The US Oncology Network

October 5, 2020

VIA ELECTRONIC SUBMISSION THROUGH www.regulations.gov

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

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

Dear Administrator Verma:

On behalf of The US Oncology Network (The Network), which represents over 10,000 oncology physicians, nurses, clinicians, and cancer care specialists nationwide, thank you for the opportunity to comment on the "Medicare Program; CY 2021 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies (CMS-1734-P)" Proposed Rule, as published in the Federal Register on August 17, 2020.

The Network is one of the nation's largest and most innovative networks of community-based oncology physicians, treating more than 995,000 cancer patients annually in more than 450 locations across 25 states. The Network unites over 1,400 like-minded physicians around a common vision of expanding patient access to the highest quality, state-of-the-art care close to home and at lower costs for patients and the health care system. We are committed to working with the Centers for Medicare & Medicaid Services (CMS) to enhance the delivery of cancer care and protect patient access to high-quality, affordable care in the most efficient manner.

To facilitate your review, we have broken our comments into the following sections:

## CY2021 Physician Fee Schedule (PFS) Proposed Rule

*Budget Neutrality Adjustment*
Federal Medicare law requires CMS to apply a budget neutrality adjustment when aggregate changes in program payment are projected to increase or decrease by more than $20 million. Due to CMS' finalization of payment policy updates for evaluation and management (E/M) visits beginning on January 1, 2021, along with other proposed changes, CMS is proposing to reduce the current Medicare PFS conversion factor by 10.6%, from $36.0896 in 2020 to $32.2305 in 2021. CMS notes this dramatic reduction to the conversion factor, impacting all services paid under the PFS, is required to comply with the statutory budget neutrality requirement. While The Network supports the E/M changes finalized last year and their 2021 implementation, due to the COVID-19 public health emergency (PHE), we encourage CMS to work with Congress to waive the budget neutrality adjustment for the upcoming year.

When the E/M payment updates were finalized in the CY 2020 PFS final rule, stakeholders could not have predicted the emergence of a global health pandemic that upended the delivery of healthcare services across the country. The Network's practices quickly adapted standards of care to protect patient, caregiver, and clinical staff safety while maintaining timely, quality access to excellent cancer care. This required significant resource investments as our providers expanded telehealth services, modified patient waiting and examination rooms, procured necessary personal protective equipment, and developed new care protocols. The early weeks of the pandemic also significantly reduced new patient volumes and led to the suspension of some treatments for established patients, imposing further financial pressure on practices. While The Network is hopeful for the development and approval of COVID-19 therapeutics and vaccines soon, layering on a 10.6% reduction to the PFS conversion factor as healthcare providers continue responding to the pandemic would add significant disruption to an already strained system. Rather than worrying about mounting financial pressures, physicians should be focused on patient care.

*Telehealth and Other Services Involving Communication Technology*
The Network appreciates the swift, decisive, and broad action taken by the federal government to extend telehealth flexibilities to patients and providers in the wake of the COVID-19 public health emergency (PHE). These actions were critical to maintaining continuity of cancer care in the early months of the pandemic and have demonstrated enduring value even as telehealth services have plateaued from earlier this year. Patients and providers have successfully adapted to the delivery of many virtual healthcare services, though The Network acknowledges there will always be an essential basket of services that require in-person, face-to-face visits. The Network also understands the future of telehealth policy must thoughtfully consider implications of privacy, access, technology, fraud and abuse, and payment policy. While not a panacea, broader availability of telehealth services can enhance the delivery of cancer care and should remain an accessible tool to patients and providers.

The telehealth flexibilities extended by CMS in light of the PHE work in close coordination with legislation passed by Congress that permitted the Secretary of HHS to temporarily waive or modify restrictions on the use of telehealth in Medicare. Specifically, the temporary relaxation of geographic restrictions and limitations on originating sites was imperative to meaningfully operationalize the widespread use of telehealth services during the COVID-19 pandemic. These policies enabled patients to access healthcare providers from their homes regardless of distance. The Network urges CMS to work with Congress to permanently lift these telehealth restrictions while maintaining appropriate safeguards to protect patients and minimize fraud and abuse, which should include the reinstatement of patient privacy protections included in the Health Insurance Portability and Accountability Act (HIPAA) at the conclusion of the PHE. Without these permanent changes, CMS' telehealth proposals would have much less impact.

CMS is seeking information that would be helpful for determining additional services proposed for inclusion in the Medicare telehealth list. In the absence of established, oncology-specific telehealth guidelines, The Network developed a decision support framework to assist providers in determining the appropriateness of delivering care in the telehealth setting. This framework encourages providers to use their clinical judgment while carefully considering three things: whether a physical examination appears to be needed, if the patient is experiencing an urgent or life-threatening situation, and whether they are conducting a new patient visit. When a physical examination appears to be needed or the patient is experiencing an urgent or life-threatening situation, telehealth would generally not be appropriate. However, in some cases telehealth may allow providers to triage and assess patient needs on an urgent basis, potentially preventing unnecessary emergency department (ED) visits. The appropriateness of patient visits furnished via telehealth is a location-specific determination that should be made between patient and provider in the context of the local environment, including the COVID-19 PHE.

*Category 1 Medicare Telehealth Services List*
For 2021, CMS is proposing to add 9 HCPCS codes to the Medicare telehealth list on a Category 1, permanent basis. The agency states that these services are similar to those already on the Category 1 list, and in some cases reflect new codes proposed to take effect on January 1, 2021, along with the associated refinements and payment revisions for office/outpatient evaluation and management (E/M) visits. Of the codes proposed for addition to the Category 1 telehealth list, The Network specifically supports the inclusion of the visit complexity inherent to E/M

add-on code (GPC1X) and the new prolonged office or other outpatient E/M service code (99XXX). Once active, these codes should be considered alongside the traditional E/M office/outpatient visit codes (99201-99215), which are already on the Category 1 telehealth list. The Network also supports the inclusion of group psychotherapy (90853) and neurobehavioral status exam (96121) codes on the Category 1 Medicare telehealth list.

*Category 3 Medicare Telehealth Services List*
CMS is proposing to include a handful of additional HCPCS codes on the Medicare telehealth list on a new Category 3, temporary basis, which would extend through the calendar year in which the PHE ends. While these codes are not widely applicable to cancer care in the community setting, The Network agrees with the addition of emergency department (ED) visits (99281-99283) to the Category 3 Medicare telehealth list. This addition is useful for quicker resolution of oncology patients presenting to the ED with minor to moderately complex problems, allowing the patient's cancer care team to efficiently and effectively coordinate care using telehealth. While Levels 4-5 ED visits (99284-99285) are temporarily on the Medicare telehealth list for the COVID-19 PHE, The Network does not believe these visits should be added to the list on a Category 1 basis given the case complexity.

*Services Not Proposed for Addition to the Medicare Telehealth Services List*
The agency is also soliciting comment on whether additional HCPCS codes should be added to the Medicare telehealth list on either a Category 1 (permanent) or Category 3 (temporary) basis. The Network generally supports the exclusion of services CMS identifies, particularly for coverage on a Category 1 basis, including all levels of physical, occupational, and speech therapy services, since the majority of these services require in-person interaction to be effective. Similarly, included in the list of services CMS is seeking comment on is radiation treatment management services (77427), which CMS temporarily added to the Medicare telehealth list for the COVID-19 PHE. While the temporary inclusion of this code during the pandemic was welcome and appropriate, providing radiation oncologists flexibility in treating patients, The Network does not believe this code should be added to the Medicare telehealth list on a permanent, Category 1 basis. The use of this code requires a weekly, in-person visit and physical examination that should not be routinely furnished in a virtual setting.

CMS notes it received a request for the inclusion of the medical genetics services code (96040) on the Medicare telehealth list. The agency disagrees with this request, stating that these services are considered bundled into office/outpatient E/M visit codes, which are already on the Medicare telehealth list. The Network urges CMS to reconsider this position as many Medicare billing-eligible physicians and nonphysicians use this code when providing critical genetic counseling services. These services align well with the telehealth setting and should be reflected on the Medicare list. Additionally, The Network has long-supported legislation updating Medicare law to include highly trained genetic counselor services. Because of outdated program rules, patient access to genetic counselors is significantly limited. The Network urges CMS to work with Congress to expand Medicare beneficiary access to genetic counseling services, which help providers and patients navigate individualized treatment and make informed decisions.

*Communications Technology-Based Services*
CMS is seeking comment on additional benefit categories that may be appropriate for reimbursement as communications technology-based services (CTBS) and is proposing the inclusion of two additional HCPCS codes for practitioners who cannot independently bill for E/M services. These two additional codes include remote assessment of recorded video and/or images submitted by an established patient (G20X0) and brief CTBS by a qualified professional who cannot report E/M services provided to an established patient (G20X2). The Network supports this proposal as it would extend coverage to some nursing triage and care coordination services provided on an "incident to" basis. Oncology practices have invested significant resources in the infrastructure around patient care, including measures to support the patient between office visits, which assists in reducing total cost of care. Much of this investment is furnished by non-provider clinicians (i.e. Registered Nurses, navigators) ineligible for reimbursement under the Medicare program and therefore provided at practice expense.

*Audio-Only and Virtual Visits*
On March 31, 2020, CMS issued an interim final rule (IFR) establishing Medicare payment for audio-only telephone E/M visits furnished during the PHE (99441-99443). This action allows patients to continue receiving

necessary medical care while respecting social distancing guidelines. It is particularly helpful for patients who lack broadband internet access, live in rural areas, or do not have the necessary technology for synchronous, audio-video communication. CMS subsequently increased payment for audio-only E/M visits, but is now proposing not to continue paying for these visits after the PHE. The Network believes there may be instances in which audio-only payment for E/M services furnished under the Physician Fee Schedule are appropriate after the PHE, provided that safeguards for appropriate use are developed to prevent fraud and abuse. The Network notes that many discussions between patients, caregivers, and consulting providers occur using audio-only, telephone communication. This was true prior to the emergence of COVID-19 and represented a segment of time and services that were otherwise unreimbursed to the provider.

The Network supports the CMS proposal to develop new coding and payment for services similar to the virtual check-in but for a longer unit of time and an accordingly higher value. This would provide a preferable alternative to an audio-only visit while recognizing the time and service of the provider. The Network notes that the billing of CBTS (codes G2010, G2012 and G2061-G2063) includes a number of restrictions limiting code use. For example, practitioners cannot bill this code if the patient had a related E/M service in the past seven days nor if the telehealth service leads to a subsequent E/M or procedural service within 24 hours or the soonest available appointment. Relaxing these restrictions and allowing these codes to be billed via telehealth would provide a timely alternative to care and may serve as a bridge between a telehealth interaction and a same- or next-day oncology practice visit, when necessary. This would reduce utilization of expensive ED visits while preserving patient access to needed care. The Network also supports the CMS proposal to maintain these services under general supervision.

*Direct Supervision by Interactive Telecommunications Technology*
CMS is proposing to allow direct supervision to be provided using real-time, interactive audio-video technology through the later of the end of the calendar year in which the PHE ends, or December 31, 2021, subject to the supervising physician's clinical judgment. The Network supports this proposal as it would make it easier for advanced practice providers (APPs) to satisfy "incident to" requirements.

CMS is seeking comment on guardrails or limitations necessary to ensure patient safety and clinical appropriateness when direct supervision is provided through audio/video telecommunications, and whether such policies should be temporary or permanent in nature. The Network supports the permanence of direct supervision by interactive telecommunications technology when an APP is performing a procedure within state scope of practice laws and/or when nurses provide certain services under the supervision of a physician or APP. Should such a policy be extended on a permanent basis, in the absence of defined guardrails, The Network would develop best practices to maintain patient safety and appropriateness. For example, nurses would not be authorized to administer chemotherapy without a supervising physician or APP on site. The Network has experience with remote supervision and is confident in its ability to provide appropriate training.

*Care Management Services and Remote Physiologic Monitoring Services*
The Network appreciates CMS' multi-year effort to improve payment for care management and coordination services. In 2021, the agency is proposing to increase payment for care management services by refining codes related to remote physiological monitoring (RPM), transitional care management (TCM), and other services. The Network supports this proposal and believes it is imperative that the following services remain reimbursable as part of care management, including remote care management: care plan oversight (CPO), TCM, advance care planning (ACP), and principal care management.

RPM technologies have significantly improved patient care management. While there may be some present application of RPM services in the delivery of oncology care, such as blood pressure or heart rate monitors, oncology-specific applications are not yet widely available. However, The Network sees technology moving toward specialty-specific RPM solutions, and for this reason, supports the appropriate and timely valuation of these services. The Network supports CMS' proposal to make permanent the ability of auxiliary staff to furnish RPM services under the general supervision of the billing physician or APP (99453-99454) and encourages the agency to consider reducing the 16-day data limit required before being permitted to bill such RPM services. In some

cases, it may be clinically appropriate to provide shorter-term monitoring. For example, monitoring a patient's temperature prior to surgery or monitoring a patient following the administration of highly neutropenic chemotherapy may not require 16 or more days of RPM, yet would still be appropriate for billing. Adding RPM code specificity around acuteness would also be appropriate.

*Refinements to Values for Office/Outpatient Evaluation and Management (E/M) Visits*
The Network applauded CMS for its adoption of the AMA RUC-recommended values for payment of office/outpatient E/M visits in the CY 2020 PFS Proposed Rule, which was subsequently finalized. This policy, in addition to increasing work RVUs, will ease provider burden and permit code selection based on medical decision-making (MDM) or time, with a relaxation of history and performance of physical exam requirements if medically appropriate. The Network also supports the finalized payment polices for an add-on prolonged visit code (99XXX) for appropriate Level 5 E/M visits and a visit complexity code (GPC1X), which is particularly applicable to oncology care.

In both the 2020 and 2021 proposed Physician Fee Schedule rules, CMS discussed and sought comment and recommendations regarding adjustments to the relative values of certain services, such as transitional care management (TCM), based on changes in values associated with the office/outpatient Evaluation and Management (E/M) visit codes. It refers to these codes as "analogous" as many were valued via a building block methodology and have office/outpatient E/M visits explicitly built into their definition and valuation. CMS indicated that it might adjust the RVUs for these services to reflect proposed changes in the RVUs for the office/outpatient E/M codes.

CMS discusses several factors related to certain services/codes proposed for inclusion under its analogous codes policy. CMS noted in 2020 and again in the 2021 Proposed Rule that "some of these services always include an office/outpatient E/M visit(s) furnished by the reporting practitioner as part of the service, and therefore, it may be appropriate to adjust their valuations commensurate with any changes made to the values for office/outpatient E/M visits." CMS also notes the RUVs for these codes were determined by the building block methodology.

For example, CMS proposes to increase in the RVUs for TCM (99496) because the code requires a face-to-face visit requiring high complexity and proposes an increase commensurate with the proposed RVUs for the corresponding E/M visit. CMS has also pointed out that there are some services that are "similar in many respects to the office/outpatient E/M visit code set, but do not specifically include, were not valued to include, and were not necessarily valued relative to, office/outpatient E/M visits. These codes inherently include work associated with assessment and work associated with management, similar to work included in the office/outpatient E/M visits, which involve time spent face-to-face assessing and treating the patient." CMS notes the RVUs for these codes were determined by a methodology using magnitude estimation. For example, in the proposed rule, CMS proposes to increase the RVUs for Assessment and Care Planning for Patients with Cognitive Impairment (CPT code 99483, formerly HCPCS code G0505). The RVUs for this code were determined by using magnitude estimation and CMS proposes to increase RVUs based on a magnitude estimate of the proposed increase in CPT code 99215.

The Network broadly agrees with CMS' proposal and notes that additional services should be considered as analogous to office/outpatient E/M visits with corresponding increases in valuation. Specifically, based on CMS statements in support of certain codes' revaluation as "analogous" we request that CMS also consider Radiation Treatment Management Services (77427) as an analogous code and reconsider its proposal to exclude global surgical codes as analogous under the finalized office/outpatient E/M payment updates.

*Radiation Treatment Management Services*
Radiation therapy (RT) is often used alongside other treatment modalities and may precede or succeed services performed by medical and/or surgical oncologists.

The AMA's 2020 CPT code book describes Radiation Treatment Management as "reported in units of five fractions or treatment sessions, regardless of the actual time period in which the services are furnished." More specifically,

the services provided are described as follows:

> "Radiation treatment management requires and includes a minimum of one examination of the patient by the physician for medical evaluation and management (e.g. assessment of the patient's response to treatment, coordination of care and treatment, review of imaging and/or lab test results with documentation) for each reporting of the radiation treatment management service."

The radiation oncologist's relationship with a new patient is initially billed as a regular office/outpatient E/M visit. Once RT commences, all related services are bundled into a global period and billed under fee-for-service Medicare using code 77427. These services include the professional component of RT, billed for every 5 treatment fractions, along with weekly treatment management visits between the radiation oncologist and the patient, which may include related services like port film reviews and dosimetry adjustments. While E/M services are routinely furnished during the RT global period under code 77427, office/outpatient E/M codes may not be billed during this time or in the 90 days following the conclusion of RT unless the patient is presenting with a new problem.

CMS recognized code 77427 as a new code in the CY 2000 Physician Fee Schedule Final Rule (FR Vol. 64.). At that time, it established a Work RVU of 3.31, based on the AMA RUC recommendation. This valuation included 0.33 units for office/outpatient E/M code 99213 and 0.17 units for E/M code 99214 as recorded in the physician time file. In light of the fact that CMS now proposes to increase the work value for 99213 from 0.97 to 1.23 and increase the value for 99214 from 1.5 to 1.92, we request a commensurate increase in the work value of CPT code 77427 from 3.37, to approximately 3.51.

*Global Surgical Codes*
CMS is maintaining its position to exclude a revaluation of global surgical codes to reflect the office/outpatient E/M payment updates while the agency continues to collect and analyze data on the number and level of E/M visits performed as part of these global surgical periods. The agency states its desire for additional data and questions the appropriateness of using a building block approach on top of magnitude estimation. While The Network appreciates these concerns, our surgeons routinely perform E/M visits as part of the bundle of services furnished within the global billing period.

Excluding global surgical codes as analogous and appropriate for a revaluation under the 2021 E/M payment update creates a disparity among physicians providing the same service to patients and is particularly unfair to the subset of surgical oncologists performing large numbers of E/M visits within the global period. CMS also finalized E/M add-on codes for visit complexity (GPC1X) and prolonged visits (99XXX) last year. The Network notes that these codes are not available to surgeons billing under global surgical codes, even though many of them are providing cancer care to the same complex patients. This only widens the disparity among physicians. For these reasons, The Network echoes the position of the RUC and other surgical specialty groups in urging CMS to reconsider its position.

*Scope of Practice and Related Issues*
In response to the COVID-19 PHE, CMS temporarily waived a number of regulatory requirements making it easier for NPPs and other health professionals to practice at the top of their license, education, and experience to meet patient needs. The Network echoes the comments of the Advanced Practitioner Society for Hematology and Oncology (APSHO) in requesting CMS make permanent a number of these policies. Such action would be consistent with the administration's stated policy and would serve to further strengthen America's healthcare system.

*Supervision of Diagnostic Tests by Certain NPPs*
CMS is proposing to make permanent to ability of some NPPs to supervise diagnostic tests performed consistent with state law and scope of practice requirements. This policy was temporarily implemented in a May 1, 2020 IFC. The Network supports making this policy permanent, along with the proposal to remove the physician supervision requirement for diagnostic tests performed by physician assistants (PAs).

*Pharmacists Providing Services Incident To Physicians' Services*
On May 1, 2020, CMS issued an IFR clarifying that pharmacists may provide services "incident to" physician or NPP services, such as medication management, when operating under the appropriate level of supervision and consistent with state law. The Proposed Rule reiterates pharmacists are considered auxiliary personnel under "incident to" regulations. The Network supports this policy and recognition that pharmacists are an important part of a patient's care team and should be authorized to practice at the top of their license, consistent with state laws.

*Proton Beam Treatment Delivery*
After conducting a practice expense survey and extensive stakeholder discussions, the AMA RUC recommended CMS establish national reimbursement rates for proton beam therapy (PBT). CMS is rejecting this recommendation and proposing to maintain contractor pricing for PBT codes (77520, 77522, 77523, and 77525) in 2021. CMS notes some equipment prices associated with PBT are extraordinarily high and that integrating such high prices may distort relatively across the PFS. The Network agrees with CMS' perspective and supports the agency's proposal to maintain contractor pricing for PBT equipment.

*Part B Drug Payment for Drugs Approved through 505(b)(2) Pathway*
CMS is proposing to amend the definition of a multiple source drug to include a reference to drugs approved through the section 505(b)(2) pathway outlined in the Food, Drug, and Cosmetic Act. This change is described as a codification of existing policy, allowing CMS to move drugs using the 505(b)(2) pathway from single-source drug codes to multi-source drug codes. However, this reassignment proposal also has potentially significant provider reimbursement effects under Medicare Part B. According to CMS, assigning 5-10 new section 505(b)(2) products to single source drug codes could increase Medicare spending by $75-330 million per year, suggesting significant savings can be achieved under this approach. While The Network appreciates CMS' focus on decreasing drug costs, we request CMS provide greater transparency around this proposal, outlining the drugs proposed for reassignment, and conducting a more detailed and rigorous regulatory impact analysis.

The Network echoes ASCO's concerns that this proposal could disrupt patient access to effective anti-cancer treatments and could lead to additional barriers to care through expanded use of utilization management policies like prior authorization and step therapy. These policies interfere with the doctor-patient relationship by allowing third parties to deny treatment that has been prescribed based on a physician's assessment of clinical need. As ASCO noted, many oncology drugs lack effective and appropriate substitutes. It is imperative that CMS carefully assess the safety implications of its proposal on cancer patients.

**CY2021 Updates to the Quality Payment Program (QPP)**

*Merit-Based Incentive Payment System (MIPS) Structural Changes*
In recognition of the added provider burden imposed by the COVID-19 PHE, CMS is intentionally limiting proposed changes to the Quality Payment Program. Most notably, the agency is proposing not to introduce an initial set of MIPS Value Pathways (MVPs) in 2021, instead deferring implementation until 2022. The Network expressed concern with MVPs in previous comments and appreciates CMS' recognition that transitioning to a new MIPS program during a global pandemic is inadvisable. Further, we support the continuation of the traditional MIPS program as MVPs are developed and implemented over time. The Network reiterates previous comments recommending CMS provide additional clarity on the development of quality measures, including how Qualified Clinical Data Registry (QCDR) measures are included in MVPs.

*Alternative Payment Model (APM) Performance Pathway (APP)*
In an effort to provide a predictable and consistent MIPS reporting standard, reduce reporting burden, and encourage continued APM participation, and because of the delay in MVP implementation, CMS is proposing a new, voluntary APP beginning in 2021. The APP would serve as an alternative MIPS reporting and scoring pathway for eligible clinicians. The Network supports the proposed APP option for MIPS APMs, but does have some concern with the scoring standards for this pathway. We recommend CMS maintain the MIPS APM scoring standard as part of the APP since clinicians are familiar with these measures. Alternatively, CMS could allow eligible clinicians to report using the proposed APP scoring standards or the MIPS APM scoring standard.

Extending this flexibility, particularly amidst the ongoing PHE, would facilitate meaningful participation while minimizing excessive provider burden. As proposed, the APP quality measure set would make oncologists accountable for patient quality outcomes related to diabetes and hypertension. This approach is unreasonable and supplants appropriate measures for oncology care, such as Advanced Care Planning (ACP) and Plan of Care for Pain. For these reasons, The Network encourages CMS to provide APP scoring flexibility while thoughtfully considering appropriate reporting and scoring measures.

*MIPS Performance Category Reporting and Scoring Updates*
Again, The Network is appreciative and generally supportive of the minimal MIPS policy changes being proposed for performance year 2021. Among the category reporting and scoring updates, we are particularly supportive of the proposal to increase the Query of Prescription Drug Monitoring Programs (PDMPs) measure within the Promoting Interoperability category to 10 bonus points. While the measure may not be ready for required reporting, PDMP queries promote quality care and help identify potential patient risk that may be otherwise unknown to providers.

*MIPS Final Scoring Methodology and Payment Adjustments*
CMS is not proposing any scoring policy changes for the Cost, Improvement Activities, or Promoting Interoperability categories. The Network agrees with this approach and the minor proposed changes to the Quality Performance category.

CMS is proposing to adjust its policy for identifying topped out measures, which currently receive a 7-point maximum when topped out for 2 consecutive years. Due to reporting flexibilities extended during the COVID-19 PHE, the performance-period based benchmarks typically used to identify topped out measures may be skewed. To address this concern, CMS is proposing an exception for the 2021 performance period, whereby topped out measures would be identified using historically-based benchmarks from the 2020 MIPS performance period and returning to performance-period based benchmarks for the 2021 performance period. While The Network appreciates CMS' goal of flexibility, we are concerned this change may add complexity to measure reporting, particularly since providers would not have visibility into measures that would be subject to the topped out policy in 2021. This could have the unintended effect of lowering provider scores and may discourage the reporting of measures that, absent the proposal, would otherwise be reported. Therefore, The Network encourages CMS to consider modifications to the proposal that would ensure providers are not negatively affected by topped measures.

*Complex Patient Bonus*
CMS first established a complex patient bonus in 2018 that has remained unchanged in 2019 and 2020. As part of CMS' analysis around the impact of the COVID-19 PHE, CMS is now proposing to increase the patient complexity bonus to the maximum 10 point available for the 2020 performance year, a doubling from the current 5 point maximum. The Network strongly supports this proposal and encourages CMS to consider extending this change through performance year 2021 should the PHE persist.

*Performance Category Weights*
The Network agrees with CMS' proposal to reduce the performance threshold for QPP Year 5 by 10 points, from 60 to 50 points, while maintaining the 85-point threshold for exceptional performance. This adjustment acknowledges the pressures clinicians face from COVID-19 and would be especially welcomed by smaller practices.

*APM Entity Group Score Reweighting and Hardship Exemption*
CMS is proposing to allow APM entities to apply for a reweighting of their MIPS performance categories as a result of adverse impacts from the COVID-19 public health emergency beginning with the 2020 performance period. Following the release of the Proposed Rule, CMS subsequently extended additional flexibilities to non-APM practices, allowing them to opt-out of the 2020 MIPS program in whole or in part due to COVID-19. The agency would require interested providers to submit a hardship exemption to qualify, in which they could request a

reweighting of performance categories. The Network supports these flexibilities and echoes other stakeholders in commenting that practices should not be financially penalized for the effects of the COVID-19 pandemic.

*Feedback and Performance Improvement*
CMS notes that the COVID-19 PHE has delayed the release of performance year 2019 feedback reports. The Network appreciates CMS' update on these valuable reports and would like to share some concerns with how they are compiled and disseminated. The online portal used to distribute QPP feedback reports is immensely confusing and difficult to navigate. Additionally, it would be helpful if the agency shared scoring information even when it's not applicable to the specific practice or clinician. A holistic understanding of CMS' data helps providers improve performance and patient care.

*APM Incentive Payment*
CMS notes the statutorily required APM Qualifying Participant (QP) and partial QP status thresholds are increasing and plateauing beginning with performance year 2021/payment year 2023. The Network understands CMS lacks the authority to adjust these thresholds, but we do encourage the agency to consider the impact of this change on providers. For example, practices participating in the Oncology Care Model (OCM) must include all patients in the model, even those who are not actively receiving treatment. This makes it difficult for clinicians to quality for QP status, particularly as the patient count percentage threshold will increase from 35% in performance year 2020 to 50% in performance year 2021. This threshold applies even when practices are enrolled in two-sided risk. The Network believes lowering the QP status thresholds will still encourage participation in value-based care initiatives, even among practices with substantial OCM patient populations.

**Conclusion**

On behalf of The US Oncology Network, thank you for the opportunity to provide comments on Proposed Rule CMS-1734-P. We welcome the opportunity to discuss the issues outlined above and any other critical issues impacting community cancer care with you and your staff. Should you have any questions, please contact Ben Jones, Vice President of Government Relations and Public Policy at Ben.Jones@usoncology.com.

Sincerely,

Marcus Neubauer MD

Marcus Neubauer, MD
Chief Medical Officer
The US Oncology Network