September 10, 2018

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: Revisions to Payment Policies under the Medicare Physician Fee Schedule, Quality Payment Program and Other Revisions to Part B for CY 2019 (CMS-1693-P)

Dear Administrator Verma:

AMDA – The Society for Post-Acute and Long-Term Care Medicine appreciates the opportunity to provide our comments to the Centers for Medicare & Medicaid Services (CMS) on the CY 2019 Physician Fee Schedule (PFS) and Quality Payment Program (QPP) proposed rule.

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 (PA/LTC) 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.

We appreciate that the focus of this year’s proposed rule was to reduce burden on clinicians both in the evaluation and management (E&M) documentation requirements and reporting into the Quality Payment Program (QPP). We agree that clinicians need administrative burden relief so that they focus more on patient care. While we support these general efforts, we feel CMS must work in a collaborative and open manner with the stakeholder community to achieve the desired outcomes. Below we outline specific areas that we feel CMS should finalize and express concern about CMS’ approach to payment changes in the physician fee schedule.
**Payment Provisions**

**Streamlining Evaluation and Management (E/M) Payment and Reducing Clinician Burden**

The Society supports the Centers for Medicare & Medicaid Services’ (CMS) “Patients Over Paperwork” initiative. We appreciate your outreach to our community and are solidly behind your goal of reducing administrative burdens for physicians so that they can devote more time to patient care. The proposals included in the 2019 Medicare physician payment rule demonstrate your willingness to address these issues.

However, the Society joins the many national physician specialty societies opposing finalizing collapsing the payment structure as proposed in the rule. We believe this proposal has not been well vetted and has not been tested to assess the true impact on patient access for the most chronically ill population. CMS may not have given sufficient attention to specialties that treat the frailest older adults to ensure that these proposals will not hurt patient access to these uniquely skilled clinicians.

Likewise, this proposal only addresses the office-based E&M visits and leaves out reworking of other E&M visits, including inpatient, skilled nursing facility, residential and other locations of care. According to the Medicare database, there were close to 50,000 E&M encounters in nursing homes alone. If this proposal were finalized, clinicians who treat patients in the office and in the nursing home setting (or hospitals, residential/domiciliary locations, and other non-office settings) would now have to abide by two different sets of rules. Their electronic health records will have to keep track of two different sets of documentation requirements. This amounts to more administrative complexity, not less.

If CMS plans to address other E&M codes in the future, we stand strongly against the process CMS undertook to issue this proposal. That is, we strongly urge CMS to work with the Society and other interested stakeholders on any proposals related to nursing home and other E&M services. We feel that CMS’ lack of transparency in the process they undertook to come up with the current E&M proposal was shortsighted and creates an unfortunate precedent for policy making that sends the wrong message. We stand ready to work with CMS and the stakeholder communities to address the long-standing issues related to E&M documentation requirements. We believe this administration is serious about reducing administrative burden, and we would like to help the agency achieve that goal in a manner that is fair to everyone and does not create a strong potential for decreasing access to needed resources for a vulnerable patient population.

**Medicare Telehealth Services**

The Society was disappointed that CMS decided not to propose to remove the frequency limitation for subsequent nursing facility care services in CY 2019. 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 PA/LTC setting, which is vital to the continuum of care and where a large number of 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 PA/LTC 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 (QPP)**

As always, we remain committed to working with CMS to provide feedback on the QPP and highlight ways to improve successful participation. Working in PA/LTC, 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. PA/LTC 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.

While we believe CMS has taken steps forward on all these points, we believe more work is necessary to ensure that any quality reporting program adequately compare clinicians who take care of similar populations. Simply put, more work needs to be done on risk adjustment models and specialty comparison groups to ensure equity in the system. Accordingly, the Society submitted an application in August of 2017 for a specialty code designation for clinicians who practice in the PA/LTC setting (POS 31/32). We strongly urge CMS to work with its Division of Practitioner Services on a rapid resolution of this matter that would allow clinicians to be compared on a more equal scale. (See Addendum 1)

Additionally, the Society has adopted an official position statement asking CMS to clearly define risk stratification indices and develop a cost-to-risk algorithm. This algorithm should be based on previous utilization data and should incorporate specific, patient-level characteristics, including functional status, age, and frailty, to accurately evaluate clinicians’ performance. We strongly urge CMS to monitor implementation of these programs to ensure that they do not disincentivize clinicians from providing care to the most clinically complex and frequently the costliest patients, who are often cared for in the post-acute and long-term care sector. A recent study in the Journal of the American Medical Association (JAMA) found that the value-based programs hurt clinicians who see high-risk patients.\(^1\) Therefore, we continue to stress that it is vital that the Administration consider not only physician specialties, but also the place of service (POS) of their encounters and their patient mix, including factors related to health status, stage of disease, comorbidities, functional status, local demographics, and socioeconomic status.

I. MIPS Policies

---

**Bonus Points**

CMS proposes to maintain a small practice bonus but modifies its application by adding three points to the quality performance category score rather than adding 5 points to the final MIPS score. CMS also proposes to allow small groups to use claims as a collection type beginning in the 2019 performance year. CMS proposes to maintain the complex patient bonus for the 2021 payment year.

The Society strongly supports CMS continuing to award bonus points for clinicians who see more complex patients. As we have stated, these clinicians have previously been disadvantaged in this program and this would take steps to resolve that issue. We continue to recommend that these additional bonus points be equal and are significant enough so that these adjustments provide a more equitable program.

**Cost Performance Category**

We remain concerned about the application of the cost category within MIPS. CMS proposes to increase this category to 15 percent of the total score for the 2019 performance period. Based on previous data from a number of QRUR reports, we know that clinicians practicing in the PA/LTC environment score poorly in the cost category because the risk stratification included in the two measures used for that category does not adequately account for the complexity of the patients these clinicians take care of. We submitted detailed analysis of this data in response to last year’s final rule and include it in our comments here again (See Addendum 2)

We understand that CMS is proposing new episode-based measures and we are committed to working with CMS to continue to develop more. We have several members who serve on the Acumen panels that are currently developing the measures. However, at this time, these episodes will not be applicable to the PA/LTC based clinicians. Therefore PA/LTC will continue to be scored based on the two currently available cost measures that have been problematic since the Value-Based Modifier (VBM) program.

We urge CMS to not finalize the proposal to increase the weight of the cost category until such time that the risk adjustment and proper comparison amongst PA/LTC based physicians is adopted in the MIPS program.

**Attribution**

We continue to support CMS’ policy to exclude SNF POS 31 encounters from attribution toward the cost category of MIPS. We believe this exclusion helps mitigate the negative impact this category has on PA/LTC clinicians. However, the Medicare Shared Savings Program (MSSP) proposed rule proposed an alternative methodology to using POS codes for this attribution. We agree with that proposal in that rule and believe that for the sake of uniformity and correct attribution the same rule should be adopted for attribution to the cost measures. Specifically, the language in the MSSP proposed rule reads:

> On Page 418899 of Federal Register copy “As previously discussed in section I.E.3.a, ACOs and other stakeholders have expressed concerns regarding our current policy of identifying services billed under CPT codes 99304 through 99318 furnished in a SNF by using the POS modifier 31. We continue to believe it is appropriate to exclude from assignment services billed under CPT codes 99304 through 99318 when such services are furnished in a SNF. However, we agree with stakeholders that it might
increase the accuracy of beneficiary assignment for these vulnerable and generally high cost beneficiaries if we were to revise our method for determining whether services identified by CPT codes 99304 through 99318 were furnished in a SNF to focus on whether the beneficiary also received SNF facility services on the same day. We believe it would be feasible for us to directly and more precisely determine whether services identified by CPT codes 99304 through 99318 were furnished in a SNF by analyzing our facility claims data files rather than by using the POS modifier 31 in our professional claims data files. Operationally, we would exclude professional services claims billed under CPT codes 99304 through 99318 from use in the assignment methodology when there is a SNF facility claim in our claims files with dates of service that overlap with the date of service for the professional service. Therefore, we propose to revise the regulation at § 425.400(c)(1)(iv)(A)(2), effective for performance years starting on January 1, 2019 and subsequent performance years, to remove the exclusion of claims including the POS code 31 and in its place indicate more generally that we would exclude services billed under CPT codes 99304 through 99318 when such services are furnished in a SNF.”

**Promoting Interoperability (PI)**

We appreciate CMS moving towards a focus on interoperability. This is an area that has plagued clinicians practicing in the PA/LTC sector, especially as it related to reporting MIPS data. Given that these clinicians see patients in multiple settings, there is not HIT infrastructure to support MIPS reporting for the patient population whose information resides in different facility-based EHRs and rarely flows back to the clinician’s office. The increased difficulty of getting lab and pharmacy data makes these clinicians particularly unique in their challenges to report necessary data for MIPS. This is one of the most urgent concerns Society members report in terms of immediate concerns for viability of their practices. Interoperability is an integral step forward to managing data and quality improvement for these clinicians.

Up until this point, many PA/LTC physicians have been taking advantage of currently available hardship exemptions. We have commented in the 2017 and 2018 rules and in previous rules on the meaningful use (MU) program that meeting requirements for PA/LTC clinicians is extremely difficult. We strongly urge CMS to adopt the facility-based definition and apply it to this category to allow for automatic hardship exemptions, and only have it scored if they elect to do so (opt-in). Currently, hospital-based clinicians, ambulatory surgical center (ASC) clinicians, and other specialties such as pathology and radiology have automatic exemptions. To reduce administrative burden and to align policies in the program the same process needs to be established for PA/LTC based clinicians.

We are aware that groups are now trying to meet requirements due to gradually increasing availability of certified technology (CEHRT) in PA/LTC. However, even those that may try to meet these requirements are unable to do so due to e-prescribing measure requirements. In the legacy e-prescribing incentive program, PA/LTC clinicians had an exemption for this requirement, but this exemption has not carried over into PI. Exempting prescriptions by prescribers in the SNF/NF setting from all denominators for ‘prescribing’ would eliminate a significant barrier to meeting the PI category for those that elect to do so.

Hence, we request consideration of an automatic hardship exemption from PI for PA/LTC clinicians (those who make most of their visits in the SNF or NF place of service). For those who opt in to ACI
Comments on PFS/ QPP Proposed Rule CY 2019

AMDA—The Society for PA/LTC Medicine

reporting, there should be an ability to exempt e-prescribing from the reporting requirement for those clinicians who do not have that service available with the nursing home dispensing pharmacies.

**Expansion of Facility-based Measurement for Post-Acute Care Settings**

We appreciate CMS’ inclusion of a request for information to expand facility-based scoring from hospital and ambulatory surgical centers (ASC) to post-acute settings. We agree that this has the potential to significantly reduce administrative burden and align clinician and facility incentive programs. Overall, we believe that CMS should adopt a voluntary and flexible approach for facility-based scoring. We agree with the language in the hospital-based proposal that allows CMS to pick the best score between facility-based and MIPS score. This option will not work for all clinicians but it will be a great way to reduce their reporting requirements for many.

We urge CMS to develop a technical expert panel on facility-based scoring as the agency reviews comments receives on this RFI and starts to develop a proposal for next year’s rule. We believe this area deserves further consideration and input prior to being finalized. The Society stands ready to work with CMS to lead this work.

**Specific Questions**

**Attribution:**

• *Would a similar approach as used for HVBP work for PAC settings?*

We believe the overall approach in the hospital-based proposal makes sense. However, we highlight several important differences. One is that clinicians who practice in PA/LTC have both post-acute (POS 31) patient and long-term residents in the facility (POS 32). We believe both should be used for attribution purposes. Second is that clinicians in PA/LTC, even more so than in the hospital, practice in several facilities and most practitioners work in other practice settings. The Medicare Claims Database shows that around 15 thousand such clinicians perform majority of their work in the skilled nursing facility and nursing facility settings while there are around 35 thousand that only do some of the work. Research in this area shows a continued increase in clinicians practicing exclusively in the SNF/NF setting.²

Therefore, we believe CMS should run impact analysis to achieve the proper threshold to determine the impact on PA/LTC – based clinicians. Without such further analysis, we believe that the proper threshold should simply be more than 50 percent, or a majority of services provided in the SNF/NF setting.

• *What level of influence do MIPS eligible clinicians have in determining performance on quality measures for individual settings and programs in the PAC setting?*

Several Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) and SNF Quality Reporting Program (QRP) measures are significantly influenced by clinicians. Currently there is a big disconnect between SNF practitioners’ available MIPS measures and their facility QRP measures. Other than in their role as medical directors, a majority of PA/LTC clinicians are not directly involved in facility Quality Assurance and Performance Improvement (QAPI) process. Allowing

---

² Kira L. Ryskina, MD, MS; Daniel Polsky, PhD; Rachel M. Werner, MD, PhD. Physicians and Advanced Practitioners Specializing in Nursing Home Care. *JAMA* 2017 November 28; 318(20):2040-2042. doi:10.1001/jama.2017.13378
facility scores to be used in lieu of separately reportable and not applicable MIPS measures will be an important step forward to aligning these incentive programs.

- What PAC QRP measures may be best utilized to measure clinician performance? and What methods should we use to identify the appropriate measures for scoring, and what measures would be most influenced by clinicians? Should all measures that are reported as part of the PAC QRPs be included or a subset?

The following current measures could be applicable to determine MIPS scores:

- Functional Status
- Medication reconciliation
- Total Medicare spending per beneficiary
- Discharge to community
- Hospital readmissions/ potential preventable readmissions

We urge CMS to adopt a flexible approach to applying facility-based measures. Clinicians should be able to pick 3 measures on which they believe they have a significant amount of influence in their facility of choice. Given that there is a great variability of how engaged clinicians may be in certain areas of facility quality scores, picking measures they are most involved with provides enough flexibility and incentive. To ease reporting, the Minimum Data Set (MDS) could be used a registry for reporting these measures.

This is one area that could be further worked on through a TEP process. We urge CMS to work with the Society and other stakeholders to develop a consensus-based approach on most applicable measures. In February 2017, the Society along with other stakeholders presented several measures that are most influenced by clinicians at CMS’ Spotlight Series. We urge CMS to take a similar approach to select and test measures that are most applicable to clinicians.

- Should we consider all PAC settings or with a subset, such as IRF QRP or LTCH QRP?

While it is worthwhile to create one uniform approach to facility-based scoring, the reality is that the settings are designed for very different populations that reflect differently in quality and cost measures. The specialties of clinicians that see patients in these facilities could also differ (e.g., physiatrists in Inpatient Rehab Facility). Therefore, we believe CMS should look to design programs tailored to each of the post-acute settings. However, as the IMPACT Act is implemented there may be ways to further harmonize these programs. At the current time, we recommend CMS develop a SNF/NF based approach. A TEP could help CMS with details of a potential proposal in other settings as well.

Skilled Nursing Facility Specialty Measure Set

The Society was pleased to see the new proposed Skilled Nursing Facility Specialty Measure Set. We believe this is the first step to delineating the SNF/NF setting as an integral but different area of practice of medicine that deserves its own consideration within MIPS and APM programs. While there are many “reportable” measures included in the MIPS program, some measures are counter to recommendations for the SNF/NF population. While the Society is working with measure steward of some of those measures, it would take some time before those measures are adjusted. SNF/NF based clinicians currently looking for
measures to report have no way of finding that on the QPP website and are often confused about which specialty set they should look to. Should this proposal be finalized, it will allow those practicing in SNF/NF to identify such measures directly from CMS.

The Society has recommended a set of measures to choose from for its members. We urge CMS to consider these measures for the published SNF/NF specialty set.

1. #6 Coronary Artery Disease (CAD): Antiplatelet Therapy
2. #7 Coronary Artery Disease (CAD): Beta-Blocker Therapy- Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%)
3. #47 Advance Care Plans
4. #110 Preventative Care and Screening: Influenza Immunization
5. #118 Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%)
6. #154 Falls: Risk Assessment (Two part measure pair with #155)
7. #155 Falls: Plan of Care (Two part measure pair with #154)
8. #317 Preventative Care and Screening: Screening for High Blood Pressure and Follow-up Documented
9. #326 Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy

II. Alternative Payment Models Policies

Advanced APMs

While we appreciate changes in the MIPS APM scoring, we strongly urge CMS to expand the number of Advanced APMs (AAPMs) by providing more flexibility on what it defines as an advanced APM. Currently, there are no APMs in the Advanced APM category that would allow clinicians who practice in PA/LTC setting to qualify. The Bundled Payment for Care Initiative and the Initiative to Reduce Hospitalizations Among Nursing Facility residents are APMs, but they do not qualify as an Advanced APM in their current form. Both programs have shown significant quality improvement and cost savings primarily driven by incentives in PA/LTC practice changes. Given that these are the only two APMs focused on the PA/LTC population, we strongly urge CMS to work to establish a process to allow these models to be modified so that they can qualify and allow flexibility to allow participants to qualify in the first year of the program. Other programs, such as CPC+, should be considered for their application to the PA/LTC population. Current quality measures used in the program do map to SNF residents and yet they are not included in the model.

The Society has also worked with other specialties and CMS to design a physician-focused APM. With that in mind, we supported two proposals that were considered by PTAC – one by Avera Health based on Telehealth in the SNF and the other by the American Academy of Hospice and Palliative Medicine (AAHPM) dealing with palliative care. Unfortunately, despite strong interest in both models and a vote to move these forward by the committee, the Secretary rejected both models although expressed a desire to work on the AAHPM proposed model. We view the positive response by the PTAC to both models as an important signal that these models must be a priority for the Administration and should be implemented within the near future. Likewise, senior CMS officials have indicated that there is a need for post-acute only Advanced APMs in the current system. Earlier this year, the American Medical Association (AMA) at its Annual House of Delegates meeting adopted a resolution calling for the development of post-acute based APMs and we look forward to working with them and other stakeholders to develop such models.
We strongly urge CMS to work with its colleagues at CMMI and the stakeholder community to develop such models.

**Role in Gainsharing Arrangements**

Clinicians in PA/LTC play a critical role in building post-acute networks and are key partners in reducing rehospitalizations and reducing cost. However, in many instances, that requires physicians to make more frequent face-to-face visits that might trigger them as outliers, with concerns about meeting the “medical necessity” requirements for Evaluation & Management coding of these visits. This may trigger Program Integrity audits that are costly, burdensome and discourage clinicians from participating in these models.

CMS must therefore ensure that clinicians have the capability to have gain-sharing arrangements in the APMs so that they can be appropriately reimbursed for the care they provide, and that clinicians not be penalized for keeping a close watch on the very ill post-acute patient population.

Likewise, we urge CMS to consider start-up and overhead cost to the practice in its definitions of “risk.” Practices are spending a great deal of capital including new EHR systems to be able to participate in these models. Given the uncertainty of the PA/LTC market, these decisions are financially difficult. CMS must analyze existing data and consider these costs in the total risk calculations.

We stand ready to work with CMS and the PA/LTC stakeholders to develop such models within both existing and new APM models.

**Conclusion**

We deeply appreciate your consideration of our recommendations, and your continued endeavors to improve the quality of medical care Medicare beneficiaries receive as well as to reduce the burdens on clinicians. We are committed to working collaboratively and constructively with CMS and others as final regulations are prepared and the agency works to implement these welcome and much-needed reforms.

Sincerely,

Cari Levy, MD, PhD, CMD
President

Attachments
Addendum I

August 9, 2017

Ryan Howe, Director, Division of Practitioner Services
Center for Medicare Management
Center for Medicare & Medicaid Services
Mail Stop C4-01-26
7500 Security Boulevard
Baltimore, MD 21244

Dear Mr. Howe,

AMDA: The Society for Post-Acute and Long-Term Care Services (AMDA) 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 post-acute and long-term care (PA/LTC) settings. AMDA’s 5,500 members work in skilled nursing facilities, long-term care and assisted living communities, CCRCs, home care, hospice, PACE programs, and other similar settings.

AMDA requests CMS consideration of a new specialty code for long-term and post-acute care medicine. Below we have responded to the criteria that need to be met for consideration.

- Requested specialty has the authority to bill Medicare independently.
  - AMDA members have the capacity and authority to bill Medicare independently on behalf of their patients. In fact, AMDA members are unique in that the majority of their patients are Medicare beneficiaries.

- Stated reason/purpose for code.
  - The current physician specialty codes listed at the Internet Only Manual (IOM), Pub. 100-04, Chapter 26, Section 10.8/2 do not capture the field of long-term care and post-acute medicine. As MACRA is implemented, it is critical to understand the specifics of the practice of long term care medicine.
• Evidence that the practice pattern of the specialty is markedly different from the dominant parent specialty.
  o The current physician specialty codes listed at the Internet Only Manual (IOM), Pub. 100-04, Chapter 26, Section 10.8/2 do not capture the field of long-term care and post-acute medicine. Currently, AMDA members bill under the codes for Family Practice (08), Internal Medicine (11), Osteopathic Medicine (12) or Geriatric Medicine (38). However, these codes do not fully encompass the field because they are either too complex or they have other extraneous components lacking in the other fields such as visits are often conducted at multiple skilled nursing facilities.

  o There are three differentiating factors for AMDA members.

    ➢ AMDA members take care of frail elderly with multiple chronic conditions whereas the general practice of internal or family medicine predominately take care of the healthier elderly. The clinical competence to take care of this population differs from the current competence obtained in general internal or family medicine.
    ➢ The second factor is the setting itself. Physicians need to have special knowledge and skills to comply with the vast regulatory framework of the nursing facility (SNF/NF) patients and residents.
    ➢ The third factor is the cost of taking care of this population. The current value-based reporting programs highlight the need to separate physicians taking care of this population from internal/family medicine physicians. Quality resource and use reports show that AMDA members take care of a much higher cost population and are penalized because they are unable to differentiate themselves from the larger specialty.

• Evidence of any specialized training and/or certification required.
  o Medical directors in post-acute and long-term care settings including: skilled nursing facilities, nursing homes, continuing care retirement communities, veteran’s affairs, subacute care, home care, and hospice are eligible for certification. Once awarded, certification is valid for six years, after which recertification is required to maintain ABPLM CMD status.

  o The American Board of Post-Acute and Long-Term Care Medicine (formerly the AMDA Certified Medical Director Program) was developed by AMDA in 1991, after three years of research and development using surveys, consensus conferences, and experts to define the core skills and knowledge necessary for effective medical direction. The ABPLM currently offers a certification program for medical directors in post-acute and long-term care medicine (ABPLM CMD) and is exploring development of a credential for attending physicians in post-acute and long-term care settings. The ABPLM CMD program is
administered by the American Board of Post-Acute and Long-Term Care Medicine (AMDCP), an independent not-for-profit organization.

- A 2009 study, commissioned by the AMDA CMD program found that having a CMD contributes positively to a nursing home’s quality of care. Analysis of data showed that quality scores represented a 15% improvement in quality for facilities with CMDs. The study appears in the July 2009 issue of the Journal of the American Medical Directors Association (JAMDA).

- Since the program’s inception, over 3,500 physician medical directors have received the CMD designation.

- Requested specialty treats a significant volume of Medicare patients.

- The CMS Nursing Home compendium 2015 edition includes the following information about all billed providers based on all the skilled nursing facility codes 99304-10, 99315-16, 99318:
  - All Billed providers for 2014: 44,978
  - Number of nursing homes for the fourth quarter of 2014: 15,634
  - Residents in nursing home for calendar year 2014: 1,400,000

- Is the specialty recognized by another organization such as the ABMS?

  - The specialty is not recognized by another organization such as the American Board of Medical Specialties (ABMS) or the American Board of Physician Specialties (ABPS).

- Does the Specialty have a corresponding Healthcare Provider Taxonomy Code?

  - There are at least two relevant crosswalks on the CMS Supplier to Healthcare Provider Taxonomy dated November 12, 2015: A1(8) Skilled Nursing Facility, 31400000X – Nursing and Custodial Care Facilities/Skilled Nursing Facility, A3(10) Other Nursing Facility, 313M0000X – Nursing and Custodial Care Facilities/Nursing Facilities.

We look forward to working with you to secure a new specialty code for long-term and post-acute care physicians. If you have questions on this letter or require a meeting, please contact Alex Bardakh at abardakh@paltc.org or (410) 992-3132.

Sincerely,

Heidi K. White, MD, MHS, M.Ed., CMD, President
Addendum II

Illustrating Negative Impact of Cost on PA/LTC Practices

The Society sought QRUR reports from PA/LTC based ECs. Some PA/LTC groups have shared their QRUR data over the past 5 years. They agreed to share these data to illustrate how Resource Use would affect their MIPS performance. Below are some examples of our findings.

The following linear scale is copied from a CY 2016 QRUR Report from a LTPAC Medical Group. It is typical.

![Exhibit 7-AAB. Costs for All Attributed Beneficiaries Domain](image)

<table>
<thead>
<tr>
<th>Cost Measure</th>
<th>Your TIN</th>
<th>All TINs in Peer Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of</td>
<td>Per Capita or Per</td>
</tr>
<tr>
<td></td>
<td>Eligible Cases</td>
<td>Episode Costs</td>
</tr>
<tr>
<td>Per Capita Costs for All Attributed</td>
<td>3,746</td>
<td>$25,534</td>
</tr>
<tr>
<td>Beneficiaries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare Spending per Beneficiary</td>
<td>0</td>
<td>—</td>
</tr>
</tbody>
</table>

Note: Only the measures for which your TIN had the minimum number of eligible cases or episodes are included in the domain score. For the Per Capita Costs for All Attributed Beneficiaries measure, the minimum number of eligible cases is 20. For the Medicare Spending per Beneficiary measure, the minimum number of eligible episodes is 125. The benchmark for a cost measure is the case-weighted national mean cost among all TINs in the measure’s peer group during calendar year 2016. For the Per Capita Costs for All Attributed Beneficiaries measure, the peer group is defined as all TINs nationwide that had at least 20 eligible cases. For the Medicare Spending per Beneficiary measure, the peer group is defined as all TINs nationwide that had at least 125 eligible episodes.

Under VBM, CMS normalized all cost measures using statistical modeling. Deviations were expressed using Standard Deviations as the measurement. Presuming that CMS is using a Statistically Valid model for calculating Standard Deviations ($\sigma$) the following graph shows a standard populations frequency
distribution expressed in Standard Deviations

The following Table taken from 26 QRUR reports shows a consistent pattern – the groups are always significantly above the mean – average at 4.27 standard deviations – range 3.9 – 5.45.

<table>
<thead>
<tr>
<th>Cost for All Attributed Beneficiaries Domain</th>
<th>QRUR Data for Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTPAC Group 1</td>
<td>5.45</td>
</tr>
<tr>
<td>LTPAC Group 10</td>
<td></td>
</tr>
<tr>
<td>LTPAC Group 11</td>
<td>5.38</td>
</tr>
<tr>
<td>LTPAC Group 12</td>
<td>5.27</td>
</tr>
<tr>
<td>LTPAC Group 13</td>
<td></td>
</tr>
<tr>
<td>LTPAC Group 14</td>
<td>4.4</td>
</tr>
<tr>
<td>LTPAC Group 15</td>
<td></td>
</tr>
<tr>
<td>LTPAC Group 16</td>
<td></td>
</tr>
<tr>
<td>LTPAC Group 2</td>
<td></td>
</tr>
<tr>
<td>LTPAC Group 3</td>
<td></td>
</tr>
<tr>
<td>LTPAC Group 4</td>
<td></td>
</tr>
<tr>
<td>LTPAC Group 5</td>
<td>4.94</td>
</tr>
<tr>
<td>LTPAC Group 6</td>
<td></td>
</tr>
<tr>
<td>LTPAC Group 7</td>
<td></td>
</tr>
<tr>
<td>LTPAC Group 8</td>
<td>5.04</td>
</tr>
<tr>
<td>LTPAC Group 9</td>
<td></td>
</tr>
<tr>
<td><strong>Average Cost Score</strong></td>
<td><strong>5.22</strong></td>
</tr>
</tbody>
</table>

We believe these data illustrate that the risk adjustment methodology for Total Per Capita Cost measure for all attributed beneficiaries is flawed for ECs providing primary care to PA/LTC based population.
Finding Solutions – Alternative Risk Adjustment Methodologies

The Society sought input from its members on various risk adjustment models currently being used for population health value-based measurement. Several members indicated that they use other methodologies in their Accountable Care Organizations and other population based risk scores. We strongly and urgently ask CMS to test these various models.

- Medicare Advantage Program offering Institutional Special Needs Plan (I-SNP)