



Sound Policy. Quality Care.

September 11, 2017

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1676-P
P.O. Box 8016
Baltimore, MD 21244-8013
Submitted electronically via Regulations.gov

RE: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program (CMS-1676-P)

Dear Ms. Verma,

The Alliance of Specialty Medicine (the “Alliance”) represents more than 100,000 specialty physicians from 13 specialty and subspecialty societies. The Alliance is deeply committed to improving access to specialty medical care through the advancement of sound health policy. For this reason, we are pleased to provide input on the 2018 Medicare Physician Fee Schedule (MPFS) proposed rule, which focuses on the impact of proposals on specialty physicians and the beneficiaries they serve.

Potentially Misvalued Services

Code screens

Specialty societies in the Alliance have noted that certain codes are continuously captured in CMS’ code screens and proposed as potentially misvalued year-after-year, despite the fact that the codes may have been proposed as potentially misvalued in a prior year and removed from the list. The time and effort expended to research and prepare substantive comments to convince the agency that certain codes should be removed from the list is a significant and resource-intensive activity that takes away from other important mission-driven efforts of our member organizations.

Once CMS has agreed with affected stakeholders that a code is *not* potentially misvalued, that same code should not be proposed as potentially misvalued in the subsequent five-year period, *even if it shows up in a different screen*. The likelihood that a code removed from the potentially misvalued list requires review in a subsequent five-year period, is doubtful. We urge CMS to

propose the aforementioned policy, which would significantly reduce the administrative burden on specialty societies, as well as the agency.

Proposed Valuation of Specific Codes

Members of the Alliance are generally supportive of CMS' approach this year with regard to the proposed valuation of specific codes. Our societies appreciate that CMS proposes to accept a significant proportion of recommendations by the American Medical Association (AMA) Relative Value System Update Committee (RUC), which remains the most robust mechanism for collecting data and establishing relative values. We also appreciate that CMS provides stakeholders with a discussion on alternative approaches the agency might have used to reach a different value, rather than proposing those values. This gives specialties an opportunity to consider the agency's alternative value, while also providing a pathway for CMS to finalize an alternative *at the request of stakeholders* and without violating the Administrative Procedures Act (APA) "logical outgrowth" test.

Nonetheless, we believe many of these alternatives could be raised during deliberations at meetings of the AMA RUC, when specialties and their expert physician advisors are available to engage in a dialogue with CMS representatives. **We urge CMS representatives who attend AMA RUC meetings to engage more actively in discussion with society representatives about the Agency's issues and concerns with work and practice expense values, rather than first sharing in the proposed rule when dialogue is restricted due to the rulemaking process.**

Malpractice Relative Values

Specialty physicians pay some of the highest professional liability (PLI) premiums and the Alliance is concerned about a number of flaws in the Medicare malpractice (MP) calculation that undervalue MP RVUs for some specialties. In the proposed rule, CMS outlined a plan to align the update of MP premium data used to determine the MP RVUs with the update of the MP GPCIs; this would accelerate the update of MP RVUs to 2018, instead of the fourth review that must occur no later than CY 2020, and would change updates to MP RVUs to a three-year cycle. We disagree with this approach due to the following concerns with the MP RVU data collection and methodology.

MP RVUs are determined in four broad steps: (1) calculate a national average MP premium for each specialty, (2) normalize specialty premiums to create a specialty-specific risk factor, (3) calculate unadjusted MP RVUs for each service based on the volume of practitioners that perform a service, and (4) adjust the RVUs for budget neutrality. For the first two steps, CMS has proposed data sets and techniques that are deeply flawed, and this will result in aberrant results in steps 3 and 4.

Calculating a national average MP premium for each specialty: During the last MP RVU update in 2015, CMS mapped malpractice premiums for each specialty to the county level, and then specialty premiums were weighted by total RVU per county to calculate a national average MP premium. In CY 2018, CMS has proposed to weight specialty premiums by the county share of

the total US population. We believe that using population to weight the premium is incorrect. This method does not reflect differences in risk-of-service among different areas of the country. Risk-of-service, not population, reflects how services differ in their contributions to professional malpractice liability. Geographic premium rate differences are based on risk and paid claims, not on how many people live in a geographic area. **The Alliance urges CMS to use work RVUs instead of population to weight geographic differences that are used to calculate national average premiums.**

Normalizing specialty premiums to create a specialty-specific risk factor: CMS collected information obtained from malpractice insurance premium data from all 50 States, and the District of Columbia, and Puerto Rico, but as apparent from the Proposed Rule, many specialties did not have premium data from all 50 states, and based on this CMS decided that these data would be used for specialties that met an arbitrary threshold (data available for 35 or more states). Consequently, 40% of specialties did not meet this threshold, and normalized specialty premiums were generated using cross-walks to other specialties. For all specialties, premium data are broken down into surgical and non-surgical services premiums; twenty-four specialties didn't have sufficient data for one or the other category, and consequently CMS has proposed using a derived "blended" premium. The use of incomplete data and application of "blended" premiums have led to a number of patently absurd inversions in normalized premiums; for example, in Table 8 *Proposed Risk Factors by Specialty Type*, the surgical risk factor for neurology, 13.02, is higher than that of neurosurgery, 10.66. Clearly the data used for this new analysis is flawed, and we do not believe that a single "blended" premium accurately and fairly contributes to the final calculation of MP RVU. **The Alliance urges CMS to ask its contractor to work harder to obtain surgical premium data and we recommend that CMS use the previous surgical premiums until more data can be obtained instead of using blended premiums for MP RVU calculations.**

Non-physician cross-walks: In addition, non-physician providers in 9 areas did not have data that met the above threshold; consequently, they were cross-walked to the physician specialty with the lowest MP premium data (Allergy/Immunology). Unfortunately, this still represents an overestimate of MP premiums for these non-physician providers, and with budget neutrality this will impact MP RVUs across all specialties. **We urge CMS to collect premium data for the non-MD specialties and use updated data from all fifty states.**

MP RVU Valuation for Low and No Volume Services: We commend the agency for accepting the RUC specialty designation "overrides" for very low volume services to prevent significant variation in year-to-year MP RVUs. The issue of valuing PLI RVUs for low volume codes has long been a concern for neurosurgery, the specialty with some of the very highest PLI payments. Some codes are so rarely performed or have such low Medicare volume for a particular year that the dominant specialty may be incorrect and, therefore, may not accurately reflect the risk. We agree with the RUC that code-specific "overrides" are essential when the claims data are inconsistent with the specialty that would be reasonably expected to furnish the service. Some procedures may be very low volume for Medicare but have greater volume for Medicaid or other payers, further propagating errors. This year the RUC has provided a similar

recommendation for procedures that may have no Medicare volume for a given year. **The Alliance supports the RUC specialty designation “overrides” for these codes as well.**

Transition from Traditional X-Ray Imaging to Digital Radiography

Last year, CMS implemented Modifier FX to implement provisions in the Consolidated Appropriations Act of 2016 that call for reduced payments under the PFS for the technical component (including the technical component of a global service) of imaging services that are *X-rays taken using film* by 20 percent effective for services furnished beginning January 1, 2017. In this rule, CMS is proposing another modifier (Modifier “XX”) to implement the remaining provisions that call for a 7 percent reduction in payment amounts for imaging services under the PFS that are *X-rays using computed radiography technology* (including the X-ray component of a packaged service) in CYs 2018, 2019, 2020, 2021, or 2022, and by 10 percent in CY 2023 or a subsequent year.

We recognize that CMS is implementing the law as required; however, the addition of multiple new modifiers at a time when a multitude of other regulatory changes to the Medicare payment system are underway, only adds to the significant administrative burden facing physician practices. We are concerned that many physicians’ practices with “antiquated” imaging equipment remain unaware of the requirement to use the new modifier(s). As a result, use of the new modifier(s) will not be well understood without enhanced education. While CMS is likely to issue subregulatory guidance, similar to last year, it will likely be scarce and released too close to the date by which practices would need it in order to properly modify their practice management/billing systems to accommodate the new modifier(s). Of course, the financial and criminal repercussions of omitting or incorrectly applying the modifier(s) is an even greater concern.

It is incumbent upon the agency to ease the regulatory burden as much as possible with respect to the new modifier(s). Therefore, **we urge CMS to hold physician practices harmless from financial and criminal penalties if they omit or incorrectly apply the new modifier(s) when billing for imaging services using older equipment, at least for the first three-years of the program (i.e., 2017 - 2019).** CMS should use this “grace period” to work with its Medicare Administrative Contractors (MACs) and specialty societies to educate practices on the availability of the new modifiers and associated billing/coding requirements. Similarly, **CMS must not approve audits by Recovery Audit Contractors (RACs) related to the implementation of the transition from traditional x-ray imaging to digital radiography using the aforementioned modifier(s),** given the aforementioned concerns.

Evaluation and Management (E/M) Guidelines and Care Management Services

CMS seeks input from a broad array of stakeholders, including patient advocates, on the specific changes CMS should undertake to reform the guidelines, reduce the associated burden, and better align E/M coding and documentation with the current practice of medicine.

Generally, the Alliance supports the Administration's effort to reduce administrative burden on physicians as much as possible, which would include simplification of E/M documentation guidelines. However, we are concerned about potential unintended consequences of such an effort, which is likely to take several years and expose many other, extraneous issues that will lessen the favorable impact the activity was intended to have.

Should CMS proceed with this significant undertaking, **we urge the agency to exercise extreme caution and work closely with specialty physicians who have challenges that are different than their colleagues in primary care.** Since the original guidelines were developed, the role of specialty physicians has evolved to include managing multiple, chronic comorbid conditions, prescribing of complex and highly regulated medicines and biologics, and coordinating care for the sickest and most vulnerable Medicare beneficiaries. These changes must be considered as CMS develops proposals for simplifying E/M documentation guidelines. CMS must also consider the widespread use of electronic health record (EHR) systems and other health information technologies that play a role in capturing important aspects of E/M services and help physicians with medical decision-making through clinical decision support.

In addition, prior to 2010, Medicare paid for consultation codes that were commonly reported by specialty physicians. These codes recognized the additional physician work associated with assessing the needs of typically exceedingly sick patients that could not be managed by their primary care physicians alone. In January 2010, Medicare arbitrarily eliminated consultation services. As part of a thorough review of E/M services, **we urge the agency to revisit the issue of consultation codes.** We remain opposed to the agency's decision in that regard and believe that the full consequences of the elimination of the consultation codes has not been adequately analyzed, particularly now that a number of private payors have followed the CMS lead and stopped paying for these services. The work of specialty consultations provided in both the inpatient and outpatient settings are distinctive from other E/M visits. Those important differences should be examined as part of any comprehensive update in E/M reporting.

Regarding care management services, CMS has made a concerted effort to improve beneficiary access to new chronic care management (CCM) services. The agency has initiated multiple email and social media campaigns aimed at making providers aware of these billable services and how to implement these services in practice. Unfortunately, most of the educational tools have been geared toward primary care physicians. In some cases, specialty physicians may be the most appropriate provider of CCM services. To that end, we encourage CMS to consider making specialists a larger part of its outreach efforts and designing its tools with the specialty care physician in mind.

Appropriate Use Criteria for Advanced Diagnostic Imaging Services

Section 218(b) of the Protecting Access to Medicare Act (PAMA) of 2014 establishes a new program for fee-for-service Medicare to promote the use of appropriate use criteria (AUC) for advanced diagnostic imaging services. In this proposed rule, CMS proposes to continue to establish requirements for this program. Specifically, CMS proposes that ordering professionals

must consult specified applicable AUC through qualified clinical decision support mechanisms (CDSMs) for all applicable imaging services ordered beginning in 2019, and that furnishing professionals must report on such AUC consultations on the same time frame using a combination of HCPCS level 3 codes and modifiers. However, CMS also proposes to make 2019 a “testing period” under which CMS would continue to pay claims whether or not information regarding the AUC consultation was correctly reported on the claim.

The Alliance continues to strongly oppose using AUC for withholding payment for services provided. AUC are designed to help ensure that the best information is available for clinical decision-making and to help support appropriate choices by physicians and their patients in the context of good clinical judgment and patient preferences. AUC are developed to identify common clinical scenarios, but they cannot possibly include every patient presentation, clinical scenario, or set of patient preferences.

The Alliance believes that this program places excessive burden on physicians across a broad range of specialties with little evidence of clinical benefit. Additionally, CMS has yet to finalize all of the policies that will enable physician practices to prepare for the proposed 2019 requirements and to make informed practice changes in a timely manner, including investments in CDSMs, updating of reporting and billing systems, and incorporating consultation into practice patterns.

Furthermore, we believe the AUC program is duplicative of – and even inferior to – the Quality Payment Program (QPP), which CMS established to implement the physician payment reforms enacted under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The QPP already holds clinicians accountable for quality and patient outcomes (something that the AUC program fails to do), as well as for resource use, including the use of diagnostic tests and procedures. Given the enactment of MACRA and CMS’ implementation of the QPP, we believe that this separate program is redundant and that CMS can readily incorporate the use of AUCs for diagnostic imaging into the QPP. As one example, CMS recently proposed an improvement activity for the Year 2 of the MIPS program – *Consulting AUC Using Clinical Decision Support when Ordering Advanced Diagnostic Imaging* – which the agency is poised to finalize in the fall.

The Alliance is pursuing a legislative solution that would terminate the requirements on ordering professionals to consult AUC and on furnishing professionals to report on such consultation, in recognition of the duplication and burden created by the AUC program relative to the QPP. **We urge CMS to work with Congress to achieve these goals.** In the interim, we believe a delay in CMS’ proposed requirements for consulting AUC and reporting on such consultants is essential given challenges facing specialty physicians with the implementation of this program, including the lack of available clinical decision support mechanisms (CDSMs) that are appropriate for various specialties and compatible with the wide variety of EHR and practice management systems they use, which may be different from their colleagues in primary care. **As such, we urge CMS to further delay the effective date of the AUC consultation and reporting requirements until at least 2021, or until CMS can adequately address the technical**

and workflow challenges that are expected to arise and carefully assess ways in which the QPP could meet the same goals with less clinician burden.

Physician Quality Reporting System (PQRS) Criteria for Satisfactory Reporting for Reporting Individual EPs and Group Practices for the 2018 Payment Adjustment; Clinical Quality Measurement for Eligible Professionals Participating in the Electronic Health Record (EHR) Incentive Program for 2016; and Value-Based Payment Modifier and Physician Feedback Program

Under current law, physicians and other eligible professionals are subject to requirements and related penalties under the PQRS, the EHR Incentive Program, and the Value-Based Payment Modifier (VM). While MACRA consolidates and replaces these three programs with the Merit-Based Incentive Payment System (MIPS) starting in 2019, eligible professionals are subject to payment adjustments in 2018 based on reporting and performance under these programs for 2016.

CMS makes multiple proposals that lower the reporting requirements for avoiding the 2018 PQRS and EHR Incentive Program penalties and that reduce the magnitude of applicable VM penalties if they are triggered. While we appreciate the direction of these proposals, we urge CMS to finalize policies that would further limit the impact of the penalties. **Specifically, we urge CMS to provide full relief from penalties under each of these three programs for all clinicians who at least attempted to report any data for CY 2016 performance applicable for each respective program.** Applying penalties only to clinicians who did not attempt to report anything will ensure that CMS still has a pool of funding available to reward high performers with upward payment adjustments under the VM. **We also urge CMS to finalize its proposals to reduce negative VM payment adjustments if penalties are triggered.**

We note that MACRA included a 0.5% update to the Medicare physician fee schedule conversion factor between 2016 – 2019, which aimed to provide a “period of stability” in Medicare reimbursements while physicians prepared for and transitioned to MIPS. Unfortunately, other changes in law and regulation essentially overrode the intended impact of these positive updates. Thus, the promised “period of stability” was never fully realized. By reducing the negative financial impact of now-sunset quality improvement programs, CMS would be helping restore the “period of stability” providers were granted under MACRA.

Medicare Shared Savings Program (MSSP)

MSSP Initial Application

We have concerns that CMS proposes to no longer require Medicare Accountable Care Organization (ACO) applicants to submit narratives describing how they would distribute shared savings payments. Instead, CMS proposes to simply have each ACO state that it has a method and a plan to receive shared savings payments and to distribute those payments to its ACO

participants and ACO providers/suppliers, as required by statute. CMS proposes it would also continue requiring ACOs to publicly report information on their web sites about shared savings and losses, including the proportion distributed among ACO participants.

As the agency is aware, there is no requirement that MSSPs share any savings with ACO participants and ACO providers/suppliers, such as specialty physicians, at all. We have continuously raised concerns about this issue. **Shared savings should be distributed to ACO participants and ACO providers/suppliers commensurate with their level of engagement with the ACOs assigned population and overall contribution to the ACO's success.** By removing the requirement that ACOs must provide a narrative describing how they would distribute shared savings payments, CMS is *de facto* eliminating any liability or accountability from the ACO where it may have outlined a plan that included sharing savings with specialty physicians. Further, maintaining the requirement that ACOs publicly report information on their web sites about the proportion distributed among ACO participants, such as specialty physicians, will not prove useful as there are no specific requirements as to how this information must be delineated or "parsed."

We urge CMS to reconsider its proposal, as well as put forward new requirements such that MSSP ACOs must share some portion of their savings with ACO participants and ACO providers/suppliers, including specialty physicians, that have facilitated the ACO's success through improvements in cost and quality.

MACRA Patient Relationship Categories and Codes

CMS' proposal to allow voluntary submission of patient relationship codes on or after January 1, 2018, is premature. The agency has been in the midst of developing a new set of episode-based cost and resource use measures for several months, however, none of these measures are available for use, or even review and comment, at this time. Without a better understanding of these new measures, it is ill-advised to begin reporting the very patient relationship codes that were specifically designed to attribute beneficiary costs to clinicians under these measures.

In addition, there are multiple unanswered questions that specialists face with the use of these new codes, including the following:

- What are the consequences of reporting a specific relationship?
- To whom are you really being compared?
- What happens if your relationship changes throughout the course of an episode of care?
- What happens if multiple physicians report the same relationship?
- What happens if no physicians report a relationship at all? Which physician(s) would be attributed the episode?

We are concerned that CMS is "piloting" the patient relationship codes to answer, rather than verify, a number of important questions.

Given the statute provides significant flexibility, that episode-based measures remain in development, and physicians are still trying to grasp the rules and requirements of the Quality Payment Program, in general, **we urge CMS to delay the implementation of the patient relationship codes.**

Request for Information on CMS Flexibilities and Efficiencies

The Alliance appreciates the opportunity to submit ideas that would improve the Medicare program and CMS' efficiencies. While we provide a few suggestions below, we urge CMS to continue the dialogue with the Alliance and allow the ongoing submission of ideas through various avenues.

Consideration of Specialty Physicians in Medicare Payment and Other Policies and Programs

Member organizations in the Alliance represent specialty and subspecialty organizations; however, many programs fostered by the agency do not fairly consider or even recognize all of these specialties and subspecialties in a meaningful way. Subspecialty groups that do not have a separate specialty designation in Medicare face unique challenges, given they are largely compared to their "peers" in the broader specialty. For example, Mohs micrographic surgeons are identified in claims and other datasets as relatively high-cost providers, because they are being compared to the whole of dermatology. Mohs surgeons focus their practice on skin cancer diagnosis and treatment, unlike a lot of other dermatologists who may be focused on other conditions, such as acne or psoriasis. Failure to "parse" the subspecialty providers creates challenges in CMS' value-driven payment initiatives and in determining whether Medicare Advantage Organizations (MAOs) have adequate provider networks.

Individually, many of these specialty and subspecialty providers have urged CMS to use "Level III, Area of Specialization" codes from the Healthcare Provider Taxonomy code set to develop quality and cost benchmarks to at least somewhat level the playing field. **We request that CMS begin the process for developing appropriate benchmarks for these providers using the aforementioned "third-tier" taxonomy codes. We also request that CMS update requirements for MAOs when determining network adequacy calculations to account for all specialty and subspecialty providers.**

Overall, the lack of specialty and subspecialty recognition is an important disparity in the program that severely hinders those providers who have furthered their education and training in a specific area in order to treat some of the most complex conditions, and it must be addressed moving forward. CMS must consider these concerns and recommendations and finalize policies that would ensure specialty and subspecialty physicians are properly recognized and considered in the development of CMS' policies and can meaningfully engage in CMS' programs.

Finally, CMS has historically focused its educational tools and awareness campaigns with an eye toward primary care providers, with little consideration of the impact on specialists and the care they deliver to beneficiaries. This disparity must not continue if CMS' programs and initiatives are to be successful for the whole of beneficiaries being served. **We urge CMS to make a concerted effort to include specialty physicians and the beneficiaries they serve when developing educational tools and conducting outreach.**

“On-Ramping” for New CMS Programs

In its 2018 Quality Payment Program (QPP) proposed rule, CMS provides significant relief to the broad majority of physicians as they transition to the MIPS program. However, it is important to recognize that physicians from different specialties and subspecialties and clinicians in different practice settings will continue to experience disparities in their ability to participate robustly in all aspects of MIPS. For example, some specialties and subspecialties may not have a sufficient number of measures to fully and meaningfully participate under the Quality performance category, and some clinicians may not have the information technology resources to fully participate under the Advancing Care Information performance category. In addition, clinicians new to Medicare will need more time to familiarize themselves with QPP requirements than currently provided under MACRA. MACRA currently only exempts new clinicians from MIPS requirements for the time between when they enroll and the end of that same performance period. Depending on when they enroll, the exemption may be as short as month or less, which would not provide sufficient experience with the program for new clinicians to succeed. For specialty physicians, this is even more problematic, given that the number of measures and availability of EHRs are significantly limited when compared to their peers in primary care specialties. In recognition of these challenges, **CMS should provide additional flexibility in assessing specialty physicians under a performance category. In addition, CMS should provide for an additional “on-ramping” for clinicians new to Medicare to ensure they have sufficient opportunity to learn about and prepare for MIPS participation.**

Further, the concept of “on-ramping” should not be limited to the MIPS program. CMS establishes multiple new programs in which physicians engage, voluntarily or as a requirement. Periods of transitions are essential, particularly for specialists that have unique challenges over-and-above their peers in primary care. **We urge CMS to build-in periods of transition such that specialty physicians are able to ease into new programs, which would help reduce the administrative burden on specialty physicians and their administrative staff.**

“Meaningful Use” Hardship Exemption

As we have noted in prior comments, specialty physicians face unique challenges with adopting certified EHR technology (CEHRT). The availability of clinically-relevant systems for specialists is extremely limited, not to mention the cost associated with their purchase. Moreover, the objectives and measures included in the EHR Incentive Program continue are largely irrelevant, offering little opportunity for specialists to demonstrate their use of health information technologies. CMS has not fairly emphasized the value of clinical data registries that far surpass the utility of the “meaningful use” program – a major disappointment for our member

organizations that have invested heavily in the development of tools which have a demonstrated impact on improving quality and outcomes in specialty medical care. In light of these concerns, **we urge CMS to provide additional relief for physicians by offering a new hardship exemption for administrative burden in this last year of the meaningful use program.**

Modifications to CMS' Web Site

Navigating CMS' web site for information on Medicare payment and other policies is a significant issue for specialty physicians and their administrative staff. Even specialty society staff, who are generally considered "experts" in Medicare program policies, struggle to find necessary information in response to member questions. CMS' QPP web site is a model for how information on other CMS programs should be made available, particularly on program integrity initiatives. We urge CMS to revamp its web pages to be more user-friendly, with a focus on consolidating information on key topics, such as program integrity. This would significantly reduce the time it takes for their practices to search the CMS web site for information they routinely need to carry out day-to-day operations of serving Medicare beneficiaries.

In addition, **we urge CMS to establish additional "specialty resource center" web pages as part of the Medicare Learning Network web site, similar to what it has done for other specialties' – including Ophthalmology and Anesthesiology – to provide links to relevant CMS rulings, correct coding edits, and other important information relevant to various specialties.** Alliance member organizations would be happy to work with CMS' Medicare Learning Network staff to help identify and populate the site with the most appropriate information for their specialty.

The Rulemaking Process

Alliance organizations and their members are overwhelmed by the volume of Medicare regulations that are released each year, the size of the regulations, and the short comment periods, given the complex issues that must be addressed. Often times these regulations are released in tandem, leaving little time for organizations to meaningfully consider the long-term impact multiple proposals may have on specialty physicians and the beneficiaries they serve, and offer substantive comments and feasible solutions for improving the proposals or addressing agency concerns. Certain regulations, such as annual payment rules, are also released so close to when they are statutorily required to be implemented, it is unclear whether CMS is afforded an opportunity to consider the issues our societies raise in response to its proposals. Finally, we have frequently found that "random" proposals are included in regulations that are not pertinent to the program or provider type that the regulation aims to address, which creates additional challenges for stakeholders, particularly if CMS is not ensuring affected stakeholders are notified that proposals have been included regulations out of their "traditional" scope of review.

We urge CMS to consider ways to improve its rulemaking process, including releasing annual payment regulations earlier in the year (e.g. April or May) and providing longer comment

periods (e.g., 90-120 days). We also urge CMS to streamline its regulations and ensure topics under consideration are relevant to the intended stakeholder audience.

We appreciate the opportunity to provide comments on the aforementioned issues of importance to the Alliance. Should you have any questions, please contact us at info@specialtydocs.org.

Sincerely,

American Academy of Facial Plastic and Reconstructive Surgery
American Association of Neurological Surgeons
American College of Mohs Surgery
American College of Osteopathic Surgeons
American Gastroenterological Association
American Society for Dermatologic Surgery Association
American Society of Cataract and Refractive Surgery
American Society of Echocardiography
American Society of Plastic Surgeons
American Urological Association
Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons
North American Spine Society