute.

For the second year, CMS has found it is not able to pay all physicians their earned bonus. At a minimum, CMS knew this was a problem in 2019. Yet the agency did not put any mechanism in place to resolve or at least mitigate the problem in 2020. In fact, the number of physicians CMS advised that CMS cannot pay the owed 5% bonus grew exponentially year over year. This growth far exceeds the growth of physicians who qualified for the bonus.

	<b>2019 Payment Year (PY) Data</b>	<b>2020 PY Data</b>	<b>Year-Over-Year Growth</b>
<b>Total QPs</b>	99,076	183,306	85%
<b>QPs With Missing Billing Info</b>	2,767	22,256	704%
<b>QP With Missing Billing Info as a % of Total</b>	3%	12%	

It is egregious that that CMS not only would put the burden on physicians but also not recognize such a tight deadline of Nov. 13 to correct CMS wrong information. The agency has a data and systems issue. Instead of correcting these known issues, the agency has decided to create additional significant and complex hoops for physicians to jump through. This is the opposite of its declared burden reduction successes for physicians.

### **Conclusion**

The Texas Medical Association thanks you for this opportunity to comment on the proposed rule. While TMA addressed key areas common to all physicians, our comments have not addressed many provisions that may be of primary concern to physicians in various specialties. With regard to these matters, we defer to the specialty societies that have the relevant clinical expertise to evaluate the rules.

If you have any questions or need additional information, please do not hesitate to contact Robert Bennett, TMA vice president of medical economics, at [robert.bennett@texmed.org](mailto:robert.bennett@texmed.org) or by calling (512) 370-1300.