Our Vision:
A world in which all post-acute and long-term care patients and residents receive the highest-quality, compassionate care for optimum health, function, and quality of life.

September 27, 2019

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–1715–P; Medicare Program:** CY 2020 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; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations

Dear Administrator Verma:

AMDA – The Society for Post-Acute and Long-Term Care Medicine appreciates the opportunity to provide input to the Centers for Medicare & Medicaid Services (CMS) on the 2020 Physician Fee Schedule (PFS) and Quality Payment Program (QPP) proposed rule, published in the *Federal Register* on August 14, 2019 (84 Fed. Reg. 40482).

The Society is the only medical specialty society representing the community of over 50,000 medical directors, physicians, nurse practitioners, physician assistants, and other practitioners working in the various post-acute and long-term care (PALTC) settings. The Society’s 5,500 members work in skilled nursing facilities, long-term care and assisted living communities, continuing care retirement communities (CCRC), home care, hospice, PACE programs, and other settings. In serving this population, these clinicians care for the most high-risk and costly group of beneficiaries covered by Medicare and Medicaid programs.
Physician Fee Schedule

Care Management Services

- **Recommendation:** The Society is supportive of efforts to increase the utilization of care management services; however, CMS should inform Congress that positive updates to the Medicare conversion factor are needed to expand these services.

The Society is supportive of efforts to increase the utilization of these services and expand care management to additional patients. However, asking physicians to pay for these newly described services by redistributing money away from other important physician services is unfair. CMS must account for the savings for these services in decreased hospital visits and emergency visits to offset the cost of new and expanding coverage of care management services. CMS should also inform Congress that positive updates to the Medicare conversion factor are critical to expand these services, while maintaining the integrity of the valuation within the Resource-Based Relative Value System (RBRVS). The Society supports the use of CPT to describe all physician services and recommends that CMS work with the CPT Editorial Panel to implement changes in coding to describe care management.

1. **Transitional Care Management (TCM)**

CMS examined studies that conclude that patients who receive TCM services have lower hospital readmission rates, lower mortality, and incur lower costs. Based on these findings, CMS seeks to increase the utilization of TCM services and expand payment for care management. To incentivize additional utilization, billing requirements will be modified to allow TCM codes to be reported concurrently with other codes. The Society appreciates that CMS also proposes to increase payment for the two TCM codes as recommended by the RUC. The Society recommends that CMS finalize the RUC recommendations for TCM.

CMS proposes to disregard the current CPT guidelines and allow the codes listed in the guidelines to be reported, if performed, in conjunction with TCM. CMS should work with the CPT Editorial Panel to align reporting rules. In general, it adds confusion and administrative burden when CMS implements policy changes that differ from CPT. In addition, the Society notes that the following codes have either never been surveyed or have not been recently reviewed, making it difficult to fully assess if a potential overlap exists in the services: 99091, 99358, 99359, G0181, and G0182. If CMS finalizes a policy to allow additional reporting of concurrent care management codes, CMS should issue very clear guidance that physicians should not use multiple codes to describe the same service. For example, when reporting time-based codes, the same minute should only be counted once.

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1. CPT 2019 Guidelines: A physician or other qualified health care professional who reports codes 99495, 99496 may not report care plan oversight services (99339, 99340, 99374-99380), prolonged services without direct patient contact (99358, 99359), home and outpatient INR monitoring (93792, 93793), medical team conferences (99366-99368), education and training (98960-98962, 99071, 99078), telephone services (98966-98968, 99441-99443), end stage renal disease services (90951-90970), online medical evaluation services (98969, 99444), preparation of special reports (99080), analysis of data (99091), complex chronic care coordination services (99487-99489), medication therapy management services (99605-99607), during the time period covered by the transitional care management services codes.
2. Chronic Care Management (CCM)

CMS is also proposing to adopt new add-on codes for CCM, which will allow providers to bill incrementally to reflect additional time resources that are required in certain cases. CMS requests comment on whether to implement G codes for these expanded CCM codes for 2020 or wait for anticipated changes to CPT in 2021. CMS also proposes to clarify the language describing the comprehensive care plan required for CCM codes.

The AMA and the RUC have consistently commented that CMS should work with the CPT Editorial Panel to create CPT codes, rather than G codes. Transitioning back and forth between CPT and G codes is administratively burdensome. The CPT Editorial Panel is considering an application for new add-on codes for CCM in September 2019 for the CPT 2021 publication. Clarifications regarding the patient care plans are also part of the proposal to the CPT Editorial Panel. The Society strongly supports CCM services and we are encouraged that the initial CCM code 99490 has increased from 1 million in claims in 2015 to 4 million in claims in 2018. Additional codes and changes to CCM may be warranted, however, we encourage CMS to work with the CPT Editorial Panel to describe the services and consider data from the RUC on appropriate valuation.

Finally, we strongly urge CMS to clarify whether add-on codes are billable in the skilled nursing facility (POS 31) and nursing facility setting (POS 32). Currently, CCM codes are billable in SNF/NF per CMS payment policy. We urge CMS to adopt the same policy for the add-on codes and provide educational material making this determination clear.

3. Principal Care Management (PCM)

CMS proposes to create two new codes for PCM services, which would pay physicians for providing care management to patients with a single high-risk disease. The current CCM codes require patients to have two or more chronic conditions. CMS estimates an additional $125 million in annual spending for these services, offset by reductions to the Medicare conversion factor.

This proposal deserves serious consideration and discussion and is best reviewed by the CPT Editorial Panel. CMS proposes this time-based code at the same time it is proposing an add-on code to each office visit code for a very similar patient. In addition, there may be other codes that describe the work performed for these patients, including the office visit codes, just revalued to include time spent three days prior and seven days following each office visit. It is important that the service be appropriately described without overlap with other services. We recommend that the specialty society who presented these codes to CMS prepare a CPT coding application to be considered by the February 2020 CPT meeting and, if adopted, survey for resource costs for the April 2020 RUC meeting. CMS should include these recommendations for comment in the 2021 PFS proposed rule.

Due to the similarity between the description of the PCM and CCM services, CMS proposes that the full CCM scope of service requirements apply to PCM, including documenting the patient’s verbal consent in the medical record. The Society also supports requiring that the treating practitioner obtain verbal beneficiary consent in advance of these services, which would be documented by the treating practitioner in the medical record. However, CMS should provide an exception to this requirement where the treating practitioner documents that advance consent was not possible either due to emergency conditions or other exigent circumstances where a delay could result in negative patient health outcomes.
We strongly urge CMS to clarify whether add-on codes are billable in the skilled nursing facility (POS 31) and nursing facility setting (POS 32). Currently, CCM codes are billable in SNF/NF per CMS payment policy. We urge CMS to adopt the same policy for the add-on codes and provide educational material making this determination clear.

Payment for E/M Services

The Society greatly appreciates CMS’ proposal to align the previously finalized E/M office visit coding changes with the framework adopted by the CPT Editorial Panel. We urge CMS to finalize the CPT codes, CPT guidelines, and RUC recommendations exactly as implemented by the CPT Editorial Panel and submitted by the RUC. CMS should work with the medical community to urge Congress to implement positive updates to the Medicare conversion factor to offset the justified increases to office visits.

CMS in the proposed rule asks for comment on whether it would be necessary or beneficial to make systematic adjustment to other services to maintain relativity between those services and the office/outpatient E/M visits. In particular, CMS is interested in whether adjustments are necessary for E/M codes describing visits in other settings, including home care, nursing homes, and hospice. We believe that E/M outside of the office should be valued in proper relativity to the revised office visit codes. While we don’t have specific recommendations on what the best methodology is, we ask that CMS work in consensus with the full medical community to determine the appropriate value for specific E/M codes. We do not believe there will be a one size fits all solution. We also ask that CMS ensure that documentation guidelines are consistent between the office/outpatient E/M codes and codes describing E/M services in other settings. We urge CMS to do so in a timely manner.

Many geriatricians practice in multiple sites of care including office and the nursing facility. Having a system with two separate documentation requirements could pose significant confusion and paperwork burden as electronic health records and billing software will have to keep track of two distinct documentation requirements. Further, and more importantly, providing burden relief and added payment rates to one particular aspect of primary care without parity in skilled nursing facility (SNF) care could create unintended consequence of less clinicians electing to practice in the SNF. This gap in reimbursement levels continues to widen as CY2020 is proposing a decrease for SNF family of codes. Given that SNF payment is changing to the Patient Driven Payment Model (PDPM) that will require more engagement from clinicians, this lack of parity in payment could pose serious issues in incentivizing clinicians to practice in this setting. We certainly would not want to see a system where we are asking our most vulnerable population to travel to the office setting rather than having clinicians seeing patients in the SNF. We stand ready to work with CMS and the medical community to adopt a similar approach to paperwork reduction that produces parity and incentives for clinicians to take care of our medically complex vulnerable population.

Medicare Telehealth Services

- **Recommendation:** Rescind the limitation of one telehealth subsequent nursing facility care visit every 30 days reported by CPT Codes 99307 through 99310.
The Society was disappointed that CMS decided not to propose to remove the frequency limitation for subsequent nursing facility care services in CY 2020. We again urge CMS to rescind the limitation of one telehealth subsequent nursing facility care visit every 30 days reported by CPT Codes 99307 through 99310.

We are concerned that this limitation really stifles innovation and use of telehealth in the PALTC setting, which is vital to the continuum of care and where many seriously and chronically ill Medicare and Medicaid beneficiaries receive care. Demonstration projects, such as CMS’ Initiative to Reduce Unnecessary Hospitalization’s Among Long-Stay Nursing Home Residents, have utilized telehealth and have shown positive results. Other similar demonstrations that provide waivers to these rules have shown positive results and we believe should be adopted in the Medicare program. Rather than using an arbitrary limitation on visits, CMS should allow for the use of these services when they are medically necessary, as is the case for face-to-face visits in the nursing home setting.

We further recommend that CMS direct its contractors to monitor the utilization of these telehealth services to ensure they are not overutilized. If widespread evidence of overutilization becomes apparent, then CMS should consider applying limits that ensure appropriate care is being delivered and take appropriate action against those who submit these codes excessively and without medical necessity. But there is no reason to expect that these services would be overutilized and create an atmosphere of scrutiny that will discourage the utilization of this valuable technology that can help prevent hospitalization and rehospitalization by providing a more expedient practitioner evaluation and workup.

However, until evidence of overutilization is obtained, we believe an arbitrary and very low limit could hinder access to appropriate care under the telehealth benefit, especially in underserved areas. For a busy PALTC practitioner, if a single patient in a single nursing home 40 minutes’ driving distance away has a change of condition, it may be unrealistic to make the trip and lose several hours of otherwise potentially productive clinical time to see a single patient. Further, many transfers occur at night and on weekends when clinicians may be unavailable or may not have the necessary time or capacity to evaluate a patient enough to determine whether they should be sent to the hospital. In such instances, a telehealth visit may well obviate the need for an emergency room visit. Allowing for such visits anytime there is a significant change, makes intuitive sense, and may allow for more timely practitioner assessments of patients who need them.

While previous reasoning that because of the potential acuity and complexity of SNF inpatients, a restriction on the frequency of such visits may have made sense a decade ago, it’s simply not realistic in today’s era of value-based medicine, which CMS has embraced. We remain committed to ensuring that these patients continue to receive in-person, hands-on visits as appropriate to manage their care and we continue to agree that patients in SNFs/NFs are complex and need to be seen by trained and qualified clinicians, but we believe previous concerns about overutilization of telehealth are simply outdated. Current research shows that telehealth allows patients to be monitored more closely and allows the clinician to evaluate and understand when a patient should be seen due to a change of condition. Without telehealth, these patients may not be seen at all, and end up in the emergency room as a result.

Value-based models on quality reporting and outcomes and are testing new ways of delivering telehealth in a way that is more efficient and benefits patients. As the systems move from a siloed approach to a more integrated and aligned health system, it makes no sense to issue arbitrary limitations on one sector of healthcare that do not apply to all others.
We strongly urge CMS to allow for more frequent reassessment of patients with a change of condition that is highly likely to result in a trip to the emergency department or a hospitalization. One visit a month is woefully inadequate even for a clinician to provide telehealth evaluation and then reassess whether the ordered intervention has been successful. This system requires flexibility to allow practices to test innovative methods to deliver patient care that achieves the stated desired outcomes.

**Quality Payment Program**

As always, we remain committed to working with CMS to provide feedback on the QPP and highlight ways to improve successful participation. Working in PALTC, we work with patients and their families who require care that not only prioritizes evaluation and management activities, but true person-centered care—attempting to elicit the values and goals of the patient and their family (including advance care planning discussions), understand the true needs of the individual that will help to maintain health stability including community-based services and supports, and work to establish care networks that will avoid hospitalizations and support these individuals in low cost environments. PALTC clinicians do not want to abandon this high-need and often high-cost population. The Society wants to work with CMS so that these individuals continue to have access to appropriately trained physicians, nurse practitioners and physician assistants. Thus, we urge CMS to continue to think of ways to ensure the QPP program follows the following principles:

- Streamline and harmonize reporting requirements for clinicians who practice in multiple settings including ambulatory, skilled nursing facility, long-term acute care hospital, home health and other settings in the post-acute care continuum;
- Provide a robust Alternative Payment Model (APM) pathway that can support clinicians who want to make the transition to new delivery and payment models;
- Accommodate the needs of clinicians in rural, solo, or small practices to enhance their opportunities for success and avoid unintended consequences; and
- Develop a model that attracts and retains qualified clinicians who have the specialized knowledge and skills required to care for these vulnerable, chronically-ill, and acutely-ill patients.

**MIPS Value Pathways (MVPS)**

We appreciate CMS continuing its effort to streamline and simplify the MIPS program. In that vein, we support CMS’ concept of create one pathway of reporting into the MIPS program rather than four distinct categories that are in many ways duplicative, burdensome and create more of a “check-box” approach to medical care rather than real quality improvement. We recognize the difficulty of trying to get to a streamlined program that meets the legislative framework, is administratively simple and yet creates appropriate guardrails for measuring performance. However, we are concerned that continued change in the program is part of what makes the MIPS program difficult to follow and even more difficult to implement in practice. Continued changes to measure reporting requirements, scoring and reporting methodology have practices scrambling trying to understand the changes on an annual basis and tinkering with their systems just to keep up. It seems that this time could be better spent trying to figure out ways to actually improve the practice through appropriate feedback with data from CMS and investment in their practice.
Thus, we are concerned that creating yet another complicated framework for reporting through the MIPS MVPs will lead to similar confusion leaving practices, particularly small and rural practices, confused and frustrated with the program. At the same time, we do acknowledge that larger systems may have the capacity to report into the current program and welcome a change such as proposed in the MVP. Therefore, The Society continues to urge CMS to ensure that participation in the MVP is voluntary, but that scoring is kept on part with other practices reporting into the “general” MIPS program. We are concerned that at the outset of MVP reporting, only a few specialties that have the means to devote resources to create an MVP will do so, while others that are currently focused on APM development and do not have the resources to focus on MVP creation. Those specialties will once again be left behind. Further, we urge CMS to provide a clear timeline and easy process for proposing and getting MVPs approved. We are concerned that another convoluted process will simply have societies forgoing the development

In summary, the creation of the MVP policy should follow the following guidelines:

- Ensure participation in the MVP is voluntary by allowing physicians to opt-in to an MVP or continue in the existing MIPS program;
- Focus on measures that are meaningful to physicians rather than population health administrative claims measures;
- Make the MVP track more holistic, allowing physicians to be accountable for lower-cost, higher quality care for a specific health condition, procedure, or risk factor by permitting attestation in the Promoting Interoperability (PI) category and automatically applying credit for Improvement Activities (IAs) into MVPs to reduce reporting burden;
- Establish appropriate incentives for physicians to transition to a new QPP track and report on new measures;
- Engage with specialty societies to develop MVPs in a collaborative process similar to the process for developing specialty measure sets; and
- View the first few years of MVP implementation as a pilot testing period as it will take time and effort to develop, refine, and educate physicians on this new QPP track.

MIPS Cost Performance Category

We continue to be concerned that the cost category unfairly categories clinicians who practice in the PALTC sector as the highest cost clinicians and therefore score lower than their peers in internal medicine and family medicine. We have made several requests and inquiries to CMS over the last three years to establish a self-identifier code so that clinicians who practice primarily in this setting can identify themselves as such. We have yet to hear from CMS on its decision regarding our application. We strongly urge CMS to look into this matter immediately as it adversely affects patient access to trained clinicians who take care of the most vulnerable population who have the highest risk of hospital readmission and therefore cost to the Medicare program. By leaving this issue unaddressed, CMS is putting at risk the access to quality nursing home care while at the same time stating that improving care in the nation’s nursing facilities is one CMS’ primary goals. We believe that the primary way to improve care is to work on policies that incentivize clinicians to care for this population rather than penalize them under policies such as the cost category of the MIPS program. We request that CMS take immediate action on this matter.
MIPS PI Category

We continue to request that CMS establish an automatic exemption from the PI category for clinicians who practice in the PALTC setting. These clinicians, not unlike those in the hospital or the Ambulator Surgical Center, have no control of the type of EHR the nursing facility selects. Furthermore, while hospitals and ASCs were part of the meaningful use incentive program, nursing facilities were not and therefore had no reason to comply with those regulations nor were they aware that clinicians practicing in their setting faced penalties in the legacy programs and now the MIPS program. CMS seems to treat clinicians who practice in the PALTC sector differently than any other sector as they must fill out burdensome applications on an annual basis just to avoid penalties that clinicians who practice in other settings do not face. Having these clinicians fill out applications on an annual basis serves no purpose other than spending time on paperwork in lieu of important patient care. This flies in the face of the goals of this program and serves no purpose to quality improvement. We strongly urge CMS to take immediate action on this matter and establish the same automatic exemption from the PI category as is afforded to clinicians that practice in hospital and ASCs.

MSSP

CAHPS

Concern:
- PALTC-based ACOs, which are almost entirely comprised of long-term nursing home residents, are faced with an illogical situation in the administration of CAHPS within the MSSP. CAHPS results drive ten Quality Measures and the entirety of one of four required domains, Patient/Caregiver Experience, yet the survey cannot be administered in our care setting. CAHPS specifications specifically exclude institutionalized patients such as nursing home residents. This approach results in extremely low sample size of responses and statistical insignificance. In fact, CAHPS surveys completed for Genesis Healthcare ACO in 2018 ranged from only 13 to 70 surveys, representing a low percentage our attributed beneficiaries. Furthermore, those sampled are entirely non-representative of our ACO population that reside in the long-term care setting and will not likely associate the care they received during their nursing facility stay with the primary care that is the subject of the survey. The implications of this inappropriate approach to garnering customer satisfaction with the delivery of primary care in our ACO, especially the potential for extremely low results on the CAHPS survey, may in any performance year disqualify our ACO from any shared savings altogether, regardless of savings generated and achievement of quality performance on other measures.

Solution:
- As CMS's use of CAHPS is not mandated by statute or regulation – law and regulations are general about what needs to be measured and do not dictate any specific survey tool – CMS may implement a de minimis cut-point so that CAHPS would only be required when a significant portion of the ACO population is eligible to receive the survey, or excluded if only a nominal percentage are completed. In such a situation, the associated points could be redistributed to the remaining quality measures, and the Patient Experience Domain requirement would automatically be satisfied. CMS could also consider a substitution of a validated survey of nursing home residents.
that assesses similar issues of provider access and experience intended by the current survey in lieu of the use of the CAHPS tool.

**Concerns with ACO Proposed New Measure for 2020**

The Society has deep concerns with the following proposed measures:

**Concern:**
- ACO-47, Adult Immunization Status (up to date on recommended routine vaccines for influenza, tetanus and diphtheria, or tetanus, diphtheria and acellular pertussis, zoster, and pneumococcal vaccines). CMS’s discussion of removing the pay-for-reporting year, specifically for this measure in its first year in the MSSP Measure Set is concerning. Additionally, CMS lacks adequate payment coverage for certain vaccinations included in this composite vaccination measure. In addition, we share concerns with other ACOs about supply issues that could be out of the ACO’s control and affect performance on such a measure.

**Solution:**
- ACO-47, Adult Immunization Status – The Society urges CMS to maintain the current vaccination measure ACO-14, Preventive Care and Screening Influenza Immunization, with modifications to reduce data collection burdens associated with this measure. Specifically, we request CMS allow the patient reported year of vaccination to satisfy measure criteria. Finally, we urge CMS to encourage the development of an updated pneumococcal measure to add back to the MSSP quality measure set given the clinical importance of such a measure.
  
  o Pneumococcal Vaccination for Older Adults - Complete removal and no replacement of this measure will lessen the incentive and urgency for ACOs to administer this life saving vaccination, resulting in fewer patients vaccinated, and leading to worsened outcomes and higher costs.

**Concerns with Measure Specification Changes for 2020**

**Concern:**
- The Society urges CMS to review the exclusions for the following measures and encourages CMS to revise the exclusions. Many of these interventions are not clinically appropriate in those with frailty and limited life expectancy due to advanced illness, regardless of age.

**Solution:**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Recommended Exclusion</th>
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<tr>
<td>ACO-42, Statin Therapy for Treatment of Cardiovascular Disease</td>
<td>Add Frailty, Dementia, and Advanced Illness in a Long-Term Care Setting</td>
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<tr>
<td>ACO-20, Breast Cancer Screening</td>
<td>Remove age restriction (below 65 years of age) for exclusion in a Long-Term Care Setting</td>
</tr>
<tr>
<td>ACO-19, Colorectal Cancer Screening</td>
<td>Remove age restriction (below 65 years of age) for exclusion in a Long-Term Care Setting</td>
</tr>
<tr>
<td>ACO-28, Hypertension, Controlling High Blood Pressure</td>
<td>Remove age restriction (below 65 years of age) for exclusion in a Long-Term Care Setting</td>
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MIPS APM

- **Recommendation**: CMS should encourage physicians to continue to participate in MIPS APMs, not impose more burdensome quality reporting requirements on them.

Currently under MIPS APM scoring, CMS requires MIPS APMs to submit data on APM quality measures for the purposes of MIPS reporting. When an APM has no measures available to score for the quality performance category, CMS reweights the quality performance category to zero for that MIPS APM. This might occur when none of an APM’s measures would be available for calculating a quality performance category score by the close of the MIPS submission period because measures were removed from the APM measure set due to changes in clinical practice guidelines. CMS notes that it was regularly reweighting the quality performance category for certain MIPS APMs that run on episodic or yearly timelines that do not always align with the MIPS performance periods and deadlines for data submission and scoring.

Therefore, in the CY 2020 proposed rule, CMS considers new approaches to quality performance category scoring for MIPS APMs. One option CMS proposes is to require MIPS eligible clinicians participating in MIPS APMs to report on MIPS quality measures. The Society has concerns about this approach. The MIPS APM track was developed to help move physicians into streamlined, simplified models that focus on reducing cost and improving quality. Forcing MIPS APM participants to report MIPS quality measures would be a step backwards toward four separate siloed performance categories. Rather, CMS should provide flexibility to report on quality metrics that make sense for the particular practice area. Currently, there are APM requirements that do not make sense for the population in the skilled nursing facility.

In addition, requiring MIPS APM participants to report APM quality measures through their APM entity and also report MIPS quality measures is duplicative and unnecessary. In order to become an APM, the model has to prove that it does not reduce the quality of care it provides to patients. Participants are also required to report quality measures relevant to the APM through the APM entity. Therefore, MIPS APMs are already reporting quality measures and held accountable for providing quality care to patients. CMS should not add a requirement for MIPS APM participants to report arbitrary MIPS quality measures in addition to the reporting already required through each APM.

CMS also requests comment on a proposal to apply a minimum score of 50 percent or an “APM Quality Reporting Credit” under the MIPS quality reporting category for certain APM entities participating in MIPS where APM data cannot be used for MIPS purposes. As CMS notes in the proposed rule, APM participation requires a significant investment in improving clinical practice. The Society agrees that MIPS APMs need to invest in quality performance to a degree that is equal to or greater than that required to report MIPS quality measures outside of an APM framework. Therefore, rather than giving MIPS APM participants a minimum score of 50 percent, CMS should provide full credit in the quality performance category, given the time and resources needed to participate in APMs.

CMS notes in the proposed rule that one reason it developed separate scoring for MIPS APMs was to ensure that physicians were not forced to engage in duplicative reporting. The two new approaches CMS introduces that would require physicians to report MIPS quality measures as well as APM quality measures in order to receive full credit in the quality performance category would work against that goal. They are also counter to the CMS Patients Over Paperwork efforts to reduce physicians’ administrative burdens, including MIPS-related administrative burdens. The Society believes that CMS should be encouraging
physicians to participate in MIPS through engagement in MIPS APMs, especially as this is one of most promising pathways for physicians to move into Advanced APMs. Requiring more burdensome reporting quality reporting requirements for physicians and practices participating in MIPS APMs would send the wrong signal to physicians and disincentivize innovation and participation in new payment arrangements.

**Revision(s) and Addition(s) to Denial and Revocation Reasons in §§ 424.530 and 424.535**

- **Recommendation:** we recommend that CMS not finalize its new proposal to deny or revoke an enrollment for any action a state medical board takes or, alternatively, use a more targeted approach to focus on outliers.

The Society strongly supports the efforts of CMS to protect its trust funds by ensuring that unqualified or potentially fraudulent individuals or entities are precluded from billing applicable programs. However, we have serious concerns with the proposal to allow CMS to deny or revoke an enrollment for any action a state medical board or equivalent entity takes that CMS determines led to patient harm (e.g., seeking treatment for a substance use disorder or mental health problem through a structured rehabilitation program in lieu of a disciplinary action). This proposal is a broad and unprecedented overreach, would significantly increase regulatory burden without efficiently targeting enforcement toward higher-risk providers and suppliers, and is duplicative, in part, of new revocation authority. Accordingly, the Society recommends that CMS either (1) not finalize the new proposal or (2) limit application only to providers and suppliers that are identified as outliers using data analytics.

The CMS proposal is a broad overreach and the lack of deference to state medical boards and other oversight entities is troubling. CMS states that it, “rather than state boards, is ultimately responsible for the protection of its beneficiaries.” This statement is inaccurate. The role of state medical boards is to protect the health, safety, and welfare of the residents in the state—which include Medicare beneficiaries—through implementation and enforcement of laws involving the licensing and regulation of health care providers. Safeguarding public health and patient safety are also the primary purposes of the state statutes authorizing licensing boards to regulate health care professionals. It is crucial that licensing boards carry out the responsibilities assigned to them by state legislatures without being intimidated by federal overreach from CMS.

The Society is also concerned that CMS buried such a major change to the denial and revocation authority in the annual physician fee schedule under the opioid treatment program section. Thus, the proposed rule gives the appearance of potentially only applying to “high risk” Medicare-enrolled opioid treatment programs; however, the proposed change impacts all clinicians. Moreover, CMS does not address the reality of a denial or revocation on a physician’s practice. Revocations lead to a mandated cross-termination of participation in Medicaid and most payers will also remove a clinician from their provider network when CMS takes this action. Thus, if a physician agreed to abstain from drugs or alcohol and be subject to random drug testing to simply provide evidence that no addiction exists, CMS now gives itself the authority to revoke that physician's enrollment in Medicare, which includes a mandated cross-termination in Medicaid with most payers also following suit. In addition, adoption of this policy would be completely at odds with the nationwide effort to reduce the stigma associated with seeking treatment for substance use disorders.
CMS consistently touts its data analytics capabilities but does not propose to use these capabilities in the proposal. Instead, rather than take a targeted approach based on data analysis, CMS chooses a proposal that impacts all providers and suppliers. CMS' program integrity efforts should be geared towards non-compliant providers and suppliers rather than burdening honest providers and suppliers. Compliance with this new requirement and other program integrity requirements increases regulatory burden without efficiently targeting enforcement toward higher-risk enrollees. Any program integrity proposal should be more focused on identifying and weeding out potentially fraudulent parties. Moreover, this new proposal is confusing and overlaps with new revocation authority where CMS already has given itself the authority to revoke a physician or eligible professional with an abusive pattern or practice of ordering, certifying, referring, or prescribing that represents a threat to the health and safety of Medicare beneficiaries.

The Society is working to protect patient safety by ensuring that the role of states and medical licensing boards to define appropriate medical standards at the state level is not undermined by federal overreach. CMS does not have the clinical expertise to make judgments regarding the competency of healthcare professionals to perform medical procedures. Furthermore, CMS will not have been involved in the licensing board disciplinary process or its deliberations in evaluating the genesis of the complaint, the truth of the allegations, or the reasoning to settle. Denial or revocation based on an after-the-fact desk review is wholly inadequate, will punish rehabilitating physicians inappropriately, and lead to further provider shortages. Therefore, the Society urges CMS to withdraw its proposal that impacts the complex medical issues involved in state medical licensure or, at a minimum, limit its application only to providers and suppliers that are identified as outliers using data analytics.

We appreciate the opportunity to comment on these proposals. Should you have any questions please reach out to our Director of Public Policy, Alex Bardakh at abardakh@paltc.org or 410-332-3132.

Sincerely,

[Signature]

Arif Nazir, MD, FACP, CMD, AGSF
President

[Signature]

Christopher E. Laxton, CAE
Executive Director