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September 11, 2017

SUBMITTED ELECTRONICALLY VIA
http://www.regulations.gov

Seema Verma
Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1676-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

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 Administrator Verma:

The American Geriatrics Society ("AGS") greatly appreciates the opportunity to comment on the Physician Fee Schedule ("PFS") Proposed Rule for Calendar Year ("CY") 2018 (CMS–1676-P) [hereinafter, "Proposed Rule"]. The AGS is a not-for-profit organization comprised of nearly 6,000 physician and non-physician practitioners ("NPPs") who are devoted to improving the health, independence and quality of life of all older adults. The AGS provides leadership to healthcare professionals, policy makers, and the public by implementing and advocating for programs in patient care, research, professional and public education, and public policy. Our mission is to improve the health, independence, and quality of life of all older people.

Below we discuss our comments on a number of proposals including changes to the E/M guidelines, misvalued codes, telehealth services, payment for behavioral health and prolonged preventive services, reducing administrative burdens, quality reporting criteria, revisions to the Value-based Payment Modifier (VM), and use of the patient relationship codes under the Quality Payment Program. We urge CMS to adopt the following recommendations:

I. RECOMMENDATIONS

- **CMS should consider the input of the multi-specialty coalition for an open, transparent, inclusive and iterative process to reform the E/M guidelines. Changes in the guidelines should not automatically require a review of current valuation.**
- **CMS should accept RUC recommended values and inputs that would result in expenditure decreases or hold all other professionals harmless for the decision to reject them.**

- **CMS should finalize the proposals to add additional services to the telehealth list and to eliminate the use of the "GT" modifier. CMS should also continue to identify ways to expand access to services provided by telehealth and remote monitoring services.**
- **CMS should finalize establishment of prolonged codes for preventive services (GYYY1 and GYYY2) as proposed.**
- **CMS should continue to explore ways of reducing administrative burden on physicians, particularly burden associated with the face-to-face visit requirement and the documentation to support meaningful use of electronic health records (EHRs).**
- **CMS should finalize the proposal to align the quality reporting criteria for the 2018 payment adjustment under the Physician Quality Reporting System (PQRS) and the Electronic Health Record (EHR) Incentive Program with the requirements under the Merit-based Incentive Program System (MIPS).**
- **CMS should finalize the proposed revisions to the Value-based Payment Modifier (VM) to avoid applying significant negative or positive adjustments in 2018 to plans that will be excluded from payment adjustments in 2019.**
- **CMS should incorporate the patient-relationship codes into the physician Quality Payment Program as quickly as possible, to appropriately reflect the nature of the physician's relationship with the patient.**

More detailed comments on specific proposals from the CY 2018 PFS proposed rule are set forth below.

II. PROVISIONS OF THE PROPOSED RULE

A. Evaluation & Management (E/M) Guidelines and Care Management Services

CMS solicited comments and input on ways to reform the documentation guidelines (DG) for Evaluation & Management (E/M) services. AGS is part of a multi-specialty coalition, group of diverse specialty societies, organized in 2010, whose members provide "cognitive" services to our patients, that provided separate comments in response to CMS's request (see Appendix A). The coalition recommends that CMS undertake an iterative, transparent process for reforming the documentation guidelines that involves all stakeholders. We also do not believe that DG revision should be a de facto rationale to require review of current E/M valuations.

AGS strongly urges that CMS reform the E/M guidelines and carefully considers the coalition's recommendations as it does so. The coalition letter provides additional detail but we want to reiterate the group's recommendations that CMS provide both immediate relief and support long-term reform of the E/M guidelines.

Request for Immediate Relief

- All Medicare auditors of E/M services should immediately stop reviewing medical record documentation of any history and/or any physical examination. In determining the level of service, the only documentation reviewed should be the level of medical decision-making (MDM) or, when counseling or coordination of care comprises more than 50% of the encounter, time. If the auditor is uncertain as to the level of MDM, and, for time based coding, time is not documented, then, the general content (but specifically not the length of the documentation,

the number of bullet points, or the number of systems) of the documented history and/or physical examination also should be reviewed to determine whether it supports the level of the service that was billed.

Long-Term Reform of the E/M Guidelines

- The process should be transparent, inclusive, and should result in consensus among all stakeholders.
- The current valuation of all E/M services should be presumed correct, and the goal of reforming the E/M guidelines is to make them consistent with current medical practice.

Recommendation

- **AGS recommends that CMS consider the input of the multi-specialty coalition for an open, transparent, inclusive and iterative process to reform of E/M guidelines. Changes in the guidelines should not automatically require a review of current valuation.**

B. Changes in Relative Value Unit (RVU) Impacts

AGS participates in the RUC process and the work to appropriately value codes. We are disappointed that in cases when CMS rejects recommended work valuations and direct practice expense inputs that would have resulted in expenditure decreases, all professionals are penalized for the unilateral action of CMS. CMS should either implement the recommendations or hold all other health care professionals harmless from the effects of their decision.

Recommendation

- **AGS recommends that CMS accept RUC recommended values and inputs that would result in expenditure decreases or hold all other professionals harmless for the decision to reject them.**

C. Medicare Telehealth Services

AGS supports CMS's proposal to add additional codes (G0296, 90839, 90840, 90785, 96160, 96161, and G0506) to the list of services that may be provided via telehealth. The ability to provide services via telehealth expands the tools available to geriatricians to effectively and efficiently care for a complex and fragile patient population. We urge CMS to finalize the proposed additions to the telehealth list.

We also support CMS's proposal to eliminate the required use of the "GT" modifier on professional claims for telehealth services. Use of the modifier is redundant now that CMS has created a new place of service (POS) code to identify services provided via telehealth. Eliminating required use of the modifier will simplify claims submission and AGS recommends that CMS finalize this proposal.

In addition to those proposals, CMS solicited input on ways that access to telehealth services could be further expanded within the current statutory authority. CMS has also determined that remote monitoring services are not telehealth and subject to statutory telehealth requirements. We agree with that determination. In general, AGS supports efforts to expand access to telehealth services and to services that recognize the use of technology which allows patients to receive necessary care without physically visiting the physician's office. Our patients often face mobility issues and have difficulty traveling to receive care; providing services through telehealth or using technology to remotely monitor patients allows physicians to better manage patients who cannot come to us for care. Payment for such services can support our effort to treat patients in the setting and environment that is most appropriate and responsive to their individual needs. We appreciate that CMS is exploring approaches to expand access to those services and we look forward to working with CMS on future proposals.

Recommendation

- **AGS recommends that CMS finalize the proposals to add additional services to the telehealth list and to eliminate the use of the "GT" modifier. We urge CMS to continue to identify ways to expand access to services provided by telehealth and remote monitoring services.**

D. Psychiatric Collaborative Care Management Services (CPT codes 994X1, 994X2, 994X3, and HCPCS code G0507)

CMS proposes to recognize 994X1, 994X2, 994X3 and 99XX5 and to assign the work RVUs recommended by the RUC. CMS also proposes to accept most of the RUCs recommendations for practice expense inputs for these codes but is not proposing to include clinical labor costs in the facility RVUs.

AGS applauds CMS for continuing to expand opportunities for physicians to report care management services. Care management and collaboration are integral to the high quality care provided by geriatricians. We urge CMS to finalize the RVUs for these codes as proposed.

Recommendation

- **AGS recommends that CMS finalize the RVUs for 994X1, 994X2, 994X3, and HCPCS code G0507 as proposed.**

E. Payment Accuracy for Prolonged Preventive Services (HCPCS codes GYYY1 and GYYY2)

CMS is proposing to establish two new HCPCS G codes (GYYY1 and GYYY2) that could be billed along with the preventive service codes to more accurately reflect differential resource costs when additional time is required to furnish a Medicare-covered preventive service. Beneficiary coinsurance and deductible would not apply to these codes because the codes can only be reported to describe prolonged portions of services where beneficiary coinsurance and deductible are not applicable.
CMS proposes that these codes would be used to report time beyond the typical service time of the primary procedure. CMS includes a separate file identifying the time requirements for all eligible

preventive services, using the physician work intraservice time or appropriate clinical staff time for services with no face-to-face physician work time.

AGS appreciates CMS responsiveness to stakeholder concerns about the lack of a mechanism to report additional time needed to appropriately provide preventive services to some patients. We support the proposal to establish G codes to describe prolonged services and urge CMS to finalize GYYY1 and GYYY2 as proposed.

Appropriate use of the new G codes is predicated on an accurate understanding of the typical time required to provide the relevant preventive services. We appreciate that CMS released a file showing the time for the preventive services and urge CMS to incorporate this information into other sources, such as the Provider Payment Summary feedback. Also, since the majority of codes included in the "CY 2018 Preventive Services Billed with Prolonged Preventives Codes" file are G codes, CMS should consider including the time information in the code descriptor.

CMS should recognize that those time estimates represent the time needed to typically provide the service, not the minimum time necessary to perform the service. CMS should allow physicians to bill the prolonged preventive service code when the total additional time spent on Medicare-covered preventive services meets the total necessary to report the prolonged services code, even if that additional time is distributed across multiple services performed on a single encounter.

Recommendation

- **AGS recommends that CMS finalize establishment of GYYY1 and GYYY2 as proposed. CMS should make information about the time widely available.**

F. Request for Information on CMS Flexibilities and Efficiencies

CMS invited the public to submit ideas for regulatory, subregulatory, policy, practice, and procedural changes that would improve the health care delivery system and reduce unnecessary burden for clinicians, other providers, and patients and their families. CMS indicated that it will consider the input in the development of future regulatory proposals or subregulatory guidance.

AGS appreciates the opportunity to work with CMS to improve care delivery and reduce the administrative burden on physicians. We believe that there are areas where existing requirements are impeding access to needed care or are counterproductive. For example, the face-to-face visit requirement imposed by the Affordable Care Act for numerous types of items or services, including home health and certain items of durable medical equipment, makes it difficult for some patients to receive needed care, even when those patients have a long-term relationship with a physician. We recognize that the face-to-face requirement is intended to reduce instances of fraud and abuse but question whether it is achieving that goal to a degree sufficient to justify the imposition of additional barriers to care. Another example is the documentation requirements for electronic health records (EHRs) that produce redundancies in record keeping and are a significant factor contributing to the struggles many physicians are experiencing as they transition to use of EHRs.

AGS urges CMS to explore ways that the burden of these policies can be reduced, including simplifying requirements and identifying situations in which certain requirements should not be applied. For example, CMS should consider whether use of the patient relationship codes provides an opportunity for physicians to identify an ongoing relationship with a patient that would allow the physician to order certain items without meeting the face-to-face visit requirement or otherwise identify patients and circumstances in which an exception to the face-to face visit should be applied. Standardizing a requirement for streamlined electronic Part D drug prior authorizations would be useful.

Recommendation

- **AGS recommends that CMS continue to explore ways of reducing administrative burden on physicians, particularly the burden associated with face-to-face visit requirements and the documentation to support meaningful use of EHRs.**

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

CMS proposed to revisit its previously finalized policy for satisfactorily reporting data on quality measures under the PQRS and clinical quality measures (CQMs) under the EHR Incentive Program for the CY 2016 reporting period. The proposals affect payment adjustments under those programs for 2018. These proposals would make the criteria under those programs more consistent with the criteria for reporting of quality measures under the Merit-based Incentive Payment System (MIPS), which takes effect in 2019.

AGS agrees with the proposed changes to the criteria for satisfactorily reporting quality measures under the PQRS and the EHR Incentive Programs. We concur that the proposals would simplify the reporting criteria and make it less likely that a physician will be subject to a negative payment adjustment in 2018. While we typically would not want CMS to change requirements after the end of a performance period, in this instance we believe it is acceptable because CMS is making the criteria less restrictive and doing so will better align the criteria with the requirements under MIPs. Not aligning those criteria could mean that physicians would receive a negative adjustment in 2018 under the legacy PQRS and EHR programs but receive no adjustment or a positive adjustment under MIPS. The shift between positive and negative adjustments would not reflect improvement in reporting of or performance on the quality measures but just the difference in the reporting criteria. To avoid this unnecessary potential whipsawing between negative and positive adjustments, we recommend that CMS finalizes the changes as proposed. Retaining requirements that have already been determined to be less optimal undermines the programs.

Recommendation

- **AGS recommends that CMS finalize the proposal to align the quality reporting criteria for the 2018 payment adjustment under the PQRS and the EHR Incentive Program with the MIPS quality reporting requirements.**

H. Value-Based Payment Modifier (VM) and Physician Feedback Program

CMS also proposes to modify policies for the Value-Based Payment Modifier (VM) for the CY 2018 payment adjustment period. CMS would reduce the automatic downward adjustment for groups and solo practitioners in Category 2 (those who do not meet the criteria to avoid the 2018 PQRS payment adjustment as individual solo practitioners, as a group practice, or groups that have at least 50 percent of the group's eligible practitioners (EPs) meet the criteria as individuals) to negative 2 percent (-2.0 percent) for groups with 10 or more EPs and at least one physician, and negative 1 percent (-1.0 percent) for groups with between 2 to 9 EPs, physician solo practitioners, and for groups and solo practitioners that consist only of non-physician EPs. All groups and solo practitioners who are in Category 1 (those who meet the criteria to avoid the 2018 PQRS payment adjustment as individual solo practitioners, as a group practice, or groups that have at least 50 percent of the group's EPs meet the criteria as individuals) would be held harmless from downward payment adjustments under quality-tiering for 2018, the last year of the program. CMS would reduce the maximum upward adjustment under the quality-tiering methodology to two times an adjustment factor (+2.0x) for groups with 10 or more EPs.

The effect of CMS's proposals is to reduce the negative adjustment under PQRS as well as to greatly reduce the possible upward adjustment. CMS believes it is likely that many physician practices that fall in Category 2 (and are subject to the negative adjustment) will be excluded from MIPS in 2019, due to the low-volume threshold. AGS agrees that it is not appropriate to apply a negative adjustment to those practices which have a small Medicare patient population.

Recommendation

- **AGS recommends that CMS finalize the proposed revisions to the VM to avoid applying significant negative or positive adjustments in 2018 to plans that will be excluded from payment adjustments in 2019.**

I. MACRA Patient Relationship Categories and Codes

CMS is proposing that Medicare claims submitted for items and services furnished by a physician or applicable practitioner on or after January 1, 2018, should include the applicable HCPCS modifiers shown in Table 26 of the proposed rule, as well as the National Provider Identifier (NPI) of the ordering physician or applicable practitioner (if different from the billing physician or applicable practitioner). For at least an initial period while clinicians gain experience using the modifiers, CMS is proposing that the HCPCS modifiers will be voluntarily reported on Medicare claims, and the use and selection of the modifiers would not be a condition of payment.
The quality measures that CMS proposed for 2018 and those it is currently developing for future rulemaking for the MIPS performance categories do not require patient relationship codes to properly measure clinicians' quality and resource use. CMS may work with clinicians to explore incorporating these codes in future years.

AGS supports the voluntary reporting of relationship codes. Use of the codes will help ensure appropriate attribution for cost measures under the Quality Payment Program (QPP). We urge CMS to incorporate these codes into the Medicare quality program as expeditiously as possible.

Recommendation

- **AGS recommends that CMS incorporate the patient-relationship codes into the physician Quality Payment Program as quickly as possible, to appropriately reflect the nature of the physician's relationship with the patient.**

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We thank CMS for the opportunity to comment on this proposed rule. Please call Alanna Goldstein at the American Geriatrics Society at 212-308-1414 or Paul Rudolf at Arnold & Porter Kaye Scholer LLP at 202-942-6426 if you have any questions about these comments.

Sincerely,

Debra Saliba, MD, MPH, AGSF
President

Nancy E. Lundebjerg, MPA
Chief Executive Officer

Appendix A: Multi-specialty Coalition Letter in Response to PFS Proposed Rule for CY 2018

September 11, 2017

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Seema Verma
Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
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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 Administrator Verma:

The undersigned are pleased to submit comments in response to proposed revisions to the Medicare Physician Fee Schedule (MPFS) for CY 2018. We are a group of diverse specialty societies, organized in 2010, whose members provide "cognitive" services to our patients. Our comments are limited to Section II. I, the solicitation for comments and input on ways to reform the documentation guidelines for Evaluation & Management (E/M) services.

Our members have been greatly burdened by the E/M documentation guidelines since they were established in 1995, and believe they no longer reflect the care that is actually being provided by our members. We applaud CMS for recognizing how burdensome they are and its willingness to consider substantial revisions that will reduce burden, improve accuracy, reduce redundant documentation that hinders care and, will allow physicians to spend more time with their patients and improve care for Medicare beneficiaries. Our members have also been subject to audits by various Medicare contractors (e.g., MACs, RACs, ZPICs, SMRCs). The results of these audits are widely variable; there appears to be significant inconsistency in those reviews with many of these audits inappropriately determining that the wrong level of E/M was billed, resulting in significant time and resources being spent unnecessarily by physicians and CMS on the administrative appeals process.

We agree with CMS that reforming the E/M documentation guidelines is likely to require at least two years and likely longer. The vital components of E/M services have evolved, medical practice has changed and the E/M documentation guidelines are out of date and place unnecessary burdens on physicians.

Request for Immediate Relief. We agree with CMS that medical decision-making (MDM) and time are the two most important factors in determining the level of service. That is why the undersigned are requesting CMS to grant our members immediate relief from burdensome time-consuming audits while this process unfolds. Specifically, we request that all Medicare auditors of E/M services immediately

stop reviewing medical record documentation of any history and/or any physical examination. In determining the level of service, the only documentation reviewed should be the level of MDM or, when counseling or coordination of care comprises more than 50% of the encounter, time. If the auditor is uncertain as to the level of MDM, and, for time based coding, time is not documented, then, the general content (but specifically not the length of the documentation, the number of bullet points, or the number of systems) of the documented history and/or physical examination also could be reviewed to determine whether it supports the level of MDM for the service that was billed. This will immediately improve care because it will allow physicians to spend more time with their patients, and will help to unclutter the medical record because documentation will be consistent with what physicians actually need to document for care. We would be happy to work with CMS and the various contractors who perform audits, to implement this approach.

Long Term. In the longer term, with respect to the process for reforming the guidelines, we also agree that it is important for all stakeholders to come to consensus as to what those changes should be, before they are implemented. The goals of E/M guidelines reform should include: (1) improving care, (2) reduced burden, (3) alignment of the guidelines with the activities actually being performed by physicians before, during, and after an E/M service, and (4) allowance for objective, consistent, and reliable audits that do not result in disputes and lengthy burdensome administrative appeals. We also agree that the development of the electronic health record has changed the nature of documentation of the history and physical examination and made it unnecessary to audit those components to determine what service was furnished. We also agree that medical decision-making (MDM) and time are more important determinants of the level of service furnished but note that while the time of a visit is quantifiable and easy to document, the complexity of MDM is not quantitative or easy to document. For example, arriving at a diagnosis of influenza may be simple and easy, or it may be very complicated and require very complex decision making. Therefore, while we agree with CMS' goals, we caution that having predetermined notions of the endpoint of E/M guidelines reform may not be advisable and result in unintended consequences. For example, it is very important that audits of E/M services be consistent and reliable across reviewers and contractors, and we are concerned that if MDM is going to be the major (or only) determinant of the level of E/M furnished, consistent review of medical records may be difficult to achieve.

We also agree with CMS that these revisions, in and of themselves, should not result in the need to revalue these services. The E/M documentation guidelines were never related to valuation - they are only intended to facilitate medical review and that reforming the guidelines is necessary to make them consistent with current medical practice. Keeping this in mind, we seek assurance from CMS that any revisions to the guidelines independent of changes to the E/M codes and coding structure will not result in referral of any E/M services to the RUC for review and that CMS will not undertake an independent review of the valuations of these services.

First, we recommend that the initial focus of CMS should be on establishing a reform process that is iterative (e.g., goes through multiple drafts), is inclusive of all stakeholders, transparent, and allows for multiple opportunities to comment. Specifically, we recommend that CMS take specific steps to assure that the following stakeholders are included in the process to achieve consensus on E/M guidelines revisions:

- Organizations representing physicians and other health professionals who perform E/M services
  - Including physician members and staff who are on the organizations' coding (or other relevant) committee(s)
- Organizations representing practice groups (e.g., Medical Group Management Association, Association of American Medical Colleges)
- The CPT Editorial Panel
- Individual physicians and physician practices of all sizes that represent a cross-section of those who care for Medicare beneficiaries (e.g. by practice type, size, location, specialty, and use or non-use of an electronic health record)
- All appropriate CMS components, including physicians and analysts from the Center for Medicare and Program Integrity.
- Medicaid medical officers and policy makers from CMS and from individual states
- Medicare contractors
  - Representatives from all contractor types that perform audits of E/M services (e.g., contractor medical directors, nurse reviewers)
- Commercial payers
  - Representatives from multiple payer types (e.g., BCBS, United, Kaiser) who are individuals who perform audits of E/M services
- Manufacturers and developers of electronic health records
- Independent policy makers
- Coding experts who are experienced in, or consult on, E/M coding issues
- OIG
  - Individuals who investigate and prosecute cases where billing for E/M services is an issue

The undersigned are very concerned that representatives from all types of organizations who audit E/M services (including those who conduct the audits) and who investigate alleged improper billing of E/M services must be included in this process. Such inclusivity is needed to assure that auditors and investigators agree with and implement any revisions to the standards and criteria used to perform audits and conduct investigations based on the E/M guidelines as a result, and with a deep understanding, of the proposed process. The undersigned also believe that non-physician coding experts (e.g., certified coders) must be part of the process, as they are the individuals who educate on the guidelines and perform internal audits to assess compliance with the guidelines. Therefore, they may be in the best position to understand how the guidelines will be implemented, the challenges in educating on the guidelines, and whether compliance can be assessed reliably and consistently across reviewers from organizations with very different functions (e.g., Medicare auditors, commercial auditors, Federal investigators).

Second, we recommend that CMS assure the process is transparent and provides opportunities for all the above listed stakeholders to constructively participate and be heard. We recommend that CMS hold public meetings that allow each stakeholder type to be heard. For example, CMS could convene a series of public round tables with each round table focusing on a different stakeholder group. After that, CMS could conduct additional public meetings (e.g., round tables) to come to consensus on each issue.

Third, we recommend that the process address the following issues to assure that any revisions address the current problems with the guidelines while minimizing any unintended consequences:

- History of the guidelines and how they came to be in their current form
- Problems with each element of the guidelines (history, physical examination, MDM, time)
  - Burden
  - Representation of current physician practice
  - Advantages/disadvantages
  - Qualitative vs. quantitative
  - Reliable, reproducible, consistent review
- Advantages and disadvantages of removing each element from the guidelines
- Advantages and disadvantages in increasing the weight of existing elements or of adding new elements
- Advantages and disadvantages of using time as the sole criterion for determining the level of E/M service

At the end of this process, CMS should achieve consensus that the revisions work for all stakeholders, minimize burden to all stakeholders, represent activities currently being performed during E/M services, and will result in fair, consistent, and reliable audits and investigations.

In summary, the Coalition makes the following recommendations:

Request for Immediate Relief

- All Medicare auditors of E/M services should immediately stop reviewing medical record documentation of any history and/or any physical examination. In determining the level of service, the only documentation reviewed should be the level of MDM or, when counseling or coordination of care comprises more than 50% of the encounter, time. If the auditor is uncertain as to the level of MDM, and, for time based coding, time is not documented, then, the general content (but specifically not the length of the documentation, the number of bullet points, or the number of systems) of the documented history and/or physical examination also should be reviewed to determine whether it supports the level of the service that was billed.

Long-Term Reform of the E/M Guidelines

- The process should be transparent, inclusive, and should result in consensus among all stakeholders.
- The current valuation of all E/M services should be presumed correct, and the goal of reforming the E/M guidelines is to make them consistent with current medical practice.

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We appreciate the ability to submit these comments, and we stand ready to work with CMS to achieve its goals and to improve the care furnished to Medicare beneficiaries. Please call Paul Rudolf at Arnold & Porter Kaye Scholer LLP at 202-942-6426 if you have any questions about these comments.

Signed:

- American Geriatrics Society
- AMDA – The Society for Post-Acute and Long-Term Care Medicine
- American Academy of Home Care Medicine
- American Academy of Hospice and Palliative Medicine
- American Academy of Neurology
- American College of Physicians
- American Gastroenterological Association
- American Psychiatric Association
- American Society of Addiction Medicine
- American Society for Blood and Marrow Transplantation
- American Thoracic Society