October 3, 2016

Mr. Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention:
P.O. Box 8013
Baltimore, Maryland 21244-8013

Re: CMS Proposed Rule, Medicare Program; Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model (CJR) [CMS-5519-P]

Dear Acting Administrator Slavitt:

AMDA-The Society for Post-Acute and Long-Term Care Medicine appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) Proposed Rule for Medicare Program; Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model (CJR).

The Society is the only medical specialty society representing the community of over 50,000 medical directors, physicians, nurse practitioners, physician assistants, and other practitioners working in the various post-acute and long-term care (PA/LTC) settings. The Society’s 5,500 members work in skilled nursing facilities, long-term care and assisted living communities, CCRCs, home care, hospice, PACE programs, and other settings.

The Society offers the following comments for your consideration:

Data Sharing

CMS acknowledges that its proposal to disclose beneficiary-identifiable data only to Episode Payment Model (EPM) participants at financial risk for an Acute Myocardial Infarction (AMI), Coronary Artery Bypass Graft (CAPG), or Surgical Hip/Femur Fracture Treatment (SHFFT) episode and not with EPM collaborators may present issues for collaborators in assessing their own performance under the model and the region in which they operate. CMS notes that EPM participants would be able to share data with their EPM collaborators if they are business associates under the HIPAA Privacy Rule.
CMS is also considering whether it would be feasible and appropriate to make additional non-beneficiary-identifiable aggregate data publicly available in some manner. CMS includes a long list of different types of relevant information for which it seeks feedback on whether access to that information would be helpful (e.g., numbers of simulated episodes and number of hospitals with each anchor MS-DRG at discharge in the simulated episodes; mean and median and standard deviation of total spending on simulated episodes; proportion of total simulated episode spending attributable to acute care payments for the anchor hospitalization and readmissions, etc.). CMS seeks comments on what kinds of actions and data would be most helpful to EPM collaborators, and which could be disclosed in accordance with the existing statutory and regulatory requirements for sharing data.

Comment:

The Society agrees with CMS’ concerns about data sharing of key information for EPM collaborators. Practice groups in PA/LTC medicine are often collaborators in these payment models and do not receive the information they need in order to assess their own performance and provide quality clinical care to patients in the episode. Thus, it is essential that CMS provide clear guidance on data transparency from the bundle initiators.

We believe that at the very least these data should include information included in the Quality and Resource Use Reports (QRUR). Collaborators should be able to understand their own costs as well as those for downstream providers in order to effectively enter into these financial and clinical arrangements. We believe that there should also be a standard identification that is sortable for all patients in the bundle that is accessible to collaborators and to anyone treating the patient to search and understand their financial and clinical responsibility.

**Episode Price-Setting Methodology**

CMS considers adjustments to account for clinical and resource variation but states that no standard national risk adjustment approach exists that is widely accepted for the proposed EPM episodes. CMS also states its belief that CMS Hierarchical Condition Categories (HCC) used to adjust for risk in the MA program would not be appropriate for risk-adjusting EPM episodes. CMS states it has identified several scenarios where certain pricing adjustments could be appropriate. These include:

- Adjustments for Certain AMI Model Episodes with Chained Anchor Hospitalizations
- Adjustments for CABG Model Episodes
- Adjustments for Certain AMI Model Episodes with CABG Readmissions
- Potential Future Approaches to setting Target Prices for AMI and Hip Fracture Episodes

Comment:

The Society has previously submitted comments related to risk adjustment in the MACRA proposed regulations as well as the physician fee schedule CY 2017 proposed rule. We continue to be concerned that CMS does not have a proper risk adjustment methodology in place for patients’ transitions into the PA/LTC sector. We are concerned that these bundles do not assess the risk at the time of admission in the PAC facility. A recent article in *Health Affairs* outlined how the CCJR fails to properly risk adjust and unintentionally penalizes hospitals that treat medically complex patients.1 A lot of factors that contribute to

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cost variation in PAC are outside of the control of PAC facilities and of practice groups providing care in those facilities. As we stated in our comments on the MACRA proposed regulations, the Society has adopted an official position statement asking CMS to clearly define risk stratification indices and develop a cost-to-risk algorithm. This algorithm should be based on previous utilization data and should incorporate specific, patient characteristics, including functional status, age, and frailty, to accurately evaluate EPM performance. Several current programs such as the Program for All-Inclusive Care of the Elderly (PACE) and Independence at Home (IAH) are models that have developed risk-adjustment methodologies better suited for the PA/LTC sector.

We strongly urge CMS to monitor implementation of these programs to ensure that it does not disincentivize clinicians from providing care for the most clinically complex and frequently the costliest patients, who are often cared for in the post-acute and long-term care sector. It is vital that the Administration consider not only physician specialties, but also the place of service (POS) of their encounters and their patient mix, including factors related to health status, stage of disease, comorbidities, functional status, local demographics, and socioeconomic status.

3-Day Hospital Stay Waiver

CMS proposes to waive the SNF 3-day rule for coverage of a SNF stay following the anchor hospitalization under an EPM where it is clinically appropriate. Under the CJR model, CMS does not permit the use of the waiver until the second performance year, which is when hospitals would first be at financial risk for excess spending. CMS proposes a similar policy for EPMs and would permit waivers for episodes beginning on or after April 1, 2018.

CMS also proposes to permit the use of this waiver only for discharges to a SNF with an overall rating of three stars or better on the CMS Five-Star Quality Rating System, based on information publicly available at the time of hospital discharge. Specifically, to be qualified, the SNF must be included in the most recent calendar year quarter on the Nursing Home Compare website and be rated an overall 3 stars or better for at least 7 of the 12 months based on a review of the most recent rolling 12 months of overall star ratings. CMS proposes to post on its website the list of qualified SNFs in advance of each calendar quarter. CMS believes this is an appropriate requirement for the waiver, because the potential greater risks following an early inpatient hospital discharge necessitates care by a SNF that has demonstrated the capability to provide quality care to patients with significant unresolved post-surgical symptoms and problems. CMS also notes that there is currently at least one 3-star rated SNF in all 294 MSAs that are eligible for selection for the AMI and CABG models.

Comment:

The Society has a longstanding policy supporting the 3-day stay waiver and elimination of the 3-day requirement. For simplicity of application of these programs, CMS should have a waiver for all risk-bearing programs to provide the greatest flexibility for accountable care-based models to provide the necessary care at the appropriate setting with the appropriate level of care. We urge CMS to provide these waivers at the outset of the program rather than waiting until future years when the organizations are at financial risk for excess spending.

The Society has concerns about linking the 3-day waiver to the Five Star rating system. Similar to the CCJR program, CMS is proposing to require that a SNF have three stars or greater on the Five Star rating system in order to waive the 3-day stay requirement for SNF participants of new EPMs (page 50939 of the proposed rule). The proposed policy mirrors the 3-day stay waiver policy currently being used in certain models and tracks of the Bundled Payments for Care Improvement (BPCI) initiative and Accountable Care Organization (ACO) programs, respectively. While the Society appreciates and supports the application of certain criteria to waive the 3-day stay requirement, we have concerns regarding CMS' proposal to tie the waiver to a SNF's Five Star rating. Our primary concerns are as follows:

a. The Five Star measures have been updated to better reflect the quality of care in skilled nursing facilities. While improvements continue to be made, we believe further modification and refinement is necessary to ensure these measures accurately reflect the measures in these bundles. CMS should provide flexibility and only use the measures within the Five Star program applicable to these bundles.

b. This policy will have unintended negative consequences on beneficiary freedom of choice and access to care. Ultimately the family and the patient decide their facility of choice. The family’s biggest issue is the location of the SNF, and not necessarily the Star Rating. Many rural locations don’t have 3-5 star choices and families choose the best facility possible. This policy may restrict the family’s choices and policies need to ensure that families are informed and provide informed consent for their facility of choice.

We recommend CMS adopt an alternative approach to allowing SNFs and hospitals to use the 3-day rule waiver. CMS should waive the 3-day stay requirement for all SNFs and require hospitals to provide information to consumers at time of discharge on quality of the PAC provider (e.g. SNF) that includes not only their Five Star rating, but also quality measures more applicable to PAC, particularly those related to AMI, CABG, and SHFFT.

The Society believes that CMS should tie SNF performance to waiving the 3-day stay requirement by using performance thresholds on SNF quality measures that are more directly applicable to post-acute care, particularly AMI, CABG, or SHFFT care furnished to beneficiaries, such as hospital readmission rates, discharge to community rates, improved function, and patient satisfaction rates. Reliable, valid and generally already reported measures of SNF performance exist for all of these domains. Moreover, we believe that market forces will drive the poor performing homes out of the market without the need for arbitrary thresholds.

The Society recommends that CMS modify the proposed criteria of “at least 3 stars” to “at least 3 stars overall OR at least 3 stars on both the staffing and quality measure components.” This approach would create the incentive to achieve higher staffing levels and improved performance across the 11 quality measures in the Five Star rating system. Alternatively, if CMS feels it is important to categorically exclude the very lowest-performing facilities, a consideration might be to exclude only one-star facilities from the waiver.

Advanced APM and CEHRT

EPM Participant Tracks. CMS proposes that all EPM participants decide whether or not to utilize CEHRT. Those choosing to adopt CEHRT would be in Track 1 and would be required to attest to CEHRT use. All
other EPM participants would be in Track 2 and CEHRT attestation would not be required of them. CMS seeks comment on this CEHRT proposal.

**Clinician Financial Arrangements Lists under the EPMs.** Advanced APM clinicians may be able to achieve QP status by practicing under financial arrangements that require them to support the cost or quality goals of the APM participants. Physicians and other eligible clinicians may enter into such arrangements as Affiliated Practitioners under the Track 1 EPM option, functioning as EPM collaborators, collaboration agents, or downstream collaboration agents (these terms are defined in Section III.I. of the rule). In order to make QP determinations about eligible clinicians, CMS proposes to identify such clinicians through a clinician financial arrangements list (Affiliated Practitioners list) that would be submitted by each Track 1 EPM participant to CMS. Required list elements are detailed in the proposed rule (Section III.A.2.c, FR 50810). QP status would be assessed by CMS only for clinicians appearing on clinician financial arrangement lists as of December 31 of a given performance period. CMS seeks comment on this information submission proposal, especially about approaches to submission that minimize reporting burden while providing sufficient information.

**Documentation Requirements.** CMS proposes that each EPM choosing to meet and attest to CEHRT use must maintain documentation of their CEHRT attestations and clinician financial arrangements lists. The EPM would also be required to retain the documents and provide access to them to facilitate monitoring and audits. CMS invites comment on the required documentation proposal.

**Comment:**

We appreciate CMS’ focus on expanding CCJR and BCPI bundles to qualify for Advanced APM MACRA requirements. In our comments on the MACRA proposed rule, we provided extensive comments related to the inability of PA/LTC practicing physicians to participate in eligible Advanced APMs given the exclusion of these bundles from list of eligible Advanced APMs. We continue to be concerned that the requirement for use of Certified Electronic Health Record Technology (CEHRT) creates a much greater barrier for PA/LTC based practitioners than for those in acute and ambulatory settings. While we believe adoption rates of CERHT in SNFs is on the rise, there is still a significant gap of adoption and capability of these systems to effectively communicate with community-based physicians who treat patients in these facilities to meet the necessary criteria.

We suggest that CMS monitor the adoption of CEHRT. For those facilities already adopting CEHRT, CMS should work closely with ONC and other stakeholder to develop specific use cases that will allow PA/LTC facilities and physician practices to effectively exchange necessary clinical and resource data to participate in these bundles. CMS should also provide flexibility and allow those facilities and practices without CEHRT to apply for waivers and/or use the anchor hospital to fulfill the CEHRT requirements.

**Selection of Proposed Quality Measures for the EPMs**

CMS proposed a number of quality measures for the EPMs including a single patient experience measures (HCAHPS).

**Comment:**

The Society remains very concerned that there are no required quality measures in any of the EMPS or in CJR that specifically address or reflect the quality of care physicians are delivering in PA/LTC and most of
the required measures have a 30-day time horizon that will not cover much of that care. The rule contains three measures relevant to these episodes that exist in the Merit-Based Incentive Program (MIPS) under MACRA.

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>NQF ID</th>
<th>Measure Title</th>
<th>Measure Description</th>
<th>Numerator</th>
<th>Denominator</th>
</tr>
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<tbody>
<tr>
<td>1248</td>
<td>0422</td>
<td>Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Knee Impairments</td>
<td>Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the knee in which the change in their Risk-Adjusted Functional Status is measured</td>
<td>Patient Level: The residual functional status score for the individual patient (residual scores are the actual change scores - predicted change after risk adjustment. Individual Clinician Level: The average of residuals in functional status scores in patients who were treated by a clinician in a 12-month time period for knee impairment. Clinic Level: The average of residuals in functional status scores in patients who were treated by a clinic in a 12-month time period for knee impairment.</td>
<td>All patients 14 years and older with knee impairments who have initiated rehabilitation treatment and completed the FOTO knee FS PROM at admission and discharge.</td>
</tr>
<tr>
<td>1251</td>
<td>0423</td>
<td>Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Hip Impairments</td>
<td>Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the hip in which the change in their Risk-Adjusted Functional Status is measured</td>
<td>Patient Level: The residual functional status score for the individual patient (residual scores are the actual change scores - predicted change after risk adjustment. Individual Clinician Level: The average of residuals in functional status scores in patients who were treated by a clinician in a 12-month time period for hip impairment.</td>
<td>All patients 14 years and older with hip impairments who have initiated rehabilitation treatment and complete the FOTO hip FS PROM at admission and discharge.</td>
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</table>
Clinic Level: The average residuals in functional status scores in patients who were treated by a clinic in a 12-month time period for hip impairment.

| 2904 | 0119 | Risk-Adjusted Operative Mortality for CABG | Percent of patients aged 18 years and older undergoing isolated CABG who die, including both 1) all deaths occurring during the hospitalization in which the CABG was performed, even if after 30 days, and 2) those deaths occurring after discharge from the hospital, but within 30 days of the procedure | Number of patients undergoing isolated CABG who die, including both 1) all deaths occurring during the hospitalization in which the operation was performed, even if after 30 days, and 2) those deaths occurring after discharge from the hospital, but within 30 days of the procedure | All patients undergoing isolated CABG |

The Society has undertaken significant efforts to work with the National Quality Forum under their measure incubator as well as other stakeholders to identify existing, and develop new quality measures that better reflect the quality of care physician groups provide in PA/LTC settings. The Society recently published a peer-reviewed article describing the unique needs of this population that can help tailor quality measures to the needs of these patients/residents.² We strongly urge CMS to provide funding for and work with the Society and other stakeholders to identify and develop these measures.

Given that the majority of current quality measures are acute care measures, we are unsure how PAC facilities and practice groups can share in performance scores on those measures. **We urge CMS to expand on BCPI Model 3 programs to allow new EPMs, where PAC providers can share in gains/risks of new EPMs.**

**HCHAPS**

The Society has expressed concern about the use of HCPAHS for PA/LTC based practices. There are no current requirements that we are aware of to use skilled nursing facility patient satisfaction surveys. Those that are being performed by facilities do not translate into valid appraisals of clinician performance. The current CAHPS surveys are not designed for, nor are they appropriate for, PAC-based clinicians because in

many situations the source of the information is not reliable due to the cognitive status of the patients being surveyed. Therefore, we have serious concerns about using the CAHPS survey for an episode bundle that includes the PAC sector until such surveys are available for clinicians practicing in all settings of care. However, we do believe that patient satisfaction is an important component of quality and therefore urge CMS to work with our Society and other interested specialties and stakeholders to develop appropriate patient satisfaction surveys that will accurately reflect the care in these EPMs.

**Billing and Payment for Telehealth Services (§512.605)**

As it has under other models (e.g., CJR, BPCI Models 2 and 3), CMS proposes to waive the geographic site requirements of the Act to permit telehealth services to be furnished to an eligible telehealth individual in his or her home or place of residence. Thus, providers and suppliers would be able to furnish services related to the episode (i.e., AMI, CABG, or SHFFT episode) to EPM beneficiaries via telemedicine for beneficiaries residing in any region. CMS emphasizes that the waiver of the originating site requirement applies only when telehealth services are being furnished in the EPM beneficiary’s home or place of residence during the episode.

Telehealth services would include any service on the list of Medicare approved telehealth services and reported on a claim with a principal diagnosis code that is not excluded from the proposed EPM’s episode definition, unless the service’s HCPCS code descriptor precludes delivering the service in the home or place of residence.

CMS plans to monitor patterns of utilization of telehealth services under the proposed EPMs for overutilization or reductions in medically-necessary care, and significant reductions in face-to-face visits with physicians and non-physician practitioners. CMS seeks comments on the proposed telehealth waivers and proposed home visit telehealth codes.

**Comment:**

The Society supports the expansion of telehealth services in EPMs. A recent study published in *Health Affairs* found that use of telehealth can reduce readmissions among nursing home residents. We agree that CMS should monitor the utilization of telehealth and ensure that patients get the face-to-face care that is necessary. However, unless and until evidence of overutilization is obtained, we believe that an arbitrary limit could hinder access to appropriate care under the telehealth benefit, especially in underserved areas. For a busy PA/LTC practitioner, if a single patient in a single nursing home 40 minutes’ driving distance away has a change of condition, it may be unrealistic to make the trip and use several hours to see a single patient. In such instances, a telehealth visit may well obviate the need for an emergency room visit. Allowing for such visits anytime there is a significant change of condition makes intuitive sense and also may allow for timelier practitioner assessments of patients who need them.

We have previously agreed with CMS’ reasoning that, because of the potential acuity and complexity of SNF patients, time periods were necessary and we remain committed to ensuring that these patients continue to receive in-person, hands-on visits as appropriate to manage their care. We continue to agree

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3 Grabowski, C.D. & O’Malley J.A. (February 2014). Use of Telemedicine Can Reduce Hospitalizations of Nursing Home Resident and Generate Savings for Medicare. *Health Affairs*, 33:2244-250. [http://content.healthaffairs.org/content/33/2/244.full.pdf](http://content.healthaffairs.org/content/33/2/244.full.pdf)
that patients in SNFs/NFs are complex and need to be seen by trained and qualified clinicians. However, we believe previous concerns about overutilization of telehealth are less of a possibility with the new value-based payment models. These models rely on quality reporting and outcomes and are testing new ways of delivering telehealth in a way that is more efficient and benefits patients. As the systems move from a siloed approach to a more integrated and aligned health system, it makes no sense to issue arbitrary limitations on one sector of healthcare that do not apply to all others. This system requires flexibility to allow practices to test innovative methods to deliver patient care that achieves the stated desired outcomes.

Transfers and Gain Sharing Agreements

AMI episodes can span several facilities because of transfers, but the initial admitting facility most often is accountable for the costs and quality results. For patients transferred from the initial facility to a second acute care hospital prior to discharge, the PAC planning will be led by the discharging (second) hospital, but the first hospital is the entity that will be most interested in developing sharing agreements with PAC facilities and their physicians.

Comment:
The Society is concerned that this is a very convoluted structure in which PAC physicians and their facilities must expend considerable effort to identify the hospital “owning” the care episode, and that hospital has a substantial chance of being outside the geographic area of the PAC facility, since the latter was likely arranged by the second hospital. Developing and sustaining collaboration in such a complex context will be very difficult for PAC physicians and facilities. CMS should provide a clear pathway that alleviates administrative burden on PAC practices that are tracking their financial risk and clinical responsibility.

In addition, the Society would like to see an expanded role for PAC providers in the new EPMs rule. This includes incentives to build both technology and workforce capacity and a call for a BPCI Model-3-type arrangement within the proposed rule for three new EPMs where PAC providers can share in gains/risks of new EPMs. Currently, it is up to the hospitals to distribute the bundle and be in control of the gainsharing agreements.

Nearly 1,200 post-acute care providers are participating in the risk-bearing phase of BPCI, including 1,071 SNFs, 101 home health agencies (HHAs), 9 inpatient rehabilitation facilities (IRFs), and 1 long-term care hospital. Early results indicate that Model 3 can work. CMS’ evaluation of the initial year of the model found that Model 3 participants said that they associated their involvement with the BPCI initiative with their investment in improvements across the continuum of care. Participants noted that they wanted to be valued partners with hospitals in particular and they engaged with hospitals while deciding whether to participate in the initiative. The Society believes continued testing of PAC-only bundles that include PAC based clinicians is a critical piece of CMS’ shift to value-based payment design.

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In lieu of PAC-only bundles, CMS proposes to allow participating hospitals to share reconciliation payments they receive from CMS, internal cost savings from care redesign, or repayments to CMS, if funds are owed, with providers and suppliers caring for beneficiaries in EPMs in order to align financial incentives. CMS proposes two payment types:

- **Gainsharing Payments** (Payments made from participating hospital to EPM collaborator) – Total gainsharing payments in a calendar year paid to a physician or non-physician practitioner may not exceed a cap of 50 percent of the total Physician Fee Schedule (PFS) payments for services furnished to the hospital’s EPM beneficiaries during an episode by that physician or non-physician practitioner.

- **Alignment Payments** (Payments made from EPM collaborator to participating hospital) - Payments may not exceed 50 percent of the participant hospitals’ repayment amount due to CMS in a calendar year. If no repayment amount is due, then no alignment payment may be received. The sharing arrangement must limit the amount a single EPM collaborator may make in alignment payments to a single hospital to 25 percent of the repayment amount on a hospital’s annual reconciliation report.

The Society supports the use of gainsharing arrangements to allow providers to collaborate and benefit financially across provider sectors. However, the Society believes that gainsharing alone does not recognize the importance of PAC practices and partner facilities in the episodes of care. In many cases, PAC represents a significant portion of the episode spending. However, EPM hospitals are not required to gain share with other providers. We believe that the proposed structure for these financial relationships risks excluding PAC providers from having a significant role in EPMs.

CMS proposes that PAC providers would receive gainsharing payments based on the performance of the pool of PAC providers with which the EPM hospital gain shares. The Society believes that more flexibility should be granted in the gainsharing arrangements. While the pooling approach may be preferred by some participating providers, it will unfairly reward providers in some arrangements. PAC providers may have a range of involvement in and contribution to care redesign. EPM should allow hospitals to gain share with PAC providers on a basis that rewards the individual provider’s performance without excluding others. The numerous types of arrangements between providers are difficult to predict prior to the model’s implementation. BPCI grants greater flexibility in gainsharing arrangements, allowing participants to select one of six savings pools options. A similar level of flexibility should be granted to the new EPMs.

**Accounting for Overlap with CMS ACO Models and the Shared Savings Program**

CMS is not proposing to exclude beneficiaries assigned to Shared Savings Program Track 3 ACOs, because it intends to test the approach of excluding prospectively-aligned ACO beneficiaries from the CJR model with the limited number of beneficiaries assigned to Next Generation ACOs and ESCOs in a downside risk track. It does not want to disrupt the operations of its large, permanent ACO program at this time to test this novel approach to accounting for overlap. However, CMS seeks comment on whether it should exclude from CJR those beneficiaries who are assigned to a Track 3 Shared Savings Program ACO. (See section III.D.6.c. of the proposed rule for further discussion of CMS’ proposed approach and rationale, including details on how it would operationalize such an approach if finalized for CJR or the proposed EPMs.)
CMS also is not proposing to cancel the CJR episode in cases where a beneficiary is in a CJR model and also aligned to a Pioneer ACO, MSSP ACO, or ESCO not participating in downside risk. The final rule policies for accounting for such overlap would continue to apply.

The proposal for addressing overlap between the CJR model and CMS’s ACO models and program is included in §510.305(j)(1). CMS seeks comment on its proposal to exclude beneficiaries aligned to a Next Generation ACO or ESCO downside risk track from the CJR model beginning with episodes that are initiated on or after July 1, 2017.

Comment:
The Society believes that once a practice takes downside risk, it should be excluded from the bundle initiative. Those that meet the criteria for downside risk under a MACRA Advanced APM should not be participating in other programs that would simply increase administrative burden as well as add complexity and confusion within CMS. One of the goals of MACRA was to streamline current reporting requirements; we believe that electing not to exclude MSSP Track 3 participants does not align with that objective.

Conclusion
The Society appreciates the opportunity to provide comments and looks forward to our continued work with the Administration to address the unique needs of the post-acute and long-term care population. If you have questions, please contact Alex Bardakh, the Society’s Director of Public Policy and Advocacy, at abardakh@paltc.org or 410-992-3132.

Sincerely,

Susan M. Levy, MD, CMD, AGSF
President