September 6, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244–8016

RE: (CMS-1770-P; RIN 0938-AU81) Medicare Program; CY 2023 Payment Policies Under the Physician Payment Schedule and Other Changes to Part B Payment Policies

Dear Ms. Brooks-LaSure,

On behalf of the Continuing Medical Education (CME) Coalition, I am pleased to submit comments in response to certain proposed policies included in the Centers for Medicare and Medicaid Services' (CMS) proposed rule on the Medicare Physician Fee Schedule for calendar year (CY) 2023, published in the July 29, 2022, *Federal Register*.

The CME Coalition expresses our strong support for the addition of national CME accrediting organizations and providers as new third-party intermediaries able to directly report clinician completion of accredited CME and/or Maintenance of Certification (MOC) improvement activities for the MIPS Value Pathways. As discussed in more detail below, we believe that the inclusion of CME organizations as a third-party intermediary in this capacity would allow for reduced clinician burden as well as a heightened clinician focus on patient care, particularly with regard to metrics of priority to CMS.

Founded in 2011, the CME Coalition represents a collection of CME stakeholders throughout the United States in addition to other supporters of CME. Our member organizations manage and support the development of healthcare continuing education programs that impact more than 500,000 physicians, nurses, and pharmacists annually.

Graduation from medical school and completion of residency training are the first steps in a careerlong educational process for physicians. To take advantage of the growing array of diagnostic and treatment options, physicians must continually update their technical knowledge and practice skills. CME is a mainstay for such learning. Most state licensing authorities require physicians to complete a certain number of hours of accredited CME within prescribed timeframes to maintain their medical licenses, and hospitals and other institutions may impose additional CME requirements upon physicians who practice at their facilities.

Moreover, upwards of 400,000 medical journal articles are published each year, making the practice of medicine very dynamic. The sheer volume of new scientific data and changes in medicine requires as many appropriate avenues for funding certified CME as possible. In addition, the changes to practice in medicine occur rapidly. The nature of medicine involves constant advancement, testing, and application, and it also features landmark breakthroughs, such as the discovery and testing of novel therapeutic agents.

Changes in medicine often are revolutionary. Patients and society demand that our physicians receive information instantaneously, and that updates in treatment, diagnosis, and prevention are disseminated to physicians as soon as practically possible. Without CME, health care practitioners cannot get the most recent and up-to-date advances.

The CME Coalition and other stakeholders have long advocated for the inclusion of CME in the improvement activity measurement category within the MIPS, as these courses are among the most important ways in which clinicians can improve their understanding of new treatments and therapies, improve beneficiary outcomes, and ultimately improve their practice as a whole. To reaffirm this commitment to health care improvement, the CME Coalition was proud to support the effort to create a mechanism under the MIPS that recognizes Quality Improvement CME (QI-CME) as an 'Improvement Activity.'

Consistent with their core mission, accredited CME providers have acted to support their clinician learners in several ways, including by: (1) helping clinicians to understand how to identify improvement activities, facilitate those activities, and assist clinicians in attesting to their participation; and (2) planning and presenting CME activities that will count as improvement activities. **Because CME providers are already guiding clinicians through this process, these organizations are well positioned to serve as a third-party intermediary to submit data on clinician completion of CME or MOC activities within the improvement activities performance category.**

In allowing CME providers to submit data for clinicians seeking improvement activities performance category credit for CME or MOC, clinicians would no longer need to attest to

completion of the improvement activities through the Quality Payment Program (QPP) web portal, thereby reducing provider burden.

The systems utilized by CME providers provide a streamlined approach to recordkeeping which negates the need for clinicians to report CME improvement activities to multiple oversight bodies, as is often the case when clinicians are responsible for reporting these activities by their own accord. The CME Coalition recognizes that today, there are various reporting systems for CME/CE Credit and MOC participation upon which different professions depend to accomplish this task of reporting completers and recommends that the systems already in place to report this data can be easily extended to the reporting of clinician CME activities that meet the requirements established under the MIPS program.

In designating CME providers as a third-party intermediary responsible for submitting such data on behalf of clinicians, clinician burden would be reduced as the reoccurring responsibility of navigating the submission process would be eliminated. In fact, CME providers already act in this capacity for licensure credentialing and certification. Clinicians seek accredited CME to meet the imposed requirements for these activities, which is then submitted by CME providers and reported to state licensing and certifying boards — a process that is piloted by CME providers rather than clinicians.

Additionally, reducing clinician reporting burden in this regard simultaneously allows clinicians to focus on improving patient care, which can be utilized to place a heightened focus on health equity, inclusion of patient voices, shared decision-making, and care coordination — each of which are areas of priority for CMS. The CME Coalition and CMS are aligned in their commitment to improve patient care and, as such, CME Coalition members are ready and willing to develop the capacity to submit additional improvement activities in the Improvement Activities Inventory with emphasis placed on the aforementioned CMS priority areas.

With regard to the establishment of criteria for inclusion as a third-party intermediary, the CME Coalition suggests that such organizations:

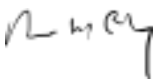
- Be an accreditor or provider of continuing education in the health professions;
- Have a mechanism to recognize improvement activities;
- Have a search engine so that upcoming activities can be identified and selected by clinicians;
- Provide transparency and accountability into their decision-making;
- Have a system for matching and tracking individual learners; and
- Have a system for reporting learners to external entities.

Further, the CME Coalition believes that new third-party intermediaries should be required to meet the current standards and policies in place for CMS-approved vendors.

Conclusion

In all, the CME Coalition advocates for the addition of national CME organizations as a new third-party intermediary able to directly report clinician completion of accredited CME and/or MOC improvement activities for the MIPS Value Pathways. As established experts in this realm, CME organizations are well positioned to provide CMS with the information necessary to verify clinician participation in these activities, which would result in the reduction of provider burden and increase in clinician focus on CMS priority areas for patient care, including health equity, inclusion of patient voices, shared decision-making, and care coordination.

Sincerely,



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