Wisconsin Medical Society

September 10, 2018

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1693-P
PO Box 8016
Baltimore, MD 21244-8016

RE: Physician Fee Schedule and Quality Payment Program (CMS-1693-P)

Dear Administrator Verma:

Comprised of nearly 13,000 physicians, residents and medical students, the Wisconsin Medical Society (Society) is the largest association of medical doctors in Wisconsin. It is our mission to improve the health of the people of Wisconsin by supporting and strengthening physicians' ability to practice high-quality patient care in a changing environment.

The combined 2019 Physician Fee Schedule (PFS) and Quality Payment Program (QPP) proposed rules update and build upon the Centers for Medicare and Medicaid Services' (CMS) previous efforts regarding reductions in paperwork, administrative burden and costs for care. The proposed rule makes refinements to the QPP and attempts to recognize the evolving use of technology in health care. The Society is encouraged by some of the proposals put forth by CMS and cautious of others. Broadly, the Society is supportive of measures that reduce physician burden, improve patient outcomes and improve flexibility in physician decision making. However, such improvements should not necessarily come at the expense of reimbursement or create new burdens for physicians. We offer comments on the following topics covered by the proposed rule.

Physician Fee Schedule

As health care has evolved from treating individual diseases to more comprehensive models of care, the demands and expectations placed on physicians have increased. These increased demands have led to a rise in physician burnout, which can adversely affect both physicians and patients. The Society is committed to working with CMS to improve the PFS to reward physicians for providing high-quality patient care, as well as the extensive amounts of time physicians spend working with patients outside of normal hours. Through our comments, it is the intent of the Society to reduce physician burden and improve patient outcomes, while ensuring high-quality, high-value care.

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Telemedicine Changes

The Society appreciates CMS's efforts to recognize the proliferation of telemedicine as a part of physician practice with its myriad new proposals regarding technology-based communication services. Specifically, the Society supports the creation of a code for "brief communication technology services." Physicians and patients have become increasingly reliant on electronic forms of communication (email, text and chat), and the benefits of creating new telemedicine codes for reimbursement would encourage increased utilization of telemedicine services for rural Medicare patients.[1] Further, increased access to telemedicine has been demonstrated to improve patient outcomes. [2, 3, 4] The Society supports and approves of the creation of this new billable service under HCPCS code GVCI1.

It is in this same vein that the Society supports the creation of new codes for services related to "interprofessional internet consultation" (CPT codes 994X6, 994X0, 99446, 99447, 99448 and 99449) and prolonged preventive service codes (HCPCS codes G0513 and G0514). We also support expanding the use of telehealth services under the Bipartisan Budget Act (BBA) of 2018 for home dialysis therapy and for individuals suffering from stroke, as specified by the rule.

Radiologist Assistants

CMS is proposing to change the requirements for physician supervision for radiologist assistants to require a direct level of supervision. The Society supports this change and views it as a way to save physician time for some tasks, while allowing radiologist assistants to be paid for their work.

Evaluation and Management (E/M) Code Changes

CMS is proposing to reduce the documentation requirements for E/M services by allowing physicians to use any of the following methods to document the appropriate level of an E/M visit:

1) 1995 or 1997 guidelines
2) medical decision making
3) time

The Society agrees with CMS's assessment that various stakeholders have long-contended that "E/M documentation guidelines are administratively burdensome and outdated with the practice of medical decision making."[5] Documentation requirements placed on physicians by hospitals and insurers, coupled with requirements to enter data manually, have been demonstrated to

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[1] A Mehrotra et al. "Utilization of Telemedicine Among Rural Medicare Beneficiaries," *JAMA*, 315 no. 18, (2016): 2015-2016, doi: 10.1001/jama.2016.2186.

[2] L Siminerio et al. "Telemedicine for Reach, Education, Access, and Treatment (TREAT): linking telemedicine with diabetes self-management education to improve care in rural communities," *The Diabetes Educator*, 40 no. 6, (2014): 797-805, doi: 10.1177/0145721714551993.

[3] A Tanguay et al. "Rural Patient Access to Primary Percutaneous Coronary Intervention Centers is Improved by a Novel Integrated Telemedicine Prehospital System," *The Journal of Emergency Medicine* 49 no. 5, (2015): 657-664, doi: 10.1016/j.jemermed.2015.05.009.

[4] KA Poulsen et al. "Satisfaction with rural rheumatology telemedicine service," *International Journal of Rheumatic Diseases*, 18 no. 3 (2015): 304-314, doi: 10.1111/1756-185X.12491.

[5] Department of Health and Human Services, "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program," last accessed September 5, 2018. https://www.federalregister.gov/documents/2018/07/27/2018-14985/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions. p. 35834.

increase physician burnout and dissatisfaction.[6] Physician burnout in turn has been associated with an increase in medical errors and lower physician safety grades, leading to lower patient outcomes.[7] The Society supports CMS's proposal to reduce the burdensome documentation requirements for physicians for E/M codes. Further, the Society will continue to support CMS's efforts to reduce administrative burdens and costs via its "Patients Over Paperwork" initiative.

CMS also proposes streamlining payment levels and reducing payment rates for E/M codes. Instead of having five separate reimbursement levels, there would be two, with levels 2 through 5 being condensed into a single rate. We are concerned about this change for several reasons. First, at a time when CMS is emphasizing quality over quantity in healthcare, it would be counterproductive to remove the ability for physicians to appropriately bill for the time to provide quality care. Treating difficult and complex patients simply requires more time. Adequate reimbursement for time spent with patients should be rewarded. Second, this change will create winners and losers, particularly among certain specialties as documented by CMS. We do not think that reductions in unnecessary administrative documentation should come at the expense of physician reimbursement without further study by CMS or relevant federal agencies.

The Society proposes that CMS study the impact of the proposed E/M rate reductions before enacting new rates. Such a study could look at how specialties would be affected, projected per capita reimbursement changes, how large health systems and small clinics could differ in terms of impact, rural/urban disparities and if certain specialties can offset the impact of the rate reductions through Quality Payment Program (QPP) bonuses. In lieu of such a study, the Society proposes that CMS consider either delaying the reimbursement cuts for at least one year or consider a phase-in approach for new reimbursement levels.

Overall, the Society supports CMS's efforts to reduce documentation requirements and administrative burdens on physicians. However, we do not support tying CMS's proposed flexibility to significant changes in reimbursement for physicians.

Geographic Price Cost Indicator (GPCI) Comment Solicitation

CMS included in its proposed rule a solicitation for comments on its reevaluation of the GPCI, as required by law. The Society greatly supports CMS's efforts to evaluate the appropriateness of the data being used to determine the GPCI elements of the PFS.

Wisconsin has one of the lowest GPCI reimbursements in the nation, which places physicians in Wisconsin at a competitive disadvantage relative to their peers. (See GPCI Attachment.) The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) temporarily increased Wisconsin's GPCI to 1.0, but that floor expired January 1, 2018. The Society contends that the GPCI methodology's reliance on "proxy" data, in place of actual physician wage and practice expense data, results in payment adjustments that downplay the true costs of operating a medical practice and further penalizes rural areas. To help equilibrate reimbursement levels across the states, the Society proposes the following updates to GPCI calculations:

1) CMS should require the use of recent market data relating to practice expenses, malpractice expenses and physician work effort to determine how various PFS indices are calculated, specifically for the GPCI.

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[6] TD Shanafelt et al. "Relationship Between Clerical Burden and Characteristics of the Electronic Environment With Physician Burnout and Professional Satisfaction," *Mayo Clinic Proceedings*, 90 no. 7 (2016): 836-848, doi: 10.1016/j.mayocp.2016.05.007.

[7] DS Tawfik et al. "Physician Burnout, Well-being, and Work Unit Safety Grades in Relationship to Reported Medical Errors," *Mayo Clinic Proceedings* (2018), doi: 10.1016/j.mayocp.2018.05.014.

2) Physician work components should be calculated directly from applicable wage data and should not rely on inaccurate proxies.
3) CMS should make permanent the 1.0 physician work (PW) and practice experience (PE) GPCI floors to ensure that all physicians are not subject to reduced reimbursements because of inaccurate data.
4) In coordination with items 1 through 3, CMS should transition to the utilizing true physician wage data from the Bureau of Labor Statistics Employment Statistics as the metric for creating the Physician Wage (PW) GPCI adjustment factor.

The Society also proposes that the Government Accountability Office (GAO) conduct a study of the GPCI to ensure that all data accurately reflects the true cost of care and does not unduly burden states with a significant number of rural physicians. Recalibrating the GPCI component of the PFS would be a benefit for all physicians, particularly in rural areas, and reward physicians who provide efficient, high-quality care.

Part B Drugs Add-on

CMS is proposing to change the wholesale acquisition cost (WAC) add-on for new drugs from 6 percent to 3 percent for the first quarter a given drug is on the market. The Society supports appropriate legislative or regulatory efforts that will ensure--to the greatest extent possible--the availability and affordability of prescription drugs for all patients. However, because of the 2011 sequester, the effective impact of this change on physicians would be an add-on of 1.4 percent, not 3 percent. Further, the proposed reduction would create cuts that would hinder the use of the affected drugs in physician offices, effectively limiting patient access to new drugs and therapies. As such, the Society does not support this change.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

CMS is proposing that RHCs and FQHCs would be newly eligible for reimbursement for care management services (code 99X47) and for communication technology-based services when at least 5 minutes of communication are provided. The Society broadly supports adequately reimbursing RHCs and FQHCs for these services as they are part of the vital safety net of care for patients. (See Health Principles Attachment). By allowing RCHs and FQHCs to receive reimbursement for these services, they could be compensated for the care they provide to some of the most at-risk patients.

Quality Payment Program

The Society has long placed an emphasis on helping physicians provide high-quality and efficient care to patients. With the QPP entering its third year of operation, the Society offers CMS the following comments to help improve the QPP, reward high-quality care and reduce physician burden.

Merit and Incentive-Based Payment System (MIPS) – Low Volume Threshold & Opt-in

Per CMS, the new low-volume threshold component (200 or fewer billed professional services) is being created to allow eligible clinicians to decide to opt-in to the MIPS. In last year's comment letter, the Society urged CMS to create an opt-in option for clinicians who wanted to participate in MIPS. The Society supports this proposal as it allows physicians the flexibility to participate in the MIPS program if they were to otherwise be excluded.

MIPS – Quality Performance Category

CMS has made several tweaks to the Quality performance category that are relevant to Society interests. First, CMS is proposing to amend the definition of its "high priority" measures to include those measures that relate to opioids, along with outcome measures. The Society applauds CMS's efforts to address the opioid crisis and the impact that it has had on the millions of people suffering from opioid addiction. The extent of the opioid crisis is wide-ranging and incentivizing good prescribing practices for opioids via the MIPS program will help to address this issue.

Second, CMS's consideration of topped-out measures to be reviewed for removal marks a positive step towards engaging with the medical community to determine whether such measures should be removed. Last year the Society commented that it was concerned that high-performing physicians may not be adequately rewarded for their outcomes if most of their reported measures were near topped-out status. The Society urged CMS to consider that any topped-out process-oriented measures be replaced with outcome-oriented measures so physicians are correctly rewarded for providing high-quality care. Further, we urged CMS to exercise caution when considering removing topped-out measures, and that CMS should solicit review from relevant and appropriate entities prior to their removal. As we stated previously, just because a measure may be topped-out, it does not mean that it is not meaningful or that it may be significantly relevant to a given specialty's overall score. However, we still do not support CMS's proposal to cap achievement points for topped-out measures.

Third, CMS is proposing to score Quality performance measures by "value" (e.g., gold, silver and bronze) while also seeking comment on how such a program would operate. The Society supports the concept of weighing Quality performance measures on some sort of sliding scale, so long as what is being measured adheres to the parameters of CMS's "Meaningful Measures" and "Patients Over Paperwork" initiatives. Such a program should reward patient outcomes as much as it does process components while reflecting actual operations in a given health care setting. However, new quality measure scales or metrics should not increase administrative complexity or physician burden. Further, if CMS were to incorporate these new value metrics they should be applicable and relevant to all specialties and settings.

MIPS – Cost Performance Category

Two items in the proposed Cost category concern the Society: the new weight given to the Cost score (15 percent) and the use of episode-based cost measures along with Medicare Spending per Beneficiary and Total Per Capita Cost of Care.

In previous years, CMS has stated that it ultimately would like to have the Cost performance category account for 30 percent of the overall MIPS score. Last year CMS increased the weight of the Cost component from 0 percent to 10 percent. In our comments last year, the Society urged CMS to either keep the Cost component at 0 percent for performance year 2018 or, rather than jumping to 30 percent in succeeding years, proposed that CMS gradually increase the Cost weight until it reaches 30 percent. Given the moderate increase from 10 percent to 15 percent, the Society suggests that for performance year 2019 and in succeeding years, CMS continue to implement any future increases at a gradual pace. The Society also requests that CMS explicitly lay out its planned changes to scoring weights for the next five years, so physicians can plan for new reporting requirements and structures.

Regarding the episode-based cost measures proposed by CMS, the Society encourages CMS to study the effectiveness of the measures before implementing them, particularly as they will only

affect some physician specialties. Further, episode-based cost measures should be vetted and endorsed by the National Quality Forum (NQF) and combined with a quality outcome component. Until such evaluation can be completed, the episode-based cost measures should not be implemented.

MIPS – Improvement Activities
The Society offers no comment on CMS's proposed changes to the Improvement Activities component of MIPS.

MIPS – Promoting Interoperability
Under the new Promoting Interoperability (PI) category, CMS is making some significant changes to the scoring of this performance category. Requiring that all eligible clinicians use a 2015 edition of certified electronic health records technology (CEHRT) to get credit for this score presents a major issue for clinicians who do not have a 2015 CEHRT. Requiring a 2015 CEHRT places a significant burden--both administrative and cost--on physicians who do not currently have a 2015 CEHRT. Rather, the Society would like CMS to allow physicians to continue using a 2014 CEHRT, if they have one, to be eligible to receive a full score under the PI category. Further, CMS should allow eligible physicians to make a good faith effort to transition to a 2015 CEHRT within the next three years. Allowing such a grace period would alleviate some of the immediate cost burdens under this new standard, particularly for small and rural practices.

CMS is also proposing to reconstruct the PI scoring category by eliminating the old base, performance and bonus scoring metrics. In doing away with the old metrics CMS is proposing that all clinicians report on all of the measures under the categories of e-prescribing, health information exchange, provider to patient exchange and public health clinical exchange data. While this change effectively reduces the number of measures that must be reported from six to four, this is a significant change from the previous scoring methodology. The Society supports the reduction of measures that must be reported, but requests that like the 2015 CEHRT requirement, clinicians be allowed sufficient time to adjust their reporting procedures to accommodate the new requirements. The Society proposes a grace period of one year whereby clinicians can report under either the old PI scoring methodology or the new scoring methodology as proposed by CMS.

The Society is also encouraged by CMS's adoption of new measures relating to fighting the ongoing opioid crisis. The Society's comments on those metrics are addressed later in these comments.

MIPS – Payment Threshold
The Society supports CMS's moderate increase of the performance threshold from 15 points to 30 points for performance year 2019. If CMS continues to raise the threshold in subsequent performance years, the Society urges CMS to continue to do so at a moderate pace. And like the Cost category recommendation, the Society requests that CMS lay out what its anticipated scoring structure will look like for the next five years.

Advanced Alternative Payment Models (APMs)
CMS is proposing that 75 percent of eligible clinicians in an APM must report using CEHRT and extending the 8 percent revenue-based nominal risk stand. The Society offers no comment on these proposals other than CMS maintain these thresholds for at least the next three years to allow APM participants to incorporate these standards into their practice. CMS is also requiring

that all outcome measures for APMs must be evidence-based, reliable and valid. The Society supports this change.

For the first time, CMS also is proposing allowing eligible clinicians to participate under the "All-Payer Option," which provides physicians the flexibility to participate in the APM program by combining their non-Medicare experience to be eligible. The Society supports the development and utilization of this new APM model and believes that it will provide incentives to increase value-based care while providing flexibility.

Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration

CMS is proposing to create a waiver aimed at helping physicians who practice in areas with an above-average proportion of Medicare patients in Medicare Advantage (MA) plans. The MAQI demonstration would allow certain participating clinicians to be excluded from the MIPS reporting requirements and payment adjustments. The Society supports this proposal provided that it demonstrates that patients continue to receive high quality care, and it reduces the burden placed on physicians.

Price Transparency RFI

Price transparency has become a catchall term for the multiple charges, discounts and rebates that are part of the current health care system and reimbursement practices. Discrepancies between billed and paid amounts create confusion for both patients and physicians alike. Transparency concerns are compounded when over half of all patients have received a "surprise bill,"[8] even when they seek care at in-network facilities.[9] All of these practices create an environment of confusion for patients and obscure the true cost of care.

In this proposed rule, CMS solicits comment on price transparency guidelines for hospitals and the prices they are required to make public for their patients. The Society would like to see CMS put forth incentives and regulations that would have both hospitals and insurers disclose to patients the true costs of care, as well as publicly posted Medicare and Medicaid payments for services, drugs, procedures and treatments that are to be made available at the time a service is rendered. Such information should be easily accessible via multiple platforms.

Further, any price transparency effort should help facilitate physician-patient discussions when making medical decisions. The fact that physicians may not know the true cost of a given service or procedure for their patients places significant burden on both the physician and the patient. It is in this vein that the Society supports transparency in hospital charges and insurance payments and believes this price transparency should extend to health care systems, insurers, payors and third-party administrators. The Society also suggests that CMS require both outcome and price transparency disclosures for hospitals and health systems.

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[8] "New Survey Reveals 57% of Americans Have Been Surprised by a Medical Bill," *NORC at the University of Chicago*, last accessed September 5, 2018, http://www.norc.org/NewsEventsPublications/PressReleases/Pages/new-survey-reveals-57-percent-of-americans-have-been-surprised-by-a-medical-bill.aspx.

[9] S Kliff, "He went to an in-network emergency room. He still ended up with a $7,924 bill," *Vox*, May 23, 2018, https://www.vox.com/2018/5/23/17353284/emergency-room-doctor-out-of-network.

Opioid Measures

The opioid crisis is one of the most dangerous and important health care issues facing all physicians and patients today. Approximately 42,000 people died from opioid-related overdoses last year,[10] even though opioid prescribing rates were at their lowest in a decade.[11] This crisis affects every community and it is incumbent upon all health care entities to actively engage in ending this crisis. The Society strongly supports CMS's focus and prioritization of policies aimed at addressing the opioid crisis, including the new bundled substance use disorder payments under the PFS, the higher scoring weights under the Quality performance category and the two new measures created under the Promoting Interoperability category of the MIPS program. The Society offers the following comments to help guide and inform CMS's creation of its new opioid measures.

Bundled Episode of Care for Substance Use Disorder (SUD) Services

CMS is proposing to create a bundled payment for SUD services under the PFS. The Society supports the creation of this type of payment and would like to see it cover all components of medication-assisted treatment (MAT), coordination of both medical treatment and counselling services and patient-physician discussions about treatment plans and expectations with a focus on evidence-based treatments. The amount to be paid for such a bundled payment should be significant enough to incentivize coordinated treatment and care. Many of the physicians who work with opioid-dependent patients already devote significant time and resources to helping them address their addiction and health, often at a financial loss to their practice. Further, bundled MAT payments should not be restricted to a fixed duration or maximum time limit. Patients undergoing MAT often need long-term treatments, some for the rest of their lives to ensure they remain opioid-free. Any bundled payment created by CMS needs to account for the long-term effects of addiction.

Evidence-based medicine has shown that a coordinated care approach for addiction is effective.[12] However, time spent discussing cases with other physicians or specialists is currently not a covered service. Coordination of care meetings can be lengthy, and often health care providers provide this service without payment. Specifically, consultations by physicians coordinating care with psychologists or psychiatrists should be covered by the proposed bundled payment. Similar reimbursement arrangements are already being applied in school systems in Wisconsin. Further, a bundled payment should eliminate any prior authorization for MAT (e.g., buprenorphine, naltrexone, methadone, etc.), while also expanding access. MAT is an evidence-based treatment that has repeatedly been proven effective for patients suffering from addiction and is a critical tool to combating the opioid crisis. Any bundled payment that does not cover MAT will fall short of providing both patients and physicians access to the full continuum of evidence-based care for addiction.

Regarding the use on non-opioid pain management, the Society encourages CMS to look at avenues to incentivize and increase non-opioid pain management therapies. This includes physical therapy and consultations about diet and exercise. Pain management is a specialty that

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[10] "U.S. drug overdose deaths continue to rise; increase fueled by synthetic opioids," *Centers for Disease Control and Prevention*, last accessed September 5, 2018, https://www.cdc.gov/media/releases/2018/p0329-drug-overdose-deaths.html.

[11] "U.S. Opioid Prescribing Rate Maps," *Centers for Disease Control and Prevention*, last accessed September 5, 2018, https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html.

[12] R Saitz et al. "The Case for Chronic Disease Management for Addiction," *Journal of Addiction Medicine*, 2 no. 2 (2008): 55-65, doi: 10.1097/ADM.0b013e318166af74.

deals with chronic pain issues, interventional procedures, non-narcotics and coordination of care between physical therapy and pain psychology. Encouraging the use of non-opioid therapies and increasing coordination of care would limit the amounts of opioids prescribed. Further, such an approach would assist the few patients who benefit from and need opioid treatments such as complicated post-surgical patients and cancer patients. The Society also requests that CMS modify its policies for Medicare Advantage plans to eliminate prior authorization requirements for non-opioid pain treatment therapies.

A well-structured bundled payment would cover all of the costs, services and time for a physician, while also incentivizing other physicians to take on patients suffering from addiction. Such a payment would increase the number of physicians treating addiction patients and increase access to care.

Query of a Prescription Drug Monitoring Program (PDMP) (MIPS-Promoting Interoperability)

CMS's proposed new measure for querying a PDMP for a Schedule-II opioid aims to encourage physicians to check their state's PDMP prior to prescribing an opioid. The Society supports the creation of this measure in principle and offers some suggestions to help improve it. The goal of this measure should be to help incentivize physicians to check and interpret a PDMP as a part of best practices and not to force physicians to carry out repetitive administrative tasks.

To assist physicians with their work flows, the Society encourages CMS to help states develop PDMPs that are user-friendly and designed in such a way that data is available immediately after a prescription is filed to clinicians or their designees. Individual PDMPs should be designed with the best available connectivity to electronic medical records and with connectivity to other PDMP databases so that clinicians or their designees can access PDMP controlled substances dispensing data across state boundaries or between prescribing agencies. Further, PDMP data should be considered protected health information, and thus protected from release outside of relevant health care entities and providers. Ideally, proper use of a PDMP should allow physicians, health systems and regulatory entities to study and evaluate the impacts of controlled substance abuse and generate useful data to help fight the opioid crisis.

Coincidentally, the Society would like CMS to focus its efforts on patient safety as it concerns PDMPs and controlled substances. Patient safety is of paramount importance when it concerns controlled substances and opioids, and all physicians should have access to a timely and accurate PDMP, especially if they prescribe controlled substances such as opioids. The Society encourages CMS to develop mechanisms to ensure this access. Further, CMS should study the value of extending PDMP requirements to include controlled substances that can fatally interact with opioids such as benzodiazepines, carisoprodol and barbiturates.

Verify Opioid Treatment Agreement (MIPS-Promoting Interoperability)

CMS is proposing that patients with over 30 days of opioid treatment within a 6-month period should have an opioid treatment agreement and that physicians should check for such an agreement in the EHR. The Society does not support a blanket requirement for patients to have an opioid treatment agreement, but encourages their use as necessary, particularly for patients on long-term opioid treatment therapy as a part of best practices.

For patients with treatment agreements, requiring physicians to check the agreement does not place an undue burden on physicians and promotes patient safety. Such a provision could even be extended to hospice and cancer patients as there may be diversion concerns regarding family

members. These patients should also still be subject to pill counts and urine drug screens for both their own safety and that of the general public. Regarding patients with multiple prescribers, only one physician/clinic should be prescribing opioids for a given patient. The person who first prescribes a narcotic should be responsible for the treatment agreement. Even if someone else sees the patient, the patient's primary prescriber would be the only one to prescribe opioids.

The Society thanks CMS for the opportunity to comment on both the Physician Fee Schedule and the Quality Payment Program. We look forward to continue working with CMS to improve patient outcomes, reward high-quality care and reduce physician burden.

Sincerely,

Clyde "Bud" Chumbley, MD
CEO, Wisconsin Medical Society