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Coalition of State Rheumatology Organizations

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September 11, 2023

Ms. Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1784-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically via www.regulations.gov

RE: Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program

Dear Administrator Brooks-LaSure:

The Coalition of State Rheumatology Organizations (CSRO) is comprised of over 40 state and regional professional rheumatology societies whose mission is to advocate for excellence in the field of rheumatology, ensuring access to the highest quality of care for the management of rheumatologic and musculoskeletal disease. Our coalition serves the practicing rheumatologist.

Through the Alliance of Specialty Medicine, CSRO provides feedback on several proposed policies in the aforementioned rule that broadly impact specialists and subspecialists, including the decline in Medicare reimbursements to physicians. Below, however, CSRO highlights additional issues that uniquely impact our members and the beneficiaries they serve.

Complexity Add-on Code

For CY 2024, CMS is set to begin paying for a "complexity add-on code" (HCPCS code G2211) that was finalized in the CY 2021 PFS to reimburse clinicians for the resources they expend in providing longitudinal care of complex patients. Given the budgetary impact of this new service on the CY 2021 conversion factor (CF) (-3.2%), Congress imposed a 3-year moratorium on its implementation to lessen the impact on the overall CF reduction of 10.2% that same year.

In the CY 2021 PFS, CMS anticipated this code would be used on ~58% of all office/outpatient evaluation and management (O/O E/M) services, but has since revised this estimate to ~38% of O/O E/M services that, under a newly proposed billing rule, could not be used in conjunction with an O/O E/M that carries a ~25 modifier. Taken together, the result is a -2.0% budget neutrality adjustment to the CY 2024 CF, and a 2.0% estimated boost to the rheumatology "pool."

CSRO appreciates the intent behind this new code and welcomes additional reimbursement for the longitudinal care we provide patients with complex, chronic

rheumatologic diseases. ***We believe the care we provide has largely been undervalued under the current E/M service codes, as it fails to account for our expertise and additional training as a cognitive specialty.*** Moreover, CMS no longer pays for consultation codes, despite the increased work that is involved in delivering this service. ***CMS should consider these sentiments as part of its request for comment on more regular and comprehensive reviews of E/M services.***

However, we do have some concerns about the budget neutrality impact on the CY 2024 CF, and even more so since Medicare's conversion factor is a basis for which Medicare Advantage and private plans set their payment rates. ***We also believe CMS' utilization estimates continue to be inflated and urge the Agency to revise them to reduce the budget neutrality impact.***

Further, given concerns that have been raised about "double counting" the time associated with this service and the associated O/O E/M that would be billed, ***CMS must provide explicit billing and coding guidance to facilitate correct documentation by clinicians and prevent misapplication of the code***, both of which could lead to unwanted program integrity audits, and potentially, payment recoupments by Medicare Administrative Contractors (MACs) and other program safeguard contractors.

Valuation of Services: Neuromuscular Ultrasound

CSRO appreciates CMS' proposed increase to the values for CPT code 76882, however we remain concerned with CMS' valuation of CPT code 76881. The low valuation for CPT 76881 results in payment that is not reflective of the resources used by rheumatology practices when providing this service, and will result in limited beneficiary access.

CSRO recognizes the challenges CMS faces when valuing services that are delivered by multiple different specialties, given the work and practice expense inputs may be different based on how each specialty provides the service. We believe there are options for overcoming this. ***CSRO would be happy to work with you to ensure the valuation and payment support the time, effort, and practice resources rheumatologists expend to deliver neuromuscular ultrasound in their offices.***

Inflation Reduction Act Implementation: Discarded Drug Rebates

To facilitate provisions in the *Infrastructure Investment and Jobs Act* that require manufacturers to provide a refund to CMS for discarded amounts from certain single-dose container or single-use package drugs, CMS requires practices to report either a JW or JZ modifier on their Part B claims to indicate whether there are discarded drug amounts, or no discarded drug amounts, following delivery of a physician-administered medication. Now, CMS proposes to require that drugs separately payable under Part B from single-dose containers that are furnished by a supplier who is not administering the drug be billed with the JZ modifier. To facilitate improved reporting, ***CSRO would like to extend an invitation to partner with CMS on developing and disseminating educational materials on reporting these modifiers.***

Request for Information (RFI): Drugs and Biologicals which are Not Usually Self-Administered by the Patient, and Complex Drug Administration Coding

CSRO greatly appreciates CMS' RFI on the aforementioned topics, which we understand stems from the long-standing challenges our organization has raised about the impact of CMS' policies on practices that administer highly-complex medications in the physician's office and the beneficiaries that depend on continued, uninterrupted access to them, and our specific request that CMS issue such an RFI to gather feedback from the provider community on these issues. This RFI demonstrates to us that CMS recognizes the challenge our practices, and ultimately our Medicare patients, are facing, and that the Agency seeks to resolve these issues.

In the paragraphs that follow, we provide feedback on the Self-Administered Drug (SAD) Exclusion list and "down coding" of complex drug administration services, and propose policy options to address those concerns. These comments complement those we have provided as part of a broader collective of organizations that share CSRO's concerns.

SAD Exclusion List

As amended by the Benefits Improvement & Protection Act of 2000 (BIPA), sections 1861(s)(2)(A) and 1861(s)(2)(B) of the Social Security Act (SSA) exclude *"drugs and biologicals which are not usually self-administered by the patient from coverage and payment under Medicare Part B."* To implement this provision, CMS established criteria,[1] based on its broad interpretation of the phrase *"not usually self-administered by the patient,"* that Medicare Administrative Contractors (MACs) must use to determine whether a drug with a self- and physician-administered formulation should be added to the SAD Exclusion List. Because drugs on the SAD Exclusion List are excluded from Part B coverage, beneficiaries that require the physician-administered formulation must pay out-of-pocket for that drug.

CSRO believes CMS' interpretation and implementation of the statute hinders access and exacerbates disparities in the care and treatment of rheumatologic conditions, and directly conflict with this Administration's efforts to improve health equity and drug affordability.

SAD Exclusion List Criteria. Underpinning the SAD Exclusion List criteria is CMS' interpretation of the phrase "*not usually self-administered by the patient,*" and specifically, how it defines various parts of this phrase. According to CMS, "*usually self-administered*" means a medication is self-administered "*more than 50 percent of the time*" by all Medicare beneficiaries who use the drug, with some consideration of the medication's indication by way of the "weighted average" approach; "*by the patient*" means Medicare beneficiaries as a collective whole.

A recent example of how CMS' interpretation and definitions work against beneficiaries can be observed in ustekinumab (Stelara), a drug with a number of approved clinical indications (e.g., plaque psoriasis, psoriatic arthritis and Crohn's disease) and with a self- and physician-administered formulation. Here, the MACs have determined that ustekinumab is usually self-administered because, based on its analysis, more than 50% of beneficiaries – *as a collective whole, using a weighted average across all indications* – are self-administering this drug.

We have shared with CMDs that beneficiaries with psoriatic arthritis are usually unable to inject ustekinumab themselves due to joint pain and swelling caused by the disease. If another medication is not appropriate and depending on a patient's financial circumstances, beneficiaries will either:

- Access the self-administered formulation through their Part D plan and seek the assistance of their rheumatologist, another health care professional, or a caregiver/family member/friend to administer their medication,
- Pay out-of-pocket for the physician-administered formulation, or
- Forego treatment altogether.

We highlighted to the MACs that the first scenario does not meet the definition of "*by the patient*," and asked Contractor Medical Directors (CMDs) to explain how they are determining that patients are actually self-administering medications, including the data on which they rely in making this

[1] Medicare Benefit Policy Manual, Chapter 15, §50.2, *Determining Self-Administration of Drug or Biological*

determination, to no avail. Because of our concerns with how this criterion is applied, we presented survey data by the Global Healthy Living Foundation (GHLF) that found, of Medicare beneficiary respondents taking a treatment that requires an injection, 35.7% are unable to self-inject and have another individual administer the injection. Here, CMDs suggested that any data they would consider for purposes of making SAD Exclusion List determinations should be peer-reviewed. We found this statement ironic considering the CMDs are not using peer-reviewed to determine whether medications are being self-administered, per CMS' requirement, nor does CMS makes it a requirement for MACs to use peer-reviewed data for this purpose. The scenario above is not limited to ustekinumab; patients with other rheumatic diseases, such as rheumatoid arthritis, have faced similar challenges when medications are relegated to the SAD Exclusion List.

Practically speaking, a medication is not usually self-administered when the patient is unable to self-administer it, for example, if they have a disability or face other social and economic challenges that limit access to the self-administered formulation. Unfortunately, CMS has not provided instructions for MACs to account for these circumstances in its implementation of the statute. Presumably, CMS is leaving it to the MACs to determine whether a drug on the SAD Exclusion List is "reasonable and necessary" for a given beneficiary on a case-by-case basis. In our experience, however, this is an infrequent occurrence if it happens at all. In fact, one CMD told a rheumatologist seeking an exception that if his patient can "swing a golf club," they can self-administer their medication.

CMS must reconsider its SAD Exclusion List policies to account for beneficiary circumstances that prevent self-administration of a SAD Exclusion List drug, including a physical, behavioral, or other disability that makes it impossible, or nearly impossible, for them to self-administer a medication, and social and economic challenge that hinders access to the self-administered formulation.

Untoward Discrimination. CMS' SAD Exclusion List policies have not kept pace with real-world use of medicines that have multiple indications and formulations, and have the unintended consequence of discriminating against patients who are unable to self-administer certain medications due to clinical or social and economic circumstances.

As noted above, when a drug is determined by a MAC to be self-administered and is added to the SAD Exclusion List, it becomes excluded from Part B coverage. This means patients who are unable to administer the drug themselves – even if the inability to self-administer is due to a physical, behavioral, or other disability – they must pay entirely out-of-pocket for the physician-administered formulation. Although this was certainly not Congress' nor CMS' intent, this approach amounts to a *de facto* denial of coverage for disabled individuals in need of a drug on the SAD Exclusion List, not to mention a denial of coverage based on the disability, because that is what creates the inability to self-administer. While not intentional, this policy inadvertently discriminates against beneficiaries with chronic illnesses who are unable to obtain and/or utilize the self-administered formulation of a drug.

In addition, the criteria used to make SAD Exclusion List determinations do not consider social and economic factors, however, beneficiaries facing such challenges are most at risk of losing access to their medications. Through this CY 2024 PFS rulemaking, CMS proposes coding and payment for the delivery of services that address health-related social needs. CMS also encourages Medicare physicians to account for social determinants of health in their care treatment and management plan. Moreover, drug affordability remains a top priority for this Administration, yet the SAD Exclusion List criteria have the effect of making medications unaffordable for those facing financial hardship.

The SAD Exclusion List criteria will continue to be problematic as new drugs come on the market with multiple indications and formulations, especially under the current criteria. Given the prominence of

addressing health equity and making medications affordable, ***we urge CMS to account for clinical, social and economic challenges in revising its SAD Exclusion List criteria.***

Policy Options. CSRO wishes to be a partner in solving this challenge and brings actionable solutions to the table. Our organization has carefully thought about ways in which the Agency could address the concerns we have raised and offer a pathway for your consideration. We would be happy to work with you on alternative options.

First, as an short-term measure to address SAD Exclusion List challenges, ***we urge CMS to direct its Medicare Administrative Contractors (MACs) to remove certain drugs from the SAD Exclusion List and postpone the addition of other medications, until a long-term solution is in place.*** We would be happy to work with you on identifying the medications that should be removed.

Second, ***we urge CMS to work with its Office of General Counsel (OGC) to reinterpret the statute to allow coverage of the physician-administered formulation of a drug that is "not usually self-administered by the patient" when a beneficiary presents with certain clinical and/or social and economic circumstances that prevent self-administration, making it "reasonable and necessary" for them to access the physician-administered formulation of a medication on the SAD Exclusion list.*** From our perspective, a medication is "*not usually self-administered by the patient*," when the patient has clinical circumstances – such as a physical, behavioral, or other disability – that make it impossible, or nearly impossible, for them to self-administer. Further, because of CMS' emphasis on addressing health equity and drug affordability, it stands to reason that a medication is "*not usually self-administered by the patient*" if social and economic challenges prevent them from accessing the self-administered formulation.

Third, based on a revised interpretation, ***CMS should amend its Program Manual to include additional criteria that account for the aforementioned clinical and/or social and economic circumstances.*** This would effectively provide a "by-pass" to the current criteria, allowing beneficiaries to access medications on the SAD Exclusion List when their clinical or social and economic circumstances prevent self-administration.

Fourth, based on amended Program Manual instructions, ***CMS should establish:***

- ***Documentation requirements that allow physicians to demonstrate in the medical record that the beneficiary's clinical and/or social and economic circumstances prevent them from self-administering a drug on the SAD Exclusion List; and,***
- ***A new billing modifier that physicians could append to their drug administration service codes to indicate that the beneficiary's clinical and/or social/economic circumstances warrant use of the physician-administered formulation of a drug on the SAD Exclusion List and is supported by the medical record documentation.***

We do not believe these revisions require rulemaking, as the Medicare statute already directs the agency to make payment for items and services that are "reasonable and necessary." From our perspective, it is "reasonable and necessary" for beneficiaries to access to the medication formulation that meets their needs. However, if the Agency is adamant that rulemaking is required, rather than waiting for the next PFS rulemaking cycle, CMS should consider either a stand-alone Interim Final Rule with Comment (IFC) or a "CMS Ruling." According to the Agency,

> *"CMS rulings are decisions of the Administrator that serve as precedent final opinions and orders and statements of policy and interpretation. They provide clarification and interpretation of complex or ambiguous provisions of the law or regulations relating to*

Medicare, Medicaid, utilization and peer review by Quality Improvement Organizations, private health insurance, and related matters.

CMS Rulings are binding on all CMS components, Medicare contractors, the Provider Reimbursement Review Board, the Medicare Geographic Classification Review Board, and Administrative Law Judges who hear Medicare appeals. These Rulings promote consistency in interpretation of policy and adjudication of disputes."

CMS has issued IFCs during the COVID-19 public health emergency (PHE) to immediately effectuate policy changes, while allowing for comment. CMS has also issued CMS rulings to expedite important policies, for example, to ensure beneficiary access to certain intraocular lenses (IOLs) in 2007.[2]

CSRO would be happy to work with you on developing appropriate documentation requirements for inclusion in CMS' Program Manuals.

Complex Drug Administration Coding

Through its Medicare Claims Processing Manual (MCPM) (Ch. 12, Sec. 30.5.D), CMS authorized MACs to *"provide additional guidance as to which drugs may be considered to be chemotherapy drugs under Medicare,"* defined as including *"treatment of noncancer diagnoses…"* The MCPM further states that *"[t]he following drugs are commonly considered to fall under the category of monoclonal antibodies: infliximab, rituximab, alemtuzumb, gemtuzumab, and trastuzumab,"* while acknowledging *"[t]he drugs cited are not intended to be a complete list of drugs that may be administered using the chemotherapy administration codes."*

Using these instructions, MACs have established articles – usually titled *Billing and Coding: Complex Drug Administration* – that erroneously deem many of the drugs infused for auto-immune conditions (e.g., rheumatoid arthritis (RA), psoriasis, and other non-oncologic conditions) as non-complex, and require physician offices to use the "therapeutic" drug administration service codes (CPT codes 96360-96379), rather than the "complex" administration service codes (CPT code series 96401-96549), despite rheumatology practices historic use of the latter.

We attempted to work with the MACs to educate them on the complexity of the medications we administer, as well as the complexity of the patients we are treating, in hopes of removing these drugs from the articles to no avail. In fact, staff with one MAC sent us the following in response to written correspondence about our concerns:

"This multijurisdictional correct coding initiative was established in response to paid claims analysis showing non-chemotherapy drugs being billed with chemotherapy infusion codes. This analysis was not limited to drugs specific to the rheumatology specialty. Once identified, the package inserts for these drugs were reviewed by the CMD members of the workgroup. This workgroup has recently expanded from the original three A/B MACs to seven A/B MACs."

The process MACs are using to determine which drugs are complex and warrant use of the complex administration codes, which appears to be limited to using the FDA label (i.e., package insert) of the medications, is of great concern. Other sources in determining complexity would include:

- Peer-reviewed medical literature,

[2] https://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/downloads/CMS1536R.pdf

- Evidence-based practice guidelines,
- Society protocols for administering selected drugs, and
- Consultation with local physicians that administer these medications.

The above mentioned sources support that the vast majority of medications included in the MAC articles have similar complexity to the "older" medications (e.g., infliximab, rituximab, alemtuzumb, gemtuzumab, and trastuzumab) that were included in the MCPM.

As a reminder, it was the intent of Congress, when it included language in the *Medicare Modernization Act (MMA)*, to allow non-oncology physicians to use the chemotherapy administration service codes when delivering non-oncologic medications in their offices. The older medications listed in the MCPM and the newer medications (that were not around at the time the program manual was written):

- Require the same level of supervision,
- Cost the same to administer (i.e., clinical labor, supplies), and
- Have no meaningful difference from the earlier biologics, as all are targeted therapies with inherent risk.

When CSRO brought this to CMS' attention, the Agency recognized that its policies related to drug administration services were out-of-date and required revision. In the interim, and while it considered a long-term solution, CMS directed the MACs to temporarily "pause" the "down coding." Specifically, on June 10th, 2022, CMS issued a Technical Direction Letters (TDLs) to the MACs that halted additional documentation requests (ADRs) when drugs identified by MACs as "therapeutic" were billed with chemotherapy administration codes. Because this did not have the intended effect, on August 12th, 2022, CMS issued a second TDL that, according to CMS staff in the Office of the Administrator (OA), "*directs that the MACs shall not make claim adjustments or edits to claims for CPT codes 96401-96549 based solely on the specific drug or agent being administered. Claims for these codes that involve administration of monoclonal, complex biological, and rheumatological therapies shall be paid as complex administration, so long as all elements of these codes that are required for appropriate billing are met, using Medicare guidance/policy*."

Since that time, we note that one MAC retired, and another MAC rescinded and replaced, its Billing and Coding Articles. Other MACs continue to update their articles, adding new codes to their down coding policies, despite the aforementioned TDLs.

Even before this RFI, CMS has urged the stakeholder community to provide resources that address the question of complexity. In response, CSRO prepared and submitted to CMS a "rubric" – Considerations for Classifying Medications as Highly Complex – to assist the Agency with establishing criteria for its MACs to use when determining whether a drug is "highly complex" and warrants use of the complex administration codes. The rubric considers the following:

- **AMA CPT requirements**: physician supervision; advanced training/competency for staff; considerations for drug preparation, dosage, storage; patient risk and severity of adverse events; and MD/DO engagement during administration service);
- **Medicare valuation**: alignment of work, clinical labor, supplies, and equipment for complex admin services for these medications; and
- **Other clinical factors that demonstrate complexity of a given medication and its administration**: Pre-labs required; labs required across treatment; load/treatment schedule; and treatment time.

We note that rheumatology practices are keenly aware of Medicare's valuation of these services, and how their time, effort and resource costs relate to the code they select. Of note, CMS' CY 2022 clinical labor pricing update, which continues to be transitioned, drastically lowered the value of these services, making the impact of these articles more detrimental to in-office administrations, which is the lowest cost setting for providing these medications.

Policy Options

As above, CSRO wishes to be a partner in solving this challenge and brings actionable solutions to the table. Our organization has carefully thought about ways in which the Agency could address the concerns we have raised and offer a pathway for your consideration. We would be happy to work with you on alternative options.

First, as a short-term measure to address this challenge, ***we urge CMS to immediately direct its MACs to permanently rescind and remove all articles titled: "Billing and Coding: Complex Drug Administration," or that have the same intended effect.*** These articles provide billing and coding guidance that are inconsistent with the AMA CPT code descriptors and associated guidance. Rheumatology practices know how to appropriately apply AMA CPT codes based on their descriptors and associated guidance, which are found in official AMA CPT publications, and with consideration of the complexity of the medications they are administering in their offices.

In addition, ***CMS must make the substance of the August 12, 2022 TDL public through program transmittal or a Medicare Learning Network (MLN) article, easing physician practice concerns about submitting complex drug administration service codes on Medicare claims, in contrast to guidance from the MACs.*** CMS' well-intended effort to "pause" the impact of these articles has been lost as most of the MACs continue to educate practices to "down code" and some have even suggested the TDL does not exist. Practices that are following what they understand is described in the TDL are concerned about compliance and future program integrity audits; others have been advised to continue following MAC guidance provided in articles since the TDL is not public.

Second, we continue to believe the billing and coding articles are unnecessary; however, if CMS believes they are needed for program integrity and other purposes, at a minimum, ***CMS should establish new criteria, based on the metrics used in CSRO's Considerations for Classifying Medications as Highly Complex, and amend its program manual with these new criteria.*** As noted above, new criteria for determining whether a physician-administered medication warrants use of the complex drug administration service code(s) should consider the following:

- AMA CPT requirements,
- Medicare valuation, and
- Additional clinical factors that demonstrate complexity of a given medication and its administration.

To complement this, ***CMS should establish documentation requirements that allow physicians to demonstrate in the medical record that the complex drug administration service code reported on their claim(s) meets the criteria.***

Finally, ***to ensure consistency across the Medicare program, CMS should:***

- ***Issue an MLN article to educate practices on the new criteria and documentation requirements, and require MACs to refer to this MLN resource, and***

- ***Revise its Program Manual to remove the language that allows MACs to "provide additional guidance as to which drugs may be considered to be chemotherapy drugs under Medicare" and prohibit MACs from establishing their own "lists" of drugs that meet complex drug administration code criteria.***

It is imperative that this billing and coding guidance is initiated and maintained at the federal level by CMS headquarters to ensure it applies nationwide, and importantly, avoids confusion and differences of opinion by CMDs on how to interpret these criteria, which is common at the MAC level.

Medicare Telehealth

Rheumatology patients continue to benefit from the telehealth flexibilities that were provided as part of the COVID-19 public health emergency (PHE), and we appreciate that CMS continues to be thoughtful in maintaining expanded access where it has the authority. We also appreciate CMS' careful implementation of requirements included in the Consolidated Appropriations Act, 2023. Because of the value telehealth brings to Medicare beneficiaries, ***we urge CMS to continue working with Congress to permanently remove originating site requirements and geographic restrictions.***

With regard to "virtual presence," as we have shared before, we generally support allowing physicians to provide direct supervision through the use of real-time audio/visual technology beyond the PHE; however, we continue to have concerns about this policy being used to facilitate the provision of complex drug therapies in the home. Complex drug therapies have serious safety warnings or the potential for adverse reactions, which would be difficult to appropriately manage in the home by the physician's clinical staff or their contractor and puts patients at risk. ***We urge CMS to closely monitor how this policy is being used in practice to ensure patients are not exposed to increased risk of harm.***

Advancing Rheumatology Patient Care MVP

Last year, CMS finalized its proposal to move forward with MIPS Value Pathways (MVPs), starting in 2023, with an introductory set of optional MVPs, including Advancing Rheumatology Patient Care. CSRO is deeply appreciative of CMS' proposal to adopt *IA_BE_ 24: Financial Navigation Program* or *IA_BE_25: Drug Cost Transparency*. It is clear that CMS recognizes that rheumatology patients require this type of assistance given the associated costs with the medications used to manage their rheumatologic disease. ***We urge CMS to finalize these IAs as proposed.***

Nevertheless, we continue to have concerns with the use of the Total Per Capita Costs (TPCC) measure for resource use. This measure does not account for ***all*** pharmaceutical costs when evaluating physician resource use, which is problematic for many rheumatologic conditions, such as rheumatoid arthritis (RA), where Part B and Part D drugs are available. We know CMS faces challenges including Part D costs in these measures, particularly because of our engagement in the rheumatoid arthritis cost measure development process convened by Acumen, CMS' contractor. However, the lack of their inclusion puts physicians who administer Part B drugs in their office at a significant disadvantage compared to those who order/prescribe drugs covered under Part D, since the former would appear to have higher Medicare expenditures than the latter. There are other challenges, too, that limit access to certain medications and formulations, including the SAD Exclusion List and Medicare Advantage and Part D drug plan formularies. This concept seemed to be difficult for Acumen staff, and even some of the academic rheumatologists that participated in the measure development process, to appreciate. ***We would be happy to work directly with CMS on a solution to this challenge.***

Finally, while CMS has touted this MVP as a "glidepath" for clinicians to participate in APMs, we remind you that there are no rheumatology-specific APMs, and most rheumatologists have not had meaningful

engagement in Medicare's Accountable Care Organizations (ACOs) since, according to the ACOs, the cost of the medications used to treat rheumatic diseases negatively impacts ACO benchmarks. We appreciate that CMS has acknowledged in the preamble the challenges specialists face in joining ACOs, and ***we urge CMS to consider making "network adequacy" a component of ACO measurement so that ACOs are more likely to incorporate us in the models.***

***

Thank you for considering our comments, and we look forward to working with you as you finalize policies outlined in this proposed rule. Please do not hesitate to contact us at info@csro.info should you require additional information.

Sincerely,

Gary R. Feldman, MD, FACR
President

Madelaine A. Feldman, MD, FACR
Vice President, Advocacy & Government Affairs