



MASSACHUSETTS MEDICAL SOCIETY

Every physician matters, each patient counts.

October 5, 2020

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: File Code CMS-1734-P. 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.

Dear Administrator Verma:

On behalf of the 25,000 physician, resident, and medical student members of the Massachusetts Medical Society (MMS), I appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on the CY 2021 Medicare Physician Fee Schedule (PFS) and Quality Payment Program (QPP) proposed rule, published in the *Federal Register* on August 17, 2020 (85 Fed. Reg. 50074). Our comments highlight key recommendations as well as areas of concern. Five primary areas of focus in our comments include:

- I. Concern over the drastic, 11 percent decrease from last year's conversion factor. In light of the financial strain physician practices are already facing due to COVID-19, we ask that CMS use all of its authority to halt further cuts to physicians. We also ask to delay implementation of the global surgical codes and GPC1X add-on code until they can be further studied.
- II. Support for CMS' proposals to permanently expand telehealth services and coverage. We provide recommendations for additional telehealth flexibilities.
- III. Recommendations on the various scope of practice proposals.
- IV. Appreciation for allowing providers flexibility with the Merit-based Incentive Payment System (MIPS) in light of COVID-19 and urging caution over adding administrative burden with changes to the Quality Payment Program (QPP).
- V. Comments on other provisions in the proposed rule.

The MMS' recommendations are outlined in more detail below. We also urge the Department to carefully consider the extensive and thoughtful commentary provided by the American Medical Association, which are enclosed with these comments.

The MMS' comments and recommendations are guided by our policies, our membership, and our commitment to providing quality, equitable care to all patients.

Key recommendations:

I. Medicare Physician Fee Schedule

The MMS supports the January 1, 2021 implementation of CMS' new evaluation and management (E/M) office visit policy and believes it will lead to administrative simplification. We understand that the proposals related to relative value units (RVUs), office and outpatient E/M visits, and the application of budget neutrality together have led to high cost levels, which must be offset by the reduced conversion factor.

However, the MMS is deeply concerned that the calendar year 2021 rate setting and conversion factor in the proposed rule will result in a significant decrease overall to physician reimbursement, which will impact community-based practices and ultimately undermine patient access to care. The proposed conversion factor is \$32.26, which is approximately an 11 percent decrease from the calendar year 2020 conversion factor, and lower than anytime since 1993. Such a drastic cut to physician payment is harmful to patient access to care, especially in light of COVID-19, which has created significant financial challenges for physician practices and led to many considering closing permanently. During the pandemic, many physician practices and health care facilities have seen large decreases in patient visits due to a combination of executive orders and patient fear about their safety and exposure to the COVID-19 virus. Increasingly, physician practices are having to make tough decisions on whether they will be able to sustain their practices and stay open after the pandemic. For example, a survey by Harvard Medical School and developed through a partnership of clinicians, researchers, and public and private entities in Massachusetts found that 20-40 percent of practices reported consolidating, selling, or closing their practice (this statistic was driven mostly by independent practices, including primary care).¹ The CY 2021 conversion factor reduction further threatens our physicians' ability to sustain their practices and continue to deliver care to their patients—and will undoubtedly undermine patients' access to care.

Furthermore, the MMS is worried that these cuts will impact certain specialties more than others, particularly physicians and other health care professionals who do not report office visit codes. As projected in Table 90 of the proposed rule, radiologists, pathologists, and physical therapists face estimated 2021 payment cuts of 9 percent to 11 percent. Specialties including general surgeons, critical care physicians, and anesthesiologists face estimated cuts ranging from 7 percent to 8 percent. The budget neutrality driven cuts will partially offset the positive impacts of the office visit changes from the CY 2020 fee schedule for primary care physicians, oncologists, pediatricians, and other specialties for whom office visits comprise a significant proportion of their services.

We strongly urge CMS to use its administrative authority to mitigate any cuts to physician payment. As the AMA recommends in their comments, **CMS could avert or mitigate these cuts to physicians by: waiving budget neutrality under the public health emergency authorities, postponing implementation of GPC1X until it is better defined, implementing GPC1X with no budget neutrality offset, phasing-in the budget neutrality cuts over multiple years, and using**

¹ Song Z, et al. "Economic and Clinical Impact of Covid-19 on Provider Practices in Massachusetts." *NEJM Catalyst Innovations in Care Delivery*. <https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0441>

overestimated costs from previous years' fee schedules to lessen this year's budget neutrality adjustment (for example, the 2013 budget neutrality offset calculation significantly overestimated the utilization of the Transitional Care Management program).

In addition, the MMS is concerned that the decision not to incorporate the revised office and outpatient E/M values in the global surgical codes will affect the relative values of the codes and could treat the same physician work differently based on whether the service is part of a standalone or post-operative visit. We support the RUC recommendations on how to implement the global surgical codes. We also support the AMA's recommendation to postpone the implementation of the GPC1X add-on code—and for CMS to convene the RUC and other stakeholders to discuss the global surgical codes and the add-on codes issues before moving forward with the proposed policies scheduled to take effect on January 1, 2021.

Lastly, we support the AMA's recommendation that CMS implement a new data collection process with the goal of an effective, transparent, and fair data collection effort. Potential changes to the underlying practice expense methodology should be explored related to practice expense relative values. We urge CMS to convene a Town Hall meeting and immediately begin working with the AMA and other stakeholders to launch a new physician practice expense survey in 2022. We also support the AMA recommendation urging CMS to finalize the CPT codes, CPT guidelines, and AMA/Specialty Society RVS Update Committee (RUC) recommendations exactly as implemented by the CPT Editorial Panel and submitted by the RUC.

II. Telehealth and Remote Patient Monitoring

The MMS appreciates CMS' efforts to respond to the challenges presented by COVID-19 and provide crucial flexibilities for telehealth policies during the Public Health Emergency. These expanded policies allowed patients to get the care they needed during the PHE.

The flexibilities and enhancements that have been granted during the COVID-19 state of emergency have accelerated the utilization of telehealth across the United States and in Massachusetts. COVID-19 telehealth policy changes ensure that Massachusetts residents have access to critical healthcare services while supporting necessary precautions to limit exposure to COVID-19, reduce the stress and burden of traveling to appointments (including the cost of tolls and parking and time lost from work), allow continued social distancing, and preserve personal protective equipment for our healthcare workforce. Telehealth (including audio-only services) has been a powerful tool—a modality change—to increase equitable access to care for all residents of the Commonwealth and promote the principles of health equity and health justice.

Telehealth utilization has grown immensely during the pandemic. According to Blue Cross Blue Shield of Massachusetts, the number of telehealth visits they covered during the first six weeks of the pandemic increased exponentially from 5,000 visits in the six weeks prior to the pandemic to 500,000 visits in the first six weeks of the pandemic, with almost half of those visits for behavioral health services.

Telehealth appointments have also improved patient compliance with appointments and reduced no-shows—one Massachusetts health system reported that show rates have been 89% during this period via telehealth versus the show rate of 80% for in-clinic-only visits during the previous year. Moreover, a study by an MMS member shows that compared to visit rates in-clinic, telehealth visits “had significantly lower no-show rates, with the greatest reductions seen for Black or African American, LatinX, and primary non-English speaking patients.”²

Telemedicine’s ability to improve show rates extends beyond increased access to necessary care: these efficiencies also translate to high-value, lower cost care. Since telehealth changes will be subject to Medicare Physician Fee Schedule budget neutrality provisions, it is important to note that expanding and making permanent telehealth flexibilities will not add substantial cost. For example, a report by the Taskforce on Telehealth Policy (convened by the National Committee for Quality Assurance, Alliance for Connected Care, and the American Telemedicine Association) found that “data collected to date indicate that the virtually unfettered availability of telehealth has not resulted in excess cost or utilization increases, even as supply and demand for in-person care has rebounded”.³ The authors argue that telehealth may improve costs because of fewer missed appointments (no-show rates) that improve compliance, fewer costly Skilled Nursing Facility patient transfers to hospitals/emergency departments, and more use of transitional care management that cuts readmissions—however, they note that additional data after the PHE would be helpful for a fuller assessment on long-term cost of telehealth.

Due to the success of telehealth since the start of the PHE, the MMS urges CMS to continue to strengthen telehealth policies and make permanent many of the flexibilities granted during the COVID-19 PHE. Specific recommendations are listed below:

- We support adding the nine codes CMS proposes be permanently added to the Medicare Telehealth Services List: CPT codes 90853 (group psychotherapy), 96121 (neurobehavioral status exam), 99XXX (prolonged E/M), 99483 (assessment and care planning for patient with cognitive impairment), 99334-99335 (domiciliary or rest home visit), and 99347-99348 (home visit). The proposed rule indicates that if the originating site restrictions that preceded the PHE are re-imposed, then home visits will only be covered when delivered via telehealth for patients receiving treatment for a substance use disorder or co-occurring mental health disorder—we urge CMS to advocate for Congress to permanently remove the originating site restriction and cover expanded home-visit care.
- MMS supports adding the third, temporary category (Category 3) of criteria for adding services to the telehealth list during a PHE. We urge CMS to **consider keeping these additional services on the Medicare telehealth list through at least 2022 or the end of the calendar year after the PHE ends** to allow

² Franciosi EB, Tan AJ, Kassamali B, O’Connor DM, Rashighi M, LaChance A, Understanding the Impact of Teledermatology on No-Show Rates and Healthcare Accessibility: A Retrospective Chart Review, *Journal of the American Academy of Dermatology* (2020), doi: <https://doi.org/10.1016/j.jaad.2020.09.019>.

³ NCQA Taskforce on Telehealth Policy (TTP): Findings and Recommendations, <https://www.ncqa.org/programs/data-and-information-technology/telehealth/taskforce-on-telehealth-policy/taskforce-on-telehealth-policy-ttp-findings-and-recommendations/>

- more time to study the benefits of providing these services outside of the pandemic context.
- *Emergency Department Visits:* We support the AMA’s recommendation to include CPT codes 99284 and 99285 for Level 4 & 5 Emergency Department Visits in addition to 99281-99283.
 - *Home Visits:* CMS proposes to permanently add two codes for home visits (99347-99348) to the Medicare Telehealth Services List, but it proposes to cover two other, higher-level home visit codes (99349-99350) as Category 3 services. We recommend those services be covered permanently.
 - *Additional Category 3 Codes:* We also support the AMA’s recommendation of including CPT codes 99217-99220 (observation care), 99221-99226 (initial hospital care), 99234-99239 (hospital discharge management), 99468-99476 (neonatal and infant critical care), 99477-99480 (intensive care), and 99291-99292 (critical care) in Category 3, in addition to those in the proposed rule. These codes are important for patients to receive high-quality specialty care in isolated rural communities, communities affected by natural disasters, communities affected by local disease outbreaks, and other situations.
- We strongly recommend that CMS **maintain payment rates for telehealth services at the same rate as in-person services at least through the end of the year following the year in which the PHE ends**, so that there is sufficient opportunity to gather data on the resources involved in delivering telehealth services. In addition, patients may not feel confident going back to in-person health visits until well-after the PHE ends. Before the PHE, telehealth services provided by physicians in a non-facility setting, such as a physician office, were paid as if they were provided in a facility setting. Significantly reduced payment rates inhibit the adoption of telehealth, as was the case prior to the PHE. In stark contrast, parity in reimbursement for telehealth services during the PHE helped facilitate the rapid uptick in utilization of telehealth to provide necessary medical care.
 - MMS supports CMS’ proposal to permanently remove the prohibition on use of “telephones” for telehealth. This flexibility was extended during the PHE, with CMS making it clear that that devices such as smartphones, which include audio and video real-time interactive capabilities, can be used for Medicare telehealth services, even though they are considered phones and can also conduct audio-only communication. Patients should be able to receive the care they need regardless of the technology used to deliver the care. This is particularly important given the digital divide between those who have access to computers and reliable, high-speed internet service and those who do not—and what that means for patients’ ability to receive equitable access to care. For example, a Pew Research Center survey found that Black and Hispanic adults are less likely to own a traditional computer or have high-speed internet at home than Whites. The study found “roughly eight-in-ten Whites (82 percent) report owning a desktop or laptop computer, compared with 58 percent of Blacks and 57 percent of Hispanics.” Similar statistics were found in broadband access, with 66 percent of Blacks and 61 percent of Hispanics reporting having broadband access compared to 79 percent of Whites. However, there were equal percentages of smartphone usage between Blacks, Hispanics, and Whites—80, 79, and 82 percents, respectively.⁴ Thus, **we support the proposal to remove references to**

⁴ Perrin A, Turner E. “Smartphones help Blacks, Hispanics bridge some – but not all – digital gaps with Whites.” *Pew Research Center*. <https://www.pewresearch.org/fact-tank/2019/08/20/smartphones-help-blacks-hispanics-bridge-some-but-not-all-digital-gaps-with-whites/>

telephones and other technologies from the list of prohibited technologies.

- MMS urges CMS to **continue payment and coverage for audio-only services.** MMS applauds CMS for its decision to approve audio-only visits for the Medicare fee-for-service program during the PHE, which promoted equitable access to care and helped bridge the digital divide. This is a particularly important issue for elderly and low-income populations who either do not have access to advanced telehealth technology, audio/visual technology, or internet access—or who have trouble navigating virtual visits with both audio and video capabilities. It is vital for these vulnerable populations to be in contact with their physicians and receive timely care. Therefore, it is essential that telephone visits continue to be covered by Medicare and they should be paid on par with in-person rates.
- MMS supports the proposed policy that the frequency limitations on Medicare telehealth visits to nursing facility settings be expanded from once every 30 days to once every 3 days (as was implemented during the PHE). During the PHE, similar frequency limitations were waived for hospital visits, though this is not made permanent in the proposed rule. We urge CMS to **consider permanently waiving the frequency limitations on telehealth hospital visits from 30 to 3 days.**
- During the PHE, CMS permitted physicians and NPPs to conduct required visits for nursing home residents via telehealth. **The MMS believes that telehealth (including audio-only services) is sufficient for these initial, required visits with the nursing facility patient due to continued exposure risk or other factors** and would urge CMS to consider making that policy permanent
 - Furthermore, MMS recommends that **telehealth is sufficient to meet in-person visit requirements for patient orders across the continuum of care.**
- CMS did not propose to update the use of the Place of Service (POS) code as if the service had been furnished in person. During PHE, this was done via the use of Modifier “95” to indicate the use of a telehealth system. It is not clear in the proposed rule whether providers should use Modified 95 after the PHE. This modifier allows for greater total reimbursement when the patient is in a location that cannot bill an originating site fee and reimburses the practitioner for providing telehealth technology. **We urge CMS to include in the final rule a provision allowing providers to continue to use Modifier 95 for the Place of Service code after the Public Health Emergency ends.**
- Recently, CMS has expanded access to other telehealth services (services using communications technology) that are not considered “Medicare telehealth” under that definition and therefore not subject to the 1834(m) restrictions. These services include virtual check-ins, e-visits, and remote physiological monitoring (RPM). The MMS supports finding ways to pay for a broader array of virtual services. **We urge CMS to consider expanding the purpose of Category 3 to include development of new codes for Communication-Based Technology Services (CBTS) and appropriate payment amounts.** In addition, we do not support limiting CBTS to “inherently non-face-to-face services.” There is a continuum of ways to deliver services to patients, and some patients may need or want a virtual approach to a service that other patients need or want to have delivered in-person. (For example, research suggests that patients with low health

literacy benefit from technology-based services that allow them more time to receive and understand information to manage their health.⁵)

- **Remote Patient Monitoring and Management (RPM)** – MMS supports CMS’ continued use and payment of CPT codes 99453, 99454, 99457, and 99458 which were developed to describe the professional and technical components of remote physiologic monitoring. CMS support of these services has had a tremendous impact on expanding access for patients in need of remote monitoring services.
 - We appreciate the RPM flexibilities added during the PHE and urge those to continue past the PHE to allow time for physicians to transition. For example, per the proposed rule, CMS will no longer allow RPM services to be provided to a new patient after the PHE. CMS should consider extending this policy until COVID-19 is no longer a threat or longer, so that patients have appropriate access to care as providers transition to new policies—and the RPM policies can be studied from an overall cost and utilization standpoint.
 - We urge CMS to consider the AMA’s concerns that the structure of the RPM codes may not be represented as intended within the CPT code set, particularly with regards to CPT codes 99457 and 99458—and the AMA’s assertion that these codes do not only describe treatment management services.
 - We agree with CMS’ clarification that practitioners may furnish RPM services to remotely collect and analyze physiologic data from patients with acute conditions as well as patients with chronic conditions.

Furthermore, MMS urges CMS to make every effort to work with Congress to obtain permanent, statutory authorization for delivery of Medicare telehealth services to patients wherever they are located—urging Congress to waive restrictions on the geographic location and originating site. Although the expansion of the services on the Medicare Telehealth Services List has been very beneficial, the most impactful change to telehealth policies in 2020 is the ability to deliver services to patients wherever they are located, including but not limited to their home, nursing home, hospitals of all types, etc. While waiting on these statutory policy changes, CMS should urge the Health and Human Services Secretary to continue extending the PHE through CY 2021 or longer to ensure patients can continue getting the care they need without being restricted by their location.

III. Scope of Practice

MMS appreciates the opportunity to comment on the scope of practice changes in the proposed rule. We provide our comments on each provision below:

- **Direct Supervision of Residents in Teaching Setting through the Audio/Video Real-Time Communications Technology**—CMS is considering policy to allow direct supervision through interactive audio/video communications technology, rather than a physician being physically present in the same office or building. The policy would allow the physician to interact with the resident through virtual means, which would meet the direct supervision requirement that they be present for the key portion of

⁵ Bickmore TW, Pfeifer LM, Jack BW. “Taking the Time to Care: Empowering Low Health Literacy Hospital Patients with Virtual Nurse Agents.” *CHI ’09: Proceedings of the SIGCHI Conference on Human Factors in Computing Systems*, April 2009

the service, including when teaching. CMS is proposing this policy until either the later of the end of the calendar year in which the PHE ends or December 31, 2021. The MMS supports permanently allowing the supervision of residents in teaching settings through audio/video real-time communications technology. Furthermore, we support the AMA's recommendation that CMS follow the Accreditation Council for Graduate Medical Education's (ACGME) recently-amended rules to allow for audio/visual supervision of residents who are providing patient services.

- *Virtual Teaching Physician Presence during Medicare Telehealth Services*—CMS also clarified that telehealth services can be provided incident-to a physicians' services and under direct supervision of the billing professional. We support allowing for the virtual presence of teaching physicians during Medicare telehealth services and believe this change should be made permanent—we believe that teaching physicians should be compensated for services performed by residents, if the resident is under the physician's personal observation, direction, and supervision to include Medicare telehealth services.
- *Supervision of Diagnostic tests by Certain Nonphysician Practitioners (NPPs)*—CMS is proposing to allow NPs, CNSs, PAs and CNMs to supervise the performance of diagnostic tests in addition to physicians. The MMS strongly opposes broad language in the proposed rule allowing for the supervision of diagnostic tests by non-physician practitioners, which is problematic since non-physician practitioners are often not permitted to perform some of the diagnostic procedures covered under the proposed rule. The scope of practice for non-physicians is predominantly regulated by the states, and the inclusion of certain services in the federal proposed rule would present challenges and potentially conflict with state law.
- *Medical Record Documentation*—The CMS proposed rule allows physicians and NPPs, including therapists, to review and verify documentation entered into the medical record by members of the medical team for their own services that are paid under the PFS. Therapy students, and students of other disciplines, working under a physician or practitioner who furnishes and bills directly for their professional services to the Medicare program may document in the record, so long as the note is reviewed and verified by the billing physician, practitioner, or therapist. The MMS supports the proposed changes to the medical record documentation requirements, so long as this provision falls in line with existing scope of practice laws and reduces the burden of redocumentation. The MMS supports efforts to reduce the administrative inefficiencies, burdens, and expenses involved in paying for health care services and believes the expanded flexibility surrounding documentation and review of medical records for billed services will allow physicians to have more time to spend engaging in direct patient care rather than redocumenting their efforts.
- *Resident Moonlighting Policies and Primary Care Exception*—We support the AMA's recommendation to permanently allow residents to moonlight in the inpatient setting—and permanently expand the services that may be offered under the primary care exception.

IV. Quality Payment Program

The MMS appreciates CMS' focus on promoting improvements to the Medicare Quality Payment Program (QPP) and introducing a more clinically relevant, less burdensome approach to the Merit-based Incentive Payment System (MIPS) via the new MIPS Value Pathways (MVPs). We support improvements to value-based payment mechanisms under the QPP. However, it is important to note that continuous changes to program terminology, participation and reporting requirements, and other measures can significantly add to physicians' administrative burden. These continuous changes can make it more difficult for physicians to formulate practice goals and better measure and improve their own performance, which can impact patient care. At a high-level, the MMS urges CMS to reduce physician burden by making the program simpler and more streamlined—and make the program more predictable, adaptable, and accessible across all specialties.

Regarding specific policies, the MMS applauds CMS for the flexibilities that it implemented during the COVID-19 pandemic, especially related to the Merit-based Incentive Payment System (MIPS). CMS established a 2020 hardship exception policy due to the COVID-19 pandemic, which allows physicians and groups to either (1) opt-out of MIPS completely and be held harmless from a penalty, or (2) opt-out of any of the individual MIPS categories. We support this policy and urge the Department to extend the extreme and uncontrollable circumstances hardship exception flexibilities these policies through at least 2021 as the pandemic remains an ongoing crisis and disruptive to the fair and accurate evaluation of physician performance in MIPS.

Additionally, due to the challenges presented during the COVID-19 pandemic, we support postponing MVP implementation until 2022. We believe postponing the implementation is especially important to provide stability and continue to encourage participation while specialty societies and physicians shift their time and focus toward developing or preparing to report on MVPs—to make the MIPS program more sustainable in the long run. We join the AMA in supporting collaboration between CMS and specialty societies to develop MVPs and urge the agency to finalize changes that will allow MVPs to be more innovative, flexible, less burdensome, and meaningful to patients.

We also reiterate the following, detailed recommendations from the AMA. The MMS:

- urges CMS to increase the composite score complex patient bonus and to expand favorable scoring policies to small practices throughout the MIPS categories.
- supports CMS' proposal to reduce the previously-finalized 2021 MIPS performance threshold from 60 to 50 points in light of the COVID-19 pandemic. CMS should consider maintaining the threshold at 45 points and to similarly reduce the additional performance threshold to incentivize ongoing participation in MIPS.
- strongly urges CMS to maintain the weight of the cost category at 15 percent and the quality category at 45 percent of the final MIPS score for the 2021 performance year in light of the unknown impact of the COVID-19 PHE on the cost measures, frontline physicians' focus on continuing to care for patients during this pandemic, and to provide physicians more time to familiarize themselves about their resource use.
- urges CMS to adopt more Improvement Activities related to the management of COVID-19, such as practices providing COVID-19 screening, diagnosis, or treatment, whether in-person or via telemedicine.

- does not support the CMS proposal to transition MIPS Alternative Payment Models (APM) to the Alternative Payment Model Performance Pathway (APP), as the quality measures should match the focus of the APM.
- urges CMS to maintain topped out measures that have a linkage to cost measures or MVPs, and to revise the existing quality measure benchmark methodology to incorporate more of a manual, data-driven approach.
- supports CMS' proposal to use performance period benchmarks for the CY 2021 MIPS performance period rather than baseline period historic data, agreeing with CMS' concerns that 2019 performance data may not be a representative sample of historic data. We also urge CMS to consider the impact COVID-19 will have on 2020 and 2021 data and setting future benchmarks.
- is concerned with CMS' proposal to truncate the performance reporting period as it relates to scoring flexibility for changes that impact quality measures. We urge CMS to work with measure stewards and relevant specialties to evaluate the data to determine whether a cut-off of nine months skews performance.
- does not support CMS' proposal to include the Risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) for Merit-based Incentive Payment System (MIPS) Eligible Clinicians. We also have concerns with the new Hospital Wide All Cause Readmission measure for MIPS.
- asks that CMS reconsider the proposed Qualified Clinical Data Registry (QCDR) testing timeline and allow QCDRs two nomination cycles to complete reliability and validity testing for new measures.
- strongly supports CMS' proposal to allow physicians to report on the HIE Bi-Directional Exchange measure by a yes/no attestation and we encourage CMS' new direction in measure design that increases flexibility while reducing physician reporting burden.
- does not support the timing of the proposal to transition the Medicare Shared Savings Program (MSSP) quality measures from the GPRO web-interface to the MIPS Alternative Payment Model (APM) Performance Pathway. Instead, we recommend CMS gather stakeholder feedback and postpone the transition until 2023.
- urges CMS to consider how electronic health record (EHR) vendor-captured data can reduce physician reporting burden. We believe CMS should create broad categories of Promoting Interoperability objectives allowing physicians to attest "yes/no" to the use of certified EHR technology (CEHRT) itself to achieve those categories.

V. **Other Key Recommendations**

The MMS supports several other policies outlined in more detail in the AMA's comments:

- The MMS supports the proposed rule's opioid use disorder policies, including the expansion of the monthly bundled payment codes to all substance use disorders and the payment of physicians in emergency departments to stabilize patients with withdrawal symptoms.
- The MMS urges CMS to limit any unnecessary complications or burdens that could impede physicians' adopting, scheduling, planning, implementing, testing, training, and using new EHRs in clinical environments. The MMS urges CMS to not require physicians to use 2015 Edition Cures EHRs before January 1, 2023.

- The MMS supports the proposal to defer requiring electronic prescriptions for controlled substances (EPCS) for Medicare Part D prescriptions until 2022 and appreciates CMS' recognition of the hardship that implementation of such a requirement in 2021 would impose on patients and physicians.
- The MMS continues to have concerns about the potential impact of cuts to payment rates for clinical testing services paid on the Clinical Laboratory Fee Schedule.
- The MMS appreciates and supports the significant flexibilities that CMS has provided for Medicare Diabetes Prevention Program (MDPP) suppliers during the COVID-19 PHE, in particular allowing patients to receive MDPP services more than once during their lifetime and allowing access to sessions provided on a virtual basis. We recommend that these flexibilities be made permanent.

As always, the Massachusetts Medical Society appreciates the opportunity to provide comment and work with the agency on our shared goal of providing the highest quality health care to patients. Should you have any questions, please contact Alexandria Icenhower, Federal Relations Manager, at aicenhower@mms.org or 781-434-7215.

Sincerely,

David A. Rosman, MD, MBA
President, Massachusetts Medical Society