SVS | Society for Vascular Surgery

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October 2, 2020

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: **CMS-1734-P**
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

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

Re: File Code CMS-1734-P; CY 2021 Revisions to Payment Policies under the Physician Payment Schedule and Other Changes to Part B Payment Policies; (August 17, 2020)

Dear Administrator Verma:

The Society for Vascular Surgery (SVS) is a professional medical specialty society, composed primarily of vascular surgeons, that seek to advance excellence and innovation in vascular health through education, advocacy, research and public awareness. SVS, on behalf of its 5,900 members, offers the following comments on the Centers for Medicare and Medicaid Services (CMS) CY 2021 Revisions to Payment Policies under the Physician Payment Schedule and Other Changes to Part B Payment Policies proposed rule.

Proposed CY 2021 Conversion Factor

CMS estimates the CY 2021 PFS conversion factor to be 32.2605, which reflects the budget neutrality adjustment of -10.61 percent and the 0 percent statutory update factor. **We are strongly opposed to CMS reducing the Medicare conversion factor from $36.0896 to $32.2605.** This decrease lowers the 2021 conversion factor below the 1994 conversion factor of $32.9050, which would be approximately $58.02 today in current dollars. This extraordinary cut to the conversion factor is triggered not only by an unprecedented increase to office/outpatient E/M codes, but almost equally by a single new CMS assigned add-on code (GPC1X) that the AMA and almost all medical specialties agree is invalid. The additional spending to support these increases, along with the increases to stand-alone office/outpatient E/M visits, totals $10.2 billion.

SVS appreciate the Agency's efforts to reduce the physician burden related to evaluation and management documentation and the willingness to work with the medical community through the AMA CPT/RUC process to update the office and other outpatient evaluation and management visit codes. However, the reduction of the conversion factor, paired with the failure to incorporate the revised office/outpatient E/M values in the global codes, will result in drastic

cuts to many physician specialties. As a result, those surgeons who rely on providing care to Medicare beneficiaries may no longer be able to support nurses and support staff to keep their offices open.

TABLE 90: CY 2021 PFS Estimated Impact on Total Allowed Charges by Specialty					
(A)	(B)	(C)	(D)	(E)	(F)
Specialty	**Allowed Charges (mil)**	**Impact of Work RVU Changes**	**Impact of PE RVU Changes**	**Impact of MP RVU Changes**	**Combined Impact***
VASCULAR SURGERY	$1,287	-2%	-5%	0%	-7%

These cuts come at a time when specialists are struggling with the financial impact of the COVID-19 pandemic in many ways, including pay cuts from the suspension of elective surgery, salary reductions, furloughs, and layoffs. **We urge CMS to thoughtfully implement any action that Congress might take to enact legislation to waive Medicare's budget neutrality requirements for these E/M adjustments.**

Documentation via Medical Decision Making (MDM) or Time

CMS reviewed the CY 2021 E/M policies that it finalized as part of CY 2020 rulemaking including a policy to adopt new coding, prefatory language, and interpretive guidance framework provided by AMA CPT. CMS also finalized that office/outpatient E/M levels 2-5 would be selected by level of medical decision-making or by time, specifically the "**total time personally spent by the reporting practitioner**" on the day of the visit (including face-to-face and non-face-to-face time).

We strongly agree with CMS' clarification that the total time (including both face-to-face and non-face-to-face) is the total time personally spent by the reporting practitioner for office or other outpatient E/M services. We note that the CPT guidelines and code descriptors are not clear and therefore would be open to interpretation. The CPT guidelines state:

> "When time is used to select the appropriate level for E/M services codes, time is defined by the service descriptions. The E/M services for which these guidelines apply require a face-to-face encounter with the physician or ***other qualified health care professional***."[1] (emphasis added)

And CPT also wrote:

> "Total time on the date of the encounter (office or other outpatient services): For coding purposes, time for these services is the total time on the date of the encounter. It includes

[1] American Medical Association (2020). *CPT 2021: Professional Edition.* 7. American Medical Association.

> both the face-to-face and non-face-to-face time personally spent by the physician ***and/or other qualified health care professional(s)*** on the day of the encounter."[2] (emphasis added)

The definition of time has been a point of confusion from the beginning when the guidelines and the codes were finalized by the AMA. Specifically, many providers believed the CPT guidelines to mean that the total time of **both** a physician and a QHP could be summed for code selection. This is concerning because some practices use QHPs as clinical staff for some activities. For example, a nurse practitioner (NP) may greet and gown a patient, take vitals, review and document history, record review of system and medication reconciliation, coordinate home or outpatient care, and/or provide education—prior to and/or after a physician's face-to-face encounter. Each of these activities performed by the NP are already separately included in the practice expense for office/outpatient E/M codes. In addition, the CPT manual does not include details about the specific activities that are accounted for in the practice expense inputs and therefore a QHP will not know that time for greeting and gowning a patient and taking vitals (for example) should not be included in total time for selecting a level of office E/M code.

As such, including NP time and physician time for code selection could represent a duplication of clinical staff services and time (i.e., double-dipping). We also know of no other instance where CPT includes the phrase "physician and/or other qualified health care provider," making this instance of that phrase an irregularity. **Therefore, we agree with CMS and believe that the most straightforward and auditable method for using time to select the level of an E/M service is to require that the time reflect the total time of the reporting practitioner.**

New Prolonged Visit Code

CMS adopted the newly established CPT add-on code 99417 (formerly identified as 99XXX) for prolonged office/outpatient E/M services:

> 99417 (*Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services)*)

The Agency states that allowing reporting of CPT code 99417 after the minimum time for the level 5 visit is exceeded by at least 15 minutes would result in double counting time. In Table 22 included in this proposed rule, CMS describes the Agency's proposed reporting of 99417:

[2] American Medical Association (2020). *CPT 2021: Professional Edition.* 8. American Medical Association.

TABLE 22: Proposed Prolonged Office/Outpatient E/M Visit Reporting – New Patient

CPT Code(s)	Total Time Required for Reporting*
99205	60-74 minutes
99205 x 1 and 99417 x 1	89-103 minutes
99205 x 1 and 99417 x 2	104-118 minutes
99205 x 1 and 99417 x 3 or more for each additional 15 minutes.	119 or more

*Total time is the sum of all time, including prolonged time, spent by the reporting practitioner on the date of service of the visit.

We strongly agree with CMS that reporting code 99417 after the minimum time of code 99205 or 99215 is met would be double counting time. Given the value and time associated with code 99417, it is inconceivable that this code should be reported for only 1 minute above the time range of codes 99205 or 99215. We believe that Table 22 represents correct reporting of 99417 and strongly urge CMS to finalize this proposed reporting requirement.

E/M Inherent Complexity Add-on Code

CMS has finalized the addition of an add-on code GPC1X (*Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious, or complex chronic condition. (Add on code, list separately in addition to office/outpatient evaluation and management visit, new or established)*) CMS continues to assert that this code is needed because the typical visit described by the revised and revalued office/outpatient E/M visit code set still does not adequately describe or reflect the resources associated with primary care and certain types of specialty visits. CMS seeks input on aspects of the code definition that are unclear, how the Agency might address the concerns, and how CMS could refine its utilization assumptions.

The SVS does not believe that code GPC1X is a separately identifiable service given the extensive changes to the office/outpatient E/M codes. Specifically, CMS stated in the CY 2019 final rule that the code was created "to recognize additional relative resources for primary care visits and inherent visit complexity that require additional work beyond that which is accounted for in the single payment rates for new and established patient levels 2 through level 5 visits." That rationale no longer holds true under the finalized policy of retaining the multiple levels, because physicians may bill a higher-level E/M code for such visits, based on the level of MDM or time.

The revised CPT MDM table and inclusion of physician or QHP face-to-face and non-face-to-face time in the revised codes was specifically meant to reflect increased resources as patient encounters were more complex or time consuming. We also note that the AMA and almost all of the medical and surgical specialties agreed that GPC1X was not necessary given the ability to upcode based on MDM or time. This is important because the AMA E/M Workgroup

specifically included an add-on code (99417) to account for more time and resources in response to the earlier CMS proposals.

Another consideration is that over the past several years, CMS and the AMA CPT Panel have created numerous new "global" codes for primary care services (e.g., TCM and CCM). These codes were specifically established to report are typically reported every 30 days for the longitudinal "between visits" work over a 30-day period. Since the inception of these codes and establishment of work RVUs, the Agency has whittled down the list of codes that may not be separately reported and now allows almost any code to be reported in conjunction with these 30-day global codes. We contend that these 30-day global codes represent the intent of GPC1X, which is providing reimbursement for holistic, patient-centered, longitudinal care.

The AMA RUC, the CPT Editorial Panel, and the large majority of the medical community has continued to express opposition to the GPC1X add-on code. CMS' refusal to acknowledge these comments appears to be an attempt to shift money to specific specialties. This add-on code, the descriptor, and the resources are not justified and instead duplicate the services described by 30-day global care management codes. **For these reasons, we continue to urge CMS not to implement this flawed and wasteful code.**

Global Services

This proposed rule does not include any new proposals to apply the office visit incremental RVU and time increases to the visits bundled into the global surgery codes. The SVS strongly rejects CMS' establishment of a two-tiered system for evaluation and management services. We are insulted by CMS' ongoing argument that they do not believe physicians are performing follow-up care with their patients. Stakeholders have articulated in great detail the fatal flaws with the RAND study, which CMS uses to defend their position that physicians are not seeing patients for follow-up care. We reiterate that it is inappropriate for CMS to not apply the RUC-recommended office visit RVU and time changes to global codes starting in CY 2021.

Time Values for Levels 2-5 Office/Outpatient E/M Visit Codes

In the CY 2020 PFS proposed rule, CMS sought comment on the times associated with the office/outpatient E/M visits as recommended by the AMA RUC. CMS acknowledged a need for clarification given that when surveying these codes for purposes of valuation, the AMA RUC requested that survey respondents consider the total time spent on the day of the visit, as well as any pre- and post-service time occurring within a timeframe of three days prior to the visit and seven days after, respectively. The resulting analysis and recommendations resulted in two conflicting sets of times: (1) the sum of the component times as surveyed; and (2) the total time as surveyed. CMS states that it believes it would be illogical for component times not to sum to the total. To address the perceived inconsistencies, CMS proposes to adopt the actual total times as the sum of the component times, instead of the RUC-recommended total time.

We agree with CMS that the time data submitted by the RUC is conflicting. We also agree that the RUC survey of the E/M codes that included collection of time before and after the day of the

encounter is inconsistent with the reporting of these codes for time only on the day of the encounter. We have previously argued that this survey methodology resulted in an overestimation of time and work. That said, we strongly agree with CMS that the total time in the CMS work time database should reflect the sum of the pre-, intra-, and post-times collected using the RUC survey. We support use of the actual total time that CMS presents in Table 17. This methodology is consistent with the total times for all other codes in the fee schedule.

Update on Technical Expert Panel Related to Practice Expense

Payments made under the MFS reflect physician work, professional liability insurance, and practice expense (PE) components. The current PE methodology for setting rates relies in part on data collected in the Physician Practice Information (PPI) Survey. In the current system, PE is broken into *direct* and *indirect* components. Direct PE includes nonphysician clinical labor, disposable medical supplies, and medical equipment that are typically used to provide a service. Indirect PE relates to such expenses as administration, rent, and other forms of overhead that cannot be attributed to any specific service. CMS has stated that they are interested in refining the PE methodology and updating the data used to make payments under the PFS. The Agency goes on to say *they believe that potential refinements could improve payment accuracy and strengthen Medicare*. While those goals are laudable, the data/results included in the *Practice Expense Methodology and Data Collection Research and Analysis Interim Phase II Report (RAND)* are alarming. Table 7.3. *Impact of Using Outpatient Prospective Payment System–Based Relative Values for Total Practice Expense Relative Value Units, by Specialty* illustrates wild shifts in potential impacts to specialties including a decrease of 27% for vascular surgery. A fundamental flaw in the study is the use of hospital outpatient costs as the basis to re-establish PE RVUs. The Agency has received countless comments over the years from stakeholders identifying egregious flaws in the outpatient cost data. So often hospitals use APC payments to quantify their costs, which is a circular methodology and highlights the unreliability of these data.

CMS also states that they would like to "obtain[ing] the data as soon as practicable". The specialty society community implores the Agency to slow down and work closely with stakeholders to analyze alternatives and/or modifications to the PE methodology. While CMS notes that they are *interested in hosting a Town Hall meeting at a date to be determined to provide an open forum for discussion with stakeholders,* it is critical that the Agency make informed decisions from the information collected in Town Hall meetings as well as utilizing Technical Expert Panels. Holding a Town Hall conference call only in name is disingenuous and will lead to uninformed policy.

There is discussion in this proposed rule as well as within the AMA to conduct another PPIS survey to update physician and practice costs. If a new PPIS survey is to be conducted, it is imperative that the Agency and the AMA work closely with specialties to determine the most cost effective and thorough way to ensure all practice costs are captured. In this time of devastating cuts in reimbursement to physicians and practices, along with the global pandemic, it is critical that specialty societies have a seat at the table to create an appropriate survey tool.

Proposed Valuation of Specific Codes for CY 2021

Toe Amputation (CPT codes 28820 and 28825)

In January 2019, the RUC identified CPT code 28820 through a site of service anomaly screen based on the review of three years of data (2015, 2016 and 2017) for services with utilization over 10,000 in which a service is typically performed in the inpatient hospital setting, yet only a half discharge day management (99238) is included. The specialties recommended to CMS prior to conducting the RUC survey that it would be appropriate for these services to have their global period changed from 090-day to 000-day. CMS did not object to the proposed global period change when provided with the rationale and the RUC agreed with the specialties that the global period change would be appropriate.

CPT Code 28820: CMS disagreed with the RUC recommended work RVU of 4.10 and proposed a work RVU of 3.51 based on a direct work RVU crosswalk to CPT code 33958 *Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older (includes fluoroscopic guidance, when performed)* (work RVU= 3.51, intra-service time of 30 minutes, total time of 118 minutes). **To reduce the value of this procedure, CMS cherry-picked a seldom-used low-valued code as a crosswalk rather than relying on the commonly performed MPC-list codes chosen by the RUC. This is a completely arbitrary and capricious crosswalk choice. Toe amputations are not subject to abuse. No one will perform a toe amputation unless a patient needs it, and typically these patients are sick diabetics.** The Agency noted that their decision to reject the RUC recommendation was principally based on a large reduction in physician total time due to the change in the code's global period without demonstrating that they also considered the disparity between the physician work intensity of the post-operative services that were previously bundled in 28820 and the physician work intensity of the skin-to-skin time of the service. With the change in global period, a much higher proportion of the total time will now be skin-to-skin time, which would logically make the overall work per unit time (WPUT) of the service higher.

The RUC recommendation was based on the 25th percentile work RVU of 4.10 from robust survey results and comparison to reference code 11044 *Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less* (work RVU= 4.10, intra-service time of 45 minutes, total time of 116 minutes) and noted that even though the reference code has more intra-service time, both codes involve similar total time and the survey code has much more intense surgical skin-to-skin time. The RUC also compared the survey code to MPC code 52441 *Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant* (work RVU= 4.50, intra-service time of 30 minutes, total time of 93 minutes) and noted that both codes have identical intra-service times and the survey code is appropriately valued somewhat less than the relatively more intense MPC reference code.

First, it is worth noting that the Agency mis-valued code 28820 when it was last reviewed. The Agency did not accept the RUC recommendation when this service was previously valued and instead used a reverse building block methodology to modify the times and work value to value the service as if it is outpatient, even though that was not reflected in the most current Medicare

claims data available at the time (54 percent inpatient). This means that the current work RVU of 5.82 is based on a flawed methodology that the intraoperative work intensity (IWPUT) of 0.017 and WPUT of 0.027 are both significantly lower than a majority of procedures and services in the PFS and do not represent relativity. Furthermore, there has been a change in the patient population typical for this code. Diabetic patients requiring 28820 have multiple co-morbidities and increasingly present for toe amputation compromised and resistant to antibiotics.

The crosswalk code that the Agency used to support its proposal to reject the RUC recommendation, 33958, is not an appropriate reference code to use for making valuation decisions. This is an atypical 000-day global code that includes a bundled inpatient hospital visit making it inappropriate to use as a direct work value crosswalk for a service that does not include bundled visits. In addition, code 33958 is rarely performed (a total of 72 times based on 2019 Medicare claims data) and involves disparate work from the survey code. Furthermore, 33958 has a low IWPUT of 0.048 which resulted from the Agency having rejected the RUC recommendation for this service for CY 2015 while still maintaining the RUC's physician time recommendations. Beyond conducting a flawed time ratio analysis of the survey code and then performing a basic search of the RUC database to identify another service with similar times and values to that analysis, it is unclear whether any other criteria were used to identify this reference code as the NPRM did not include a clinical comparison between this service and the survey code. This is a very useful example of the pernicious effect of CMS's arbitrary downward adjustment of RUC recommendations being "carried forward" to unbalance the relativity of the overall PFS.

Treating all components of physician time (pre-service, intra-service, post-service and post-operative visits) as having identical intensity is incorrect and inconsistently applying similar intensities to only certain services under review creates inherent payment disparities in a payment system which is based on relative valuation. The physician work intensity of the post-operative services that were previously bundled in 28820 is a fair amount lower than the physician work intensity of the skin-to-skin time of the service, making a change in total time comparison particularly problematic. As mentioned above, the RUC compared CPT code 28820 to key reference CPT code 11044 *Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less* (work RVU= 4.10, intra-service time of 45 minutes, total time of 116 minutes), and to MPC reference code 52441 *Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant* (work RVU= 4.50, intra-service time of 30 minutes, total time of 93 minutes), and based the work RVU recommendation of 4.10 not only on intra-service time but also on physician work intensity; this is a much more representative comparison than the one that CMS proposes to use. SVS urges CMS to accept the work RVU of 4.10 for CPT code 28820. In addition, we urge CMS to abandon crosswalks to codes whose values have been adjusted from the original RUC recommendations.

CPT Code 28825: CMS disagrees with the RUC recommended work RVU of 4.00 and proposes a work RVU of 3.41 based on an increment relationship with CPT Code 28820 *Amputation, toe: metatarsophalangeal joint*. The Agency noted that they do not believe the RUC-recommended reduction in work RVU from the current value of 5.37 is commensurate with the RUC

recommended 97 minute reduction in total time and that a further reduction in work RVUs is warranted given the significance of RUC-recommended reduction in physician time.

As with code 28820, the Agency noted that their decision to reject the RUC recommendation was principally based on a large reduction in physician total time due to the change in the code's global period without demonstrating that they also considered the disparity between the physician work intensity of the post-operative services that were previously bundled in 28825 and the physician work intensity of the skin-to-skin time of the service. With the change in global period, a much higher proportion of the total time will now be skin-to-skin time, which would logically make the overall work per unit time (WPUT) of the service higher.

The RUC recommendation was based on the 25th percentile work RVU of 4.00 from robust survey results and comparison to reference code 11044 *Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less* (work RVU= 4.10, intra-service time of 45 minutes, total time of 116 minutes) and noted that it was appropriate to value 28825's work RVU slightly lower than 11044's due to the disparity in total time (and particularly in intra-time) despite the higher intensity and complexity of work associated with 28825.

SVS agrees that relativity should be maintained between codes 28825 and 28820 and that a difference of 0.10 work RVUs is appropriate (per the RUC's recommendation). As noted in the comments on code 28820, however, CMS' recommendation of 3.51 work RVUs for code 28820 is inherently flawed given the initial mis-valuation of the procedure, the change in the patient population, and the Agency's oversight of differences in physician work intensity. Therefore, CMS' recommendation of 3.41 work RVUs for code 28825 is inherently flawed for the same reasons. **Toe amputation is not an operation that is subject to abuse. There is no perverse financial incentive that would lead a surgeon to cut someone's toe off. These operations are performed on sick diabetics. Oftentimes, the patients present with sepsis from the infected and gangrenous toe. The operations are typically performed emergently to eliminate the source of sepsis. The RUC's recommendation is entirely reasonable. The CMS recommendation to reduce the work value of this code represents an affront to diabetic Medicare patients and the physicians who are willing to care for them.** SVS urges CMS to accept a work RVU of 4.00 for CPT code 28825.

Direct Practice Expense Inputs (28820 and 28825)

Facility Pre-Service Clinical Labor Time

As select major surgical global procedures with a 090-day global move to an assignment of 000-day in recognition of multi-modal postoperative work, it is important to note that these are still the same major surgical procedures with respect to the preoperative clinical staff work. As noted in the introduction of this section, the change to a 000-day global for 28820 and 28825 was requested to account for variable postoperative care and in no way changes the major procedure pre-service clinical staff work that is typical for major surgical procedures; the RUC agreed that the 090-day global major surgery pre-service standard for the facility setting was appropriate.

Codes 28820 and 28825 are major procedures that are typically performed in a facility setting (98% and 94%, respectively) under general anesthesia on a typical patient with multiple comorbidities including diabetes and peripheral vascular disease. According to the specialties, clinical staff typically make multiple phone calls with the office of the primary care provider and other physician specialists to obtain medical history and with the patient/family to pre-plan for post discharge at-home assistance and ambulation equipment. Preoperative clearance for anesthesia and scheduling space and necessary equipment in the operating room is necessary. Clinical staff provide education about the procedure and answer patient/family questions regarding the risks, benefits, and complications of the procedure. This is not just "extensive use of clinical staff" related to procedures that have always had an assignment of 000-days or 010-days, for example endoscopy or laceration repair.

We disagree with CMS' proposed imposition of a standard for these codes without regard to the clinically significant information that has been provided. CMS re-assignment of global periods for select codes does not negate the fact that a service is a major procedure; the pre-time facility clinical staff time for a major procedure is independent of the global assignment. SVS urges CMS to accept the RUC-recommended preoperative clinical staff time of 60 minutes for codes 28820 and 28825.

Non-facility Intra-service Clinical Labor Time – CA011

CMS is proposing to refine the Non-facility clinical labor time for the "Provide education/obtain consent" (CA011) to an established standard time of 2 minutes from the RUC recommended 5 minutes.

CMS accepted extensive use of clinical staff in the non-facility setting for both codes – which did not include the 7 minutes that applies to the extensive use inputs. The societies explained and the RUC agreed that the standard non-facility 0-day global extensive use of clinical staff for this activity is 7 minutes, however, this activity will typically be provided in office on the day of service, instead of in the pre-service period. The clinical staff work related to education for this major procedure is not standard and not insignificant and we urge CMS to accept the RUC-recommended 5 minutes of education for codes 28820 and 28825.

Non-facility Intra-service Clinical Labor Time – CA013

CMS is proposing to refine the Non-facility clinical labor time for the "Prepare room, equipment and supplies" (CA013) to the standard time of 2 minutes from the RUC recommended 5 minutes.

We disagree that 2 minutes is sufficient for the clinical staff to not only set up the room in standard fashion as for an E/M service, but to also set up the supplies, cautery and suction machines (confirm running correctly) and the medium instrument pack. These supplies and multiple pieces of equipment are not typical for most office procedures. It is important to note that the 2 minutes standard was developed based on setting up a room for an E/M service, not a major procedure. It is also more important to note that CMS proposed accepting the RUC-

recommended time of 4 minutes for CA013 for E/M codes in 2021. Clearly, if an office E/M service room set up takes 4 minutes, a major procedure with multiple pieces of equipment and many supplies will require more time. SVS urges CMS to accept the RUC-recommended CA013 time of 5 minutes for codes 28820 and 28825.

Non-facility Equipment Time

CMS is proposing to refine the equipment time to conform to the proposed changes in the clinical labor time. SVS urges CMS to accept the information provided above regarding clinical staff time and apply the RUC-recommended times to the equipment time for codes 28820 and 28825.

Venography (CPT codes 75820 and 75822)

The review of CPT code 75820 (Venography, extremity, unilateral, radiological supervision and interpretation) was prompted by the Relativity Assessment Workgroup Medicare utilization screen of over 20,000 claims in a year. CPT code 75820 currently has a work RVU of 0.70 with 14 minutes of total time. This service involves the supervision and interpretation of a contrast injection and imaging of either the upper or lower extremity. For CPT code 75820, the RUC recommends 12 minutes preservice time, 20 minutes intraservice time, 10 minutes postservice time and 42 minutes of total time. The specialty societies' survey at the 25th percentile yielded a 1.05 work RVU, and it is the RUC's recommended work value. CMS is proposing the RUC recommended value for CPT code 75820.

CPT code 75822 (Venography, extremity, bilateral, radiological supervision and interpretation) was reviewed as part of the family of codes included with CPT code 75820. CPT code 75822 has a current 1.06 work RVU and 21 minutes of total time. The RUC recommended 15 minutes preservice time, 30 minutes intraservice time, 12 minutes postservice time and 57 minutes of total time, and the survey's 25th percentile work RVU of 1.48. The service is similar to CPT 75820, except that this CPT code is bilateral, involving the supervision and interpretation of a contrast injection and imaging of both of either the upper or lower extremities. The RUC recommended 1.48 work RVU and 57 minutes of total time for CPT code 75822. CMS is proposing these RUC recommended values for CPT code 75822.

SVS appreciates that CMS is proposing the RUC-recommend values for CPT Codes 75820 and 75822 as well as the direct PE inputs without refinements.

Percutaneous Creation of an Arteriovenous Fistula (AVF) (HCPCS code G2170 and G2171)

For CY 2019, based on two new technology applications for arteriovenous fistula creation, CMS established two new HCPCS codes to describe the two modalities of this service. Specifically, CMS established HCPCS code C9754 (Creation of arteriovenous fistula, percutaneous; direct, any site, including all imaging and radiologic supervision and interpretation, when performed and secondary procedures to redirect blood flow (e.g., transluminal balloon angioplasty, coil embolization, when performed)) and HCPCS code C9755 (Creation of arteriovenous fistula,

percutaneous using magnetic-guided arterial and venous catheters and radiofrequency energy, including flow-directing procedures (e.g., vascular coil embolization with radiologic supervision and interpretation, when performed) and fistulogram(s), angiography, venography, and/or ultrasound, with radiologic supervision and interpretation, when performed).

The HCPCS codes CMS created were for institutional payment systems, and thus did not allow for payment for the physician's work portion of the service. Stakeholders have stated that the lack of proper coding to report the physician work associated with these procedures is problematic, as physicians are either billing an unlisted procedure code, or are billing other CPT codes that do not appropriately reflect the resource cost associated with the physician work portion of the service. Stakeholders stated that separate coding for physician payment will allow billing when the procedures are furnished in either a physician office or an institutional setting, and be paid under the respective payment systems, as appropriate.

CMS has recognized that the lack of appropriate coding for this critical physician service has become an even greater burden given the PHE that was declared effective January 27, 2020 for the COVID-19 epidemic. In order to mitigate potential health risks to beneficiaries, physicians and practitioners as a result of having this procedure performed in an institutional setting, CMS created two HCPCS G codes for percutaneous creation of an arteriovenous fistula (AVF). CMS stated that the codes went into effective July 1, 2020 and will be contractor priced. CMS argued that this change *will allow for more accurate billing and coding of a crucial physician service that could then be performed in both institutional and office settings, thus mitigating unnecessary risk to beneficiaries, physicians and practitioners caused by disease transmission.*

The HCPCS G codes are described as follows:

- HCPCS G code G2170 (Percutaneous arteriovenous fistula creation (AVF), direct, any site, by tissue approximation using thermal resistance energy, and secondary procedures to redirect blood flow (e.g., transluminal balloon angioplasty, coil embolization) when performed, and includes all imaging and radiologic guidance, supervision and interpretation, when performed.)

- HCPCS G code G2171 (Percutaneous arteriovenous fistula creation (AVF), direct, any site, using magnetic-guided arterial and venous catheters and radiofrequency energy, including flow-directing procedures (e.g., vascular coil embolization with radiologic supervision and interpretation, CMSn performed) and fistulogram(s), angiography, venography, and/or ultrasound, with radiologic supervision and interpretation, when performed.)

However, if CMS' intent was to provide expanded access to this "*crucial physician service*" it is critical that they communicate that with their MACs. National Government Services (NGS) published a proposed local coverage determination (LCD) regarding Percutaneous Arteriovenous Fistula (pAVF) for Hemodialysis (DL38573), which included these two new G Codes on June 24th, 2020 with the comment period ending July 18th, 2020. In the LCD NGS stated "Coverage of the WavelinQ system must await resolution of ongoing safety issues as well as longer-term

data" thus eliminating reimbursement for a service that has been covered in the hospital outpatient setting since 2019. First Coast Services Options (FCSO) also issued non-coverage guidance for these services in the office-based setting.

SVS urges the Agency to provide clear messaging to their MACs regarding coverage of G2170 and G2171. CMS' change effectively eliminated coverage for this service to thousands of Medicare beneficiaries during a global health crisis, requiring America's seniors to pay out of pocket for this "critical service".

Updated Supply Pricing for Venous and Arterial Stenting Services

The use of the "stent, vascular, deployment system, Cordis SMART" (SA103) supply is no longer typical in CPT codes 37238 (Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; initial vein) and 37239 (Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; each additional vein). A new venous stent system has become the typical standard of care for these services, and a stakeholder supplied ten invoices for use in pricing this supply. As such, CMS is proposing to remove the SA103 supply item from CPT codes 37238 and 37239. CMS is proposing to replace it with a newly created "venous stent system" (SD340) supply at the same supply quantity. CMS is proposing a price of $1,750.00 for the venous stent system. SVS supports the proposed change to replace the stent for CPT Codes 37238 and 37239.

Market-Based Supply and Equipment Pricing Update

For CY 2021, CMS received invoice submissions for approximately a dozen supply and equipment codes from stakeholders as part of the third year of the market-based supply and equipment pricing update. The submitted invoices were used in many cases to supplement the pricing originally proposed for the CY 2019 PFS rule cycle. CMS reviewed the invoices as well as prior data for the relevant supply/equipment codes to make sure the item in the invoice was representative of the supply/equipment item in question and aligned with past research.

SD136 vascular sheath

The proposed price for the vascular sheath (SD136) was determined by removing the sheath from the eight submitted kit invoices and then averaging the resulting price together with the single standalone sheath invoice. SD136 can be found in over 70 CPT codes, not just RF services. SVS does not support this proposed pricing methodology. The current pricing of $52.80 is more representative of the sheaths used in the variety of procedures with SD136 as a direct supply.

SD155 catheter, RF endovenous occlusion

The proposed price for the RF endovenous occlusion (SD155) was also determined by removing

the catheter from the eight submitted kit invoices and then averaging the resulting price together with the single standalone catheter invoice. This methodology results in CMS is proposing to establish a price of $382.50 for SD155. SVS believes the methodology outlined significantly undervalues SD155. SVS urges the Agency to update the CY2021 pricing for SD155 to more appropriately reflect the actual cost of the catheter.

SD089 guidewire, hydrophilic

CMS is proposing an updated price of $13.35 for SD089 for CY2021. SVS urges the Agency to update the CY2021 pricing for SD089 to more appropriately reflect the actual cost of the hydrophilic guidewire.

Proposal to Remove Selected National Coverage Determinations (NCDs)

CMS proposed to remove nine NCDs from the Medicare National Coverage Determinations Manual. CMS solicited comments on the nine NCDs discussed in Table 37, as well as comments recommending other NCDs for CMS to consider for removal. SVS requests NCD 240.6 Transvenous (catheter) pulmonary embolectomy be added to the list of outdated/obsolete NCDs that are being considered for removal.

One of the Agency's criteria for removal is "in the case of a noncoverage NCD based on the experimental status of an item or service, the item or service in the NCD is no longer considered experimental". The procedure described in NCD 240.6 has not been considered experimental for quite some time. Numerous national and international standards and guidelines now support the routine use of catheter based pulmonary embolectomy (thrombectomy) for pulmonary embolism.

Removing the broad non-covered status for embolectomy for pulmonary embolism would eliminate the barrier to this innovative technology and reduce burden for beneficiaries and CMS. This would also allow MAC to cover the service if the MAC determined that such action was appropriate.

Withdrawal of this NCD should be prioritized because of the COVID-19 pandemic. There is rapidly mounting evidence in the peer-reviewed clinical literature about the link between COVID-19 and thrombotic complications, including a high incidence of acute PE and venous thromboembolism (VTE).

Our physician members on the front lines of the pandemic need to ensure that treatment of these critically ill patients is not compromised by outdated, non-applicable coverage policies that limit access to proven, medically necessary services. **SVS urges the Agency to add NCD 240.6 to the list of outdated/obsolete NCDs being considered for removal for CY2021.** The policy is not aligned with the current standard of care for PE treatment.

Technical Corrections to Direct PE Input Database and Supporting Files

SVS requests that CMS update the unit type for SA122 clarivein kit to "kit" in the CMS database.

Telehealth and Other Services Involving Communications Technology

Under its current policy, CMS adds services to the Medicare telehealth services list on a Category 1 basis when it determines that they are similar to services on the existing Medicare telehealth services list for the roles of, and interactions among, the beneficiary, provider at the distant site and, if necessary, the telepresenter. The Agency states that the Category 1 criteria streamlines its review process for publicly requested services that fall into this category and expedites its ability to identify codes for the Medicare telehealth services list. For CY 2021, CMS proposes to add 9 services to the Medicare telehealth services list on a Category 1 basis.

CMS' process for adding services to the Medicare telehealth list merely indicates that a given face-to-face code can be furnished and paid for using audio-video communications technology. **When making these additions, the Agency does not address the inherent differences in the provision of an in-person versus telehealth service, such as physician work, clinical staff time, and supplies and equipment—these same differences may also vary across various telehealth services and the platforms used to furnish them.** We question if CMS believes, for example, that the cost of providing a service is the same when rendered by (1) an internet-based provider group with no brick-and-mortar office presence; (2) a physician who has integrated a telehealth platform into their office's workflow and electronic systems; and (3) a physician who furnishes the service face-to-face with the patient. We are concerned that the budgetary impact on the Medicare program would be substantial if CMS proceeded to adopt a policy of paying for these three different services at the same rate, despite significant variation in practice expense and other related costs. To account for these differences, we urge CMS to create new telehealth codes for each face-to-face code added to the Medicare telehealth list that reflect the applicable underlying service and include the appropriate inputs needed to provide the service specifically via a telehealth platform. **The Agency should collaborate with the CPT Editorial Panel and the RUC to develop such codes and related guidelines for proper billing and documentation.**

CY 2021 Updates to the Quality Payment Program

Merit-based Incentive Performance System (MIPS)

MIPS Value Pathways

Proposed Rule: CMS is proposing to postpone implementation of the MIPS Value Pathways (MVP) participation option until 2022 at the earliest to allow additional time for stakeholder input on the MVP framework. CMS is proposing additions to the MVP guiding principles and MVP candidate development and submission process. CMS proposes that stakeholders consult patients and/or patient representatives as part of the MVP development process as a pre-requisite

for CMS to consider the candidate MVP and must include the full set of Promoting Interoperability measures in their MVP. CMS proposes a process to discuss any recommended modifications to the MVP candidate with stakeholders before the MVP candidate is established through rulemaking.

The SVS agrees with CMS that due to the 2019 Novel Coronavirus (COVID-19) pandemic Public Health Emergency (PHE) and the need for clinicians to focus on patient care, the timeline for implementation of any MVPs should be delayed until at least 2022. MVPs may have the potential to eliminate reporting hassles for physicians participating in MIPS, but each will require significant input from physicians in the development and implementation of MVPs. MVPs are a novel episode-based approach to MIPS that and may be helpful if CMS does not rush forward. MVPs not developed in partnership with physician organizations may not be successful in achieving the goal of increasing the clinical relevance of MIPS for both physicians and patients.

In addition, just as CMS took a phased-in implementation approach to MIPS in 2017 and 2018, the first two years of each new MVP should also be designated as a "transition period." It will take time to develop, refine, implement, and educate physicians regarding their participation in an MVP. Physicians may also be concerned that by adopting the new MVP approach, they will be at risk for a substantial negative payment adjustment. **We urge CMS to hold physicians harmless from a penalty for the first two years of their participation in a new MVP**. This transition period should be rolling and begin when a new MVP is introduced into the program.

A transition period is critical for incentivizing specialists who have been participating at a group level but would have the opportunity to move to sub-group participation in an MVP, which is potentially more administratively burdensome than reporting as a group. CMS should also consider the expenses to adopt and administer an MVP for physicians in small practices who have been reporting via electronic health records. We urge CMS to consider incentives to participating in MVPs, such as aligning scoring of MVPs with MIPS alternative payment models (APMs) and across payment systems similar to the facility-based scoring methodology.

We believe the programmatic elements utilized creation and reporting in MVPs should demonstrate the following:

- **High level of reliability:** Physician performance on any administrative claims measure should not be used for payment or be publicly reported unless a minimum reliability of 0.80 can be demonstrated with the claims data and the risk adjustment model is developed, tested, and released for comment prior to implementation. Social risk factors must be adequately addressed in the risk adjustment model before an MVP is implemented.

- **Robust testing of the validity of the measure:** The attribution approach must be tested to demonstrate that the assignment of the quality and costs measures in an MVP to specific physicians, groups, and specialties is clinically appropriate and tied to the physician's or group's ability to meaningfully influence the outcome.

- **Timely and relevant information:** Notification in real time of which patients will be attributed to a physician or group for any of the elements in an MVP could help reduce costs and avoid unnecessary services such as a readmission. Timely and relevant information is critical for physicians and practices participating in MVPs.

The SVS appreciates the opportunity to provide the following input on the revisions to the principles and the proposed process and criteria on which MIPS Value Pathways (MVP) would be assessed.

MVP Reporting - SVS believes that MVPs should be organized around specialties and sub-specialty areas of practice and at a minimum, should be delayed or voluntary only until such time as this can occur. We appreciate CMS' recognition of the importance of subgroup reporting in the second MVP guiding principle and urges the agency to provide specific information on its operationalization in the final rule. Consistent with our previous comments, we continue to believe subgroup reporting will be crucial to MVPs as it would facilitate participation by specialists who may be practicing within multispecialty groups. Currently, a clinician has three options to choose among for MIPS data reporting: individually, as a virtual group (which is limited to solo practitioners and small groups), or as a group (which includes all MIPS eligible clinicians within a TIN). Physicians who are part of a group practice would like to report separately from the larger group and instead partner with their colleagues in the same or similar specialty. **The SVS supports allowing an option for a portion of a group to report as a separate subgroup for purposes of an MVP or traditional MIPS. This would allow a specialty in a multispecialty group to form a subgroup to report on MVPs that are more clinically relevant to that particular specialty. We urge CMS to provide specific information about how subgroups can form and opt-in to MVPs within the final rule.**

Reported Outcome, Experience or Satisfaction Measures: Another proposed question that raises concern is whether the MVP would include patient-reported outcome, experience, or satisfaction measures. SVS is in the process of assessing the use of patient reported outcomes tools in vascular surgery and in developing MVP candidates for care of patients with vascular disease. **Therefore, we seek clarification in the final rule on the extent an approval of an MVP would be withheld if patient reported outcomes measures were not available at this time.**

Process to Solicit MVP Candidates: While a rolling review process would expedite MVP selection, CMS needs to create a deadline-based process that includes an opportunity for a medical society to meet with CMS during the development process of an MVP and also to hear feedback regarding its evaluation post submission. The evaluation process for MVPS must be as objective as possible and completed in coordination with the relevant specialties and sub-specialties.

Medical specialty societies must be at the table as any applicable MVP is evaluated. **SVS urges CMS to publish a process that ensures that the appropriate specialties and sub-specialties are consulted during the evaluation. And, that medical societies are given the opportunity to request a pre-meeting with CMS during the development process.**

QPP Program Hardship Exemption

Proposed Rule: CMS has proposed no change to policy for individual clinicians, groups, and virtual groups.

The SVS strongly urges CMS to extend the extreme and uncontrollable circumstances hardship exception flexibilities due to the COVID-19 public health emergency (PHE) through at least 2021. We appreciate CMS' rapid and flexible response to the public health emergency by adopting MIPS extreme and uncontrollable circumstances hardship exception policies in both 2019 and 2020. We strongly urge CMS to continue to provide flexibility to physicians by extending these policies through 2021 in the final rule. Physicians need flexibility and minimal administrative burdens to ensure they can continue to meet the needs of patients while confronting new COVID outbreaks and slowing the spread of the virus. Physician practices have been under severe distress and experienced unprecedented practice disruptions during 2020. While the duration of the pandemic is unknown, it is reasonable to expect ongoing impacts from the novel coronavirus through 2021.

Following Medicare and CDC guidelines during the public health emergency, many practices delayed or cancelled care, resulting in reduced revenues for physicians and a changing care delivery system. While many practices have received payments from the CARES Act Provider Relief Fund and loans from the Medicare Advance Payment Program, they remain in financial distress. We are deeply grateful to CMS for being a leader in expanding access to telehealth for Medicare beneficiaries, which physicians quickly implemented to continue furnishing care. However, office-based surgeries cannot be furnished by telecommunications and to resume in-person care, practices have had to institute new safety and cleaning protocols, which limits the number of patients that can be seen a day. Some patients also continue to delay in-person visits or procedures due to fear of infectious disease exposure.

It is already the case that CMS will not have a clear picture of how 2020 MIPS participation and performance was impacted by the COVID-19 public health emergency until mid-way through 2021 or later. Therefore, CMS needed to announces an extension of these flexibilities in the final rule so that more physician practices can plan and determine the best way to allocate resources toward patient safety, keeping their doors open, continuing to combat the COVID-19 pandemic, and ongoing participation in MIPS.

MIPS Performance Threshold

Proposed Rule: CMS is proposing to raise the MIPS performance threshold to avoid a penalty from 45 points in 2020 to 50 points in the 2021, which is a more gradual increase than the previously finalized increase to 60 points. CMS is also proposing to maintain the exceptional performance threshold at 85 points in 2021.

SVS has concerns with CMS raising the performance threshold while the COVID-19 public health emergency is an ongoing crisis and continues to strain physician practices which are

facing reduced revenues and increased expenses to implement new safety protocols. In light of these hardships, CMS proposes to lower the performance threshold to avoid a corresponding MIPS penalty from the previously finalized 60 points to 50 points. Clinicians on the frontlines combatting COVID-19 have not had time to focus on MIPS. None of us know what the future will bring, how long the pandemic will continue to spread in communities throughout the country, and the long-term impacts of COVID-19. **For these reasons, we strongly support CMS' proposal to lower the performance threshold for 2021 and urge CMS to maintain the threshold at 45 points.**

Maintaining the performance threshold at 45 points will also help small and rural practices, which are at risk of closing due to their financial distress and have even fewer resources to devote to participation in MIPS. In addition, stability is essential as the final rule may not be released until as late as Dec. 1, 2020, giving physicians only one month to familiarize themselves with changes to the program that could result in significant penalties.

Similarly, we urge CMS to lower the additional performance threshold to ensure it is obtainable by physicians in all specialties, practice sizes, and geographic locations who continue to confront challenges posed by the ongoing COVID-19 pandemic. We disagree with CMS that it is necessary to maintain the additional performance threshold at 85 points to incentivize high performers. We question whether keeping the threshold at 85 points would actually discourage physicians from fully participating in MIPS if they believe the threshold to earn an exceptional bonus is unattainable due to the pandemic and significant uncertainty about benchmarks, attribution, and measure denominator requirements. Although we cannot predict the status of the public health emergency in 2021, it is reasonable to assume based on currently available information that physician practices will continue to be impacted by the pandemic into 2021 and will need months if not years to recover. We strongly urge CMS to err on the side of providing more flexibility and incentives to encourage participation in MIPS while physician practices continue to fight COVID-19.

Quality Performance Category

GPRO Web-Interface

Proposed Rule: CMS proposes to eliminate the GPRO web-interface as a collection type and submission type for groups and virtual groups beginning with the 2021 performance period. All other collection types for individuals, groups and virtual groups would remain the same in 2021.

The SVS urges CMS to postpone transitioning away from the GPRO web-interface and associated measures until 2023. While only about 20 percent of users of the GPRO Web-Interface participate in MIPS, the SVS does not support CMS' current timeline to eliminate this collection type for large groups. CMS provided no advance notice on this proposal, and practices will only have one month to transition to a new collection type, upgrade their IT systems and begin reporting on all-payer data due to the timing of the release of the final rule in the middle of a global pandemic. We recognize that practices can report on the same measures through other

collection types, but CMS' proposal and argument within the rule fail to recognize the time it takes to transition, and the costs required to upgrade reporting tools.

Quality Category Performance Weight Relative to Other Category Performance Weights

Proposed Rule: CMS proposes to lower the weight of the Quality Category performance score from 45 percent to 40 percent of the MIPS final score

The SVS strongly urges CMS to maintain the weight of 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 pandemic on the cost measures, frontline physicians' focus on continuing to care for patients during this crisis, and to provide physicians more time to familiarize themselves about their resource use.

CMS was granted increased flexibility in the Bipartisan Budget Act of 2018 (BBA) to set the performance threshold and category weights, and the SVS urges CMS to follow congressional intent. Altering the category weights before the cost category has been sufficiently refined leads to less stability with the program, adds complexity, and is counter to the Patients Over Paperwork initiative. The measures under the cost category are still quite new. In addition, many have questionable reliability, and it is unknown how the COVID-19 PHE will impact costs, including the addition of payment for telehealth. Physicians need time to review their cost data and opportunity to make improvements in practice. **We urge CMS to maintain the quality performance category final score weight at 45% in 2021 while the agency reviews the impact of COVID-19 on the cost measures.**

Data Completeness Criteria

Proposed Rule: CMS is proposing to increase the data completeness threshold when reporting on a quality measure from 60% of denominator eligible patients to 70% of denominator eligible patients.

SVS opposed the increase in the data completeness threshold to 60% and we oppose this proposed increase in the data completeness threshold to 70%. We continue to believe the proposal is in direct conflict with the Administration's effort to reduce the burdens of administrative tasks and with the added burdens related to the COVID-19 pandemic, SVS urges CMS to lower the data completeness threshold to 50% for all reporting mechanisms in 2021.

The proposal fails to recognize the time it takes to implement new measures or updates to measures into practice workflows, or the registry or Electronic Health Record (EHR), and further discourages practices from reporting on new measures. It also does not consider that vascular surgeons may practice at multiple locations with different systems and EHR vendors. Also, EHR vendors often do not complete updating the measure specification until after the beginning of the performance period and often charge for any requested changes. CMS also does not release measure specifications and educational materials in a timely manner and often in the middle of the performance period. If CMS is concerned about the adequacy of vendor reporting, then CMS

should implement corrective action with the vendors, rather than increase the reporting burdens for all MIPS-eligible clinicians.

Annual program changes such as this proposal increase the administrative burden and complexity of the MIPS program. Physicians do not stop complying with quality protocol once they hit minimum threshold requirements. However, they may just stop submitting data to CMS due to the administrative burden of data collection and reporting, especially if reporting on patient reported outcome measures and all-payer data.

Therefore, until physicians and other eligible clinicians can work within an environment where data and care are integrated seamlessly across settings, and providers, it is premature to increase data completeness and encourage reporting through a registry or EHR.

Cost Performance Category

Proposed Rule: CMS is proposing to increase the weight of the Cost Category performance score from 15% to 20% of the MIPS final score in 2021 and is also proposing to add telehealth services to the existing cost measures.

SVS objects to this proposal to raise the weighting of the Cost Performance Category to 20 percent of the MIPS final score calculation for the 2021 performance year. As we discussed above in the Quality Performance Category section, we believe CMS should maintain the weight of the Cost Performance Category at 15 percent of the final MIPS score considering the ongoing impact of the COVID-19 pandemic on physicians and Medicare beneficiaries. We are concerned there will continue to be disruptions to the cost measures in 2021 and possibly beyond due to the pandemic. **SVS urges CMS to maintain the cost performance category final score weight at 15% in 2021 while the agency reviews the impact of COVID-19 on the cost measures and to give physicians more time to become familiar with the sweeping MIPS cost performance category changes that took effect in 2020 during the pandemic.**

Many physician practices continue to face financial peril due to reductions in patient visits and surgeries resulting from stay-at-home orders and due to limited personal protective equipment, and they may not have a reliable case minimum for the TPCC, MSPB and episode-based cost measures. In addition, postponing preventive and routine care will skew patient attribution toward the sickest patients. **We understand CMS is monitoring the impact of the PHE on the MIPS cost measures and urge CMS to disclose those findings as quickly as possible. If the PHE causes disruptions to attribution and reliability, validity, actionability, or would negatively impact physicians on the frontlines of the COVID-19 pandemic, we urge CMS to reweight the cost performance category to zero.**

Additionally, physicians continue to familiarize themselves with the cost measures but have only received detailed feedback on their attributed patient population and cost measure performance for CY 2018 and 2019, which is when the first wave of episode-based cost measures went into effect. However, CMS made substantial changes to the cost category in 2020, including adding 10 new episode-based cost measures and significantly revising the total per capita cost (TPCC)

and Medicare Spending Per Beneficiary (MSPB) measures. These changes took effect during the PHE when physicians' focus shifted toward diagnosing and treating a novel coronavirus, rapidly implementing telehealth, and keeping their practices afloat. We greatly appreciate CMS recognized these trying circumstances and implemented a hardship exception for 2020, and we anticipate many physicians will opt out of MIPS entirely or for the cost category. **We urge CMS not to increase the weight of the cost category to maintain stability in MIPS, to give physicians more time to familiarize themselves with the 2020 changes to the cost category, and considering the ongoing disruptions caused by the COVID-19 pandemic**.

Physician Compare

Proposed Rule: CMS proposes to define Physician Compare to mean the Physician Compare Internet Web site of the Centers for Medicare & Medicaid Services (or a successor Web site).

We appreciate CMS taking a slow and methodical approach to expanding the available data publicly reported working to ensure that it meets high reliability standards. Accordingly**, we believe CMS should use qualifying information referencing the COVID-19 pandemic regarding any data related to the 2020/2021 performance years to prevent inaccurate distinctions about quality, and that this data should not be used for Physician Compare.**

We also ask that CMS create separate benchmarks for each reporting mechanism. CMS is currently mixing various reporting mechanisms when developing the benchmarks for Physician Compare, which CMS does not do when setting MIPS benchmarks. Therefore, CMS should create separate benchmarks for each reporting method instead of aggregating data from all reporting mechanisms.

Advanced Alternative Payment Models (AAPMs)

Proposed Rule:

For CY 2021, the QP threshold scores are set to increase above an amount that is obtainable by most physicians and APM entities.

SVS urges the agency to continue incentivizing participation in Advanced APMs by using every administrative lever to lower the thresholds for CY 2021 as well as work with Congress to address the statutory QP cliff. We support CMS' proposal to more accurately calculate QP threshold scores, to establish a targeted review for QP determinations, and to make adjustments so that COVID-19 does not prevent a physician or group from becoming a QP in an Advanced APM.

The QP thresholds are set to significantly increase in 2021, with many physicians participating in AAPMs not able to meet this expanded threshold number. CMS should ensure continued participation in Advanced APMs by reducing the patient count threshold to an obtainable level and by working with Congress to amend the statutory revenue threshold amounts.

The SVS supports CMS' proposal to establish a targeted review period for correcting QP determination errors made by CMS. We understand CMS' rationale for aligning the QP determination targeted review period with the MIPS targeted review period and we seek a clarification about how this will work in the event a physician wants to request a targeted review for both their QP status and their MIPS score. Would a QP be required to submit a separate targeted review challenging an error in their QP status calculation and a MIPS targeted review at the same time, or could one targeted review be submitted for both appeals? Would CMS prioritize the QP determination targeted review and respond to that appeal first? Ideally, the physician would know whether he or she is a QP and therefore excluded from MIPS first, as it could make the MIPS targeted review null and void.

SVS appreciates the opportunity to provide feedback on the proposed rule. If additional information is required, please contact trishacrishock@gmail.com.

Sincerely,

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