

September 27, 2019

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The Honorable Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
Attention: CMS-1715-P  
P.O. Box 8016  
Baltimore, MD 21244-8016

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:

The American Academy of Sleep Medicine (AASM) appreciates the opportunity to comment on the proposed rule for the 2020 Physician Fee Schedule and Quality Payment Program, as the proposed revisions will directly impact AASM member participation and reimbursements, going forward. The comments included in this response reflect the needs of our over 9,000 individual members and 2,500 accredited sleep centers, providing sleep medicine services to the Medicare population.

**IID. Determination of Professional Liability Insurance Relative Value Units (PLI RVUs)**

*Proposed Methodological Refinements - Imputation Methodology*

In the CY 2020 Proposed Rule, the Centers for Medicare & Medicaid Services (CMS) has seemingly improved its data acquisition methodologies for identifying adequate premium data, but highlights that data are still missing. To address the missing data, CMS proposes utilizing partial and total imputation to develop a more comprehensive data set, particularly for specialties that are not identified in insurer filings, and suggests mapping to

related specialties, to fill this void. While the AASM supports CMS in attempting to identify adequate premium data, we are concerned that CMS is implementing a flawed methodology through mapping, as specialty practices differ, and these differences largely impact premium costs. The example highlighted within the rule, in which sleep medicine is linked to general practice, is problematic, as sleep medicine is specialized, and the premium costs vary greatly from that of general practice. If mapping will be implemented, AASM suggests mapping sleep medicine to neurology or pulmonology, as specialties with similar practice patterns for the treatment of sleep disorders. ***Overall, the AASM supports the efforts of CMS to develop a more comprehensive data set and encourages the Agency to implement methodologies that ensure data are as accurate as possible for all specialties.***

### **Physician Supervision for Physician Assistant Services**

The AASM supports CMS's desire to align regulations with state scope of practice laws, as all states require physician assistants (PAs) to practice with physician supervision/collaboration. However, while we support this opportunity for alignment, we are concerned with the proposed language that allows physician services to be "...evidenced by documentation in the medical record of the PA's approach to working with physicians in furnishing their services." ***As there are some states that require supervision and others that require collaboration, the AASM encourages CMS to finalize modified language, to ensure that PA services are not provided independent of physician oversight. AASM recommends that CMS specify that PA services are provided with physician collaboration or under appropriate supervision, per state laws.***

### **Review and Verification of Medical Record Documentation**

The AASM continues to support CMS's efforts to reduce administrative burden, as we note that physician burnout affects a broad swath of the clinical population.<sup>1</sup> ***AASM believes that the proposal to establish a general principle to allow the physician, the PA, or the (Advanced Practice Registered Nurse) APRN who furnishes and bills for their professional services to review and verify, rather than re-document, information included in the medical record by physicians, residents, nurses, students or other members of the medical team, is consistent with the "Patients over Paperwork" initiative and will ultimately improve care delivery by reducing administrative burden and allowing healthcare providers to spend more time focusing on the provision of high quality care.*** We encourage this principle of eliminating unnecessary duplicate documentation to be applicable to all physician fee schedule services.

### **Comment Solicitation on Consent for Communication Technology-Based Services**

AASM appreciates the opportunity to provide comment on whether a single advance beneficiary consent could be obtained for a number of communication technology-based services. Upon closely reviewing the code descriptor and attempting to educate the AASM membership on the

appropriate use of codes G2012 and G2010, we received a significant amount of feedback regarding the requirement to obtain and document patient consent for every encounter. Members were very concerned about the administrative burden associated with this requirement and noted that this additional documentation may discourage them from using and reporting these services with these codes. ***AASM members suggest that CMS revise this requirement to allow for documentation of patient consent on an annual basis in the medical record, to reduce administrative burden associated with providing these services.*** This will allow the consent to be renewed in the office as other documents are updated by administrative staff. This annual renewal may also be incorporated into platforms that host patient portals, so those patients are able to re-attempt online. We believe there is little need for concern regarding potential program integrity since the services are both patient-initiated services.

### **Comment Solicitation on Opportunities for Bundled Payments under the PFS**

CMS is soliciting comments on opportunities for bundled payments under the PFS. AASM believes that bundled payments for episodes of care support the goal of encouraging value-based care across the health care landscape, and support the Institute for Healthcare Improvement's Triple Aim, which is to provide better care for individuals, better health for populations, and lower per capita costs. ***As such, AASM supports the idea of per-beneficiary payments for condition-specific episodes of care, if the episodes are developed by or with the input of appropriate medical specialties.*** Costs of bundles can be established based on the RVUs and reimbursement amounts assigned to each procedural code, included for all patient encounters throughout the episode of care. The total reimbursement amount can then be discounted to ensure cost savings as intended by the Agency. We also encourage CMS to continue allowing voluntary participation in bundled payment programs, as providers share in the risk with the predetermined price and must cover any potential unanticipated costs that may arise from complications.

### **Payment for Evaluation and Management Visits**

The AASM participated as an engaged stakeholder through the entire development process of the AMA Evaluation and Management (E/M) Workgroup, which was convened to develop a new E/M coding structure, while considering relativity issues for these office visit services. AASM continues to support the Workgroup's recommendations submitted to CMS, as the group routinely collected and discussed feedback from medical specialty societies and other stakeholder organizations throughout the process of developing the revised coding structure, guidelines, and recommended RVUs for the office visit codes. ***AASM supports the recommended CPT coding changes, including reducing the new patient office visit levels to four by eliminating code 99201 and revising the code definitions and guidelines, as proposed.*** We encourage CMS to finalize the changes to the times and the medical decision-making (MDM) definitions for the codes, as submitted, as these revisions will allow physicians to choose the appropriate visit levels based on time or MDM. The AASM also encourages CMS to finalize the work values, physician times,

median total time and practice costs for the E/M office visits, as submitted by the RUC, given the robust data collected through the engagement of over 50 medical specialty societies in the survey process. We also encourage CMS to finalize all of these changes to be effective on January 1, 2021. While we note that CMS is seeking comment on whether systematic adjustments should be made to other services to maintain relativity between them and the E/M office visits, we encourage CMS to allow the AMA E/M Workgroup to review this issue through the CPT and RUC processes to determine if this is necessary.

### **MIPS Value Pathways (MVP) Request for Information (RFI)**

The AASM appreciates this opportunity to provide a response to this Request for Information about potential substantial changes to the Quality Payment Program. ***We absolutely agree that the program would benefit from more streamlined and cohesive reporting, as well as enhanced and timely feedback. However, we are concerned that a complete overhaul to the MIPS program, at this point, may be challenging to eligible clinicians, as they are still learning the reporting requirements and scoring methodology for the MIPS program since its implementation in 2017.*** Should CMS decide to move forward with the MIPS Value Pathways as described in the rule, we strongly urge the Agency to make participation in MVPs voluntary, as clinicians in small or solo practices will likely find the recommended changes to be more burdensome and impracticable than those in larger academic settings and/or hospital systems. We also believe that successful implementation of the MVP framework will take several years to test and refine and suggest that eligible clinicians that volunteer for participation should receive an incentive for participating during the first two years.

#### *MVP Framework*

The AASM recognizes the need to streamline reporting requirements for participation in the Quality Payment Program. However, the proposed requirements for MVPs seem to carryover the same level of complexity that exists in the current program reporting requirements. Our members have historically reported being unclear about which measures to report for participation in the MIPS program, due in part to the limited number of measures that are relevant to the sleep medicine specialty. This issue was further exacerbated by CMS removing two sleep apnea measures from the program for the 2019 reporting year, as sleep medicine professionals now have even fewer measures to report that are particularly relevant to the specialty. ***While we understand that CMS is moving forward with the Meaningful Measures initiative, we are concerned that there will continue to be limited opportunities for reporting relevant measures and activities for sleep medicine professionals, which will also translate to fewer relevant measures and improvement activities included in the MVPs.***

Our members have also expressed confusion about reporting in four separate categories for participation in the Quality Payment Program, which CMS is attempting to address by essentially combining the reporting categories within the proposed MVP framework. However, we note that

eligible clinicians will still need to attest to improvement activities, some of which would already be included in some MVPs. ***We urge CMS to consider automatic credit for improvement activities that are inherent in established MVPs.*** Additionally, CMS is proposing to make the Promoting Interoperability (PI) category mandatory while there are still some sleep medicine physicians that have not yet been able to incorporate health IT into their practice and find the PI category extremely burdensome. ***We oppose CMS's proposal to make PI reporting mandatory and suggest that CMS consider alternative ways to give credit for meeting this criterion including, but not limited to, participating in a Qualified Clinical Data Registry (QCDR) for measure reporting.***

#### *Population health measures*

CMS is proposing to include condition and specialty-specific measures and improvement activities, layered on top of a base of population health measures, which would be included in all of the MVPs. ***While the AASM understands the potential benefit in including population-based measures, we urge CMS to instead make these measures optional for groups to report.*** These proposed measures are not intended for reporting by individual clinicians or by small group practices and would not accurately highlight the quality of care provided by the reporting eligible clinician. Individuals and small practices will not likely have large enough sample sizes to determine reliability of these measures.

#### *Assignment to MVPs*

CMS seeks comments regarding how to determine MVP assignment and specifically requests comments on the amount of choice clinicians should have in selecting an appropriate MVP, for participation, suggesting that assigning MVPs will simplify the program and take away the burden of selection. ***AASM strongly opposes CMS's suggestion to assign MVPs, as clinicians should be allowed autonomy in determining which MVPs are most relevant and feasible for their practice.*** Since MVPs will include a combination of measures and improvement activities, there is no way for CMS to know or determine which of the MVPs would be most appropriate for each clinician. While there are currently existing specialty measure sets included in the MIPS program, some clinicians are not able to report the sets determined by CMS, and instead may select to report other measures and we believe that participants in the potential MVP program should have the same level of autonomy. Additionally, as a smaller medical specialty, sleep medicine is generally not included when specialty specific reporting options are created, and we are extremely concerned that our members would potentially be required to report MVPs that are not entirely applicable. We would welcome, however, CMS making recommendations for appropriate MVPs. ***We also urge CMS to reach out to medical specialty organizations to engage in MVP development to ensure that MVPs are available for all medical specialties.***

#### *Call for MVPs*

***We understand the need for a process to manage the submission of MVPs, however, we urge CMS to reconsider the Call for MVP process, potentially aligning with the current measure submission processes.*** The current measure submission process is complicated and burdensome,

and there is a significant amount of time between submission and implementation. Additionally, we strongly urge CMS to consider an approach that does not include the Measures Application Partnership (MAP) review of MVPs, as measures submitted to the MAP have to be submitted two years ahead of the intended year of implementation, and if they are not recommended for implementation, have to be revised and resubmitted during the next cycle for review. Additionally, smaller medical specialties are not generally represented on the MAP and may not have a strong voice during the review process. ***We suggest allowing MVPs to be submitted for review so that CMS staff can provide feedback, similar to the QCDR measure submission and review process.*** This process would allow for adequate communication and engagement between CMS and the submitting organization.

#### *Quality Measure Selection*

CMS is seeking comments as to whether MVPs should include only required measures and activities or if they should include a list of measures and activities for participant review and selection. ***We suggest that CMS allow eligible clinicians to select the measures and activities they would like to report within an MVP, as long as they report the minimum number required for each.*** Given differences in practice size, specialty, etc., not all measures and activities will be relevant for each sleep medicine professional and allowing participants to choose will address this concern.

#### *MVP measure and activity criteria*

As an organization focused on a smaller medical specialty, we know that many of our members are board-certified in multiple specialties and that not all MVPs seemingly related to sleep medicine will be applicable to all sleep medicine clinicians. ***That said, we suggest that the measures and activities included in an MVP should be condition-specific, as opposed to having MVPs be developed for a particular specialty. We also encourage CMS to focus on prioritizing measures and improvement activities that are evidence-based.***

#### *Data collection type*

***While we understand the goal of having a comparable data set within MVPs, AASM urges CMS not to include a specific requirement associated with data collection type.*** Smaller and solo practices may not have access to resources required for submission in the preferred format including, but not limited to, an electronic health record infrastructure. ***We would, however, support an incentive for eligible clinicians that submit data in the preferred format.*** We urge CMS to stratify data by data collection type and to develop benchmarks for each data collection type as well. Again, we encourage CMS to allow QCDR submission for MVPs.

#### *Data feedback for specialty societies and MVP developers*

***The AASM supports the provision of actionable data feedback to eligible clinicians, and we also encourage CMS to provide specialty specific data for the purposes of developing MVP proposals/submissions.*** While the provision of individual data is helpful, specialty societies will

very likely be charged with leading the development of measures and improvement activities included in MVPs and will need access to data in order to identify and address gaps and variations in care. We encourage CMS to share aggregated data in the Quality Payment Program Experience Reports. We also suggest data be stratified by specialty, practice type, and data submission type.

#### *Patient Experience and Satisfaction*

***The AASM recognizes the need for collection of additional patient experience and satisfaction data. However, we strongly oppose CMS implementing one survey to capture this data.*** We suggest CMS consider including condition and/or specialty-specific validated patient reported outcome measures. While we know that CMS has historically included Consumer Assessment of Healthcare Providers & Systems (CAHPS) in national quality reporting programs, there are several other validated tools to consider. We encourage CMS to seek input from specialties regarding which tools are being used regularly, before deciding which tools to implement in the program in future years.

#### **MIPS Quality Performance Category**

##### *Measure Removal*

In an effort to continue implementing the Meaningful Measures initiative, CMS continues to propose measures for removal from the MIPS program. ***AASM strongly opposes this approach.*** As previously stated, removing specialty specific measures from the program continues to increase the administrative burden and increase the complexity of the program for eligible clinicians. Practices invest a significant amount of time and resources to ensure participation in the MIPS program, and when CMS reduces the number of measures that are particularly relevant to a specialty, it leaves eligible clinicians scrambling to identify other relevant measures and having to modify their workflows to ensure that appropriate data are captured. These proposed changes are making participation in the program more and more burdensome for sleep medicine physicians, in direct contrast to the goals of the Patients over Paperwork initiative. It also reduces the likelihood that eligible clinicians will earn an incentive payment, especially when CMS is proposing to simultaneously increase the performance threshold. The proposed removal of so many measures may lead to the elimination of measures that are needed to demonstrate quality of care in specific specialties. ***We also strongly oppose the proposal to remove a measure from the program after only two years of implementation, as measure stewards invest many resources into measure development and may need time for measure dissemination and education for increased adoption and reporting.***

***The AASM fully supports the CMS proposals to include measures 277 – Sleep apnea: Severity assessment at initial diagnosis and 279 – Sleep apnea: Assessment of Adherence to Positive Airway Pressure Therapy to the Pulmonology specialty set. We also support the continued inclusion of these measures in the Otolaryngology and Internal Medicine specialty sets and urge***

***CMS to consider including them in the Neurology set as well.*** Many board-certified sleep medicine physicians are also board-certified in Neurology and would benefit from these measures being included. Inclusion in the Neurology set may also lead to increased reporting of these measures and more robust data on sleep apnea diagnosis and treatment.

#### *Data completeness threshold*

CMS is proposing to increase the data completeness threshold to 70 percent. ***While the AASM understands that the average data completeness for reporting on quality measures is 70 percent of denominator eligible patients, increasing the threshold is in direct contrast to the goals of the “Patients over Paperwork” initiative, established to reduce administrative burden while allowing physicians to focus on the provision of high quality care to patients.*** We urge CMS not to penalize all MIPS participants by burdening them with unrealistic requirements, as CMS implements efforts to minimize cherry-picking. This new threshold may be particularly burdensome to sleep medicine professionals as ours is a specialty that allows for the provision of services across multiple sites using the same NPI, and not all sites participate in the MIPS program or have the same reporting modality. We also know that data integration and data exchange are particularly challenging in sleep medicine as not all eligible clinicians have access to registries and/or EHRs. We urge CMS not to increase the minimum threshold.

### **Qualified Clinical Data Registry and Deeming Process**

#### *Measure testing*

***The AASM strongly opposes the CMS proposal to require measure testing as part of the QCDR deeming process starting with the 2021 performance period.*** Many specialties have quality measures that have not yet been tested for scientific acceptability, due to a lack of data and/or resources to support testing. QCDRs allow those measure stewards to implement quality measures and collect data that will allow for testing, in the future. Requiring testing data for QCDR measures will essentially create more burden and will dissuade many measure stewards from submitting measures for inclusion in the MIPS program. This requirement will also limit QPP participation, in the instance that measure stewards have no available data for testing. We encourage CMS to continue to allow QCDR stewards to include measures without testing data, allowing enough time for measure stewards to collect data for this purpose, amongst many others.

#### *QCDR licensing*

***The AASM strongly opposes the proposal to remove QCDR measures from the MIPS program if licensing requirements are not met, as measure licensing/sharing should be determined at the discretion of the measure stewards.*** The foundation of the QCDR program is to allow QCDR stewards to develop their own quality measures for implementation in the MIPS program. QCDR stewards should be allowed to develop their own licensing agreement requirements of third party use of their measures, without input from CMS, which may include data sharing, demonstrated



data mapping to ensure appropriate and accurate data collection, and educational requirements for appropriate /implementation of the measure.

## **MIPS Payment Adjustment**

***The AASM strongly opposes increasing reporting requirements and performance thresholds in the MIPS program. We, instead, recommend that CMS continue to evaluate how to make participation in the program less burdensome for eligible clinicians to participate.*** As a small medical specialty, we are particularly concerned about the potential impact on small practices, as our members attempt to meet reporting requirements and find them increasingly burdensome. We urge CMS to maintain stability of the program and focus on how to make the program more clinically meaningful for both patients and providers. We also adamantly oppose the proposed increase in the performance threshold to 60 points in 2021 and 75 points in 2022, as we do not yet know how the inclusion of new measures and clinician types will impact the mean and median. We encourage CMS to maintain current thresholds and provide more resources to help clinicians to participate, rather than making participation more difficult.

Thank you for your consideration of these comments. The AASM appreciates the Agency's efforts to revise the Medicare Physician Fee Schedule in order to prioritize clinical care for patients, while reducing administrative burden. We encourage the Agency to adopt the changes outlined in this letter. Please feel free to contact Diedra Gray, AASM Director of Health Policy, at [dgray@aasm.org](mailto:dgray@aasm.org) or 630-737-9700, for additional information or clarifications.

Sincerely,

Kelly A. Carden, MD, MBA  
AASM President

cc: Steve Van Hout, AASM Executive Director  
Sherene Thomas, AASM Assistant Executive Director  
Diedra Gray, AASM Director of Health Policy

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<sup>i</sup> Rosenstein L, Torre M, Ramos M, Rosales R, Guille C, Sen S, Mata D. Prevalence of burnout among physicians: A systematic review. JAMA. 2018; 320 (11): 1131-1150. doi: 10.1001/jama.2018.12777