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PHYSICIAN CLINICAL REGISTRY COALITION

December 19, 2016

Mr. Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5517-FC
P.O. Box 8013
Baltimore, MD 21244-8013

[Submitted online at: https://www.regulations.gov/document?D=CMS-2016-0060-3944]

Re: CMS-5517-FC – Medicare Program: Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models

Dear Mr. Slavitt:

The undersigned members of the Physician Clinical Registry Coalition (the Coalition) appreciate the opportunity to comment on the final rule on the implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114-10) provisions related to MIPS and APMs (the Final Rule).[1] The Coalition is a group of over 20 medical societies and other physician-led organizations that sponsor clinical data registries that collect and analyze clinical outcomes data to identify best practices and improve patient care. We are committed to advocating for policies that encourage and enable the development of clinical data registries and enhance their ability to improve quality of care through the analysis and reporting of these outcomes. Over 75% of the members of the Coalition have been approved as qualified clinical data registries (QCDRs) and most of the other members are working towards achieving QCDR status.

MACRA requires the Secretary of the Department of Health and Human Services (HHS) to encourage the use of QCDRs and certified electronic health record technology (CEHRT) for reporting measures under the Quality performance category.[2] When the Centers for Medicare and Medicaid Services (CMS) issued the proposed rule on the implementation of MACRA provisions related to MIPS and APMs (the Proposed Rule),[3] the Coalition submitted comments

[1] 81 Fed. Reg. 77008 (Nov. 4, 2016), *available at* https://www.gpo.gov/fdsys/pkg/FR-2016-11-04/pdf/2016-25240.pdf (the Final Rule).
[2] Social Security Act (SSA) § 1848(q)(1)(E); *Id*. § 1848(q)(5)(B)(ii)(l).
[3] 81 Fed. Reg. 28162 (May 9, 2016), available at https://www.gpo.gov/fdsys/pkg/FR-2016-05-09/pdf/2016-10032.pdf (the Proposed Rule).

on how the Proposed Rule could be modified to encourage and remove barriers to the use of QCDRs and other clinical outcomes data registries.[4] The Coalition thanks CMS for addressing several of the concerns that we raised in our comments on the Proposed Rule to support the broader use of registries. For instance, in the Quality performance category:

- The Final Rule clarified that QCDRs can share non-MIPS quality measures with other QCDRs and registries with permission from the measure owner and encourages this sharing.[5] Sharing CMS-approved and successful home-grown quality measures can result in enhanced development of new measures and also expands the usefulness of each measure because a broader pool of physicians can report on the measures.

- CMS removed the requirement that QCDRs submit one cross-cutting measure. This requirement would have forced QCDRs to focus on health care areas outside of their scope of data collection and analysis.[6]

- CMS clarified that both MIPS and non-MIPS QCDR measures reported through certified health IT can receive the end-to-end electronic bonus point.[7]

- The Final Rule created a measure score "floor" of three-points for use of new measures and measures without benchmarks, which corresponds to the overall MIPS composite score benchmark of three to avoid a negative payment adjustment. This three-point floor ensures clinicians are protected from a poor performance score when they are blinded as to performance metrics. The floor is available annually to any measure without a published benchmark, and CMS expects new measures to have the floor for the first two years until there is baseline data.[8]

- CMS decreased the reporting threshold for MIPS eligible clinicians and groups submitting quality measure data through QCDR, qualified registry, or EHR submission mechanisms from 90% to 50% of patients that meet the measure's denominator criteria for performance year 2017.[9]

The Final Rule also addresses a few of the Coalition's concerns regarding the Clinical Practice Improvement Activity (CMS refers to this category as "improvement activities" or IA) and Advancing Care Information (ACI) performance categories. Generally, the Coalition appreciates CMS's further support to continue optional QCDR reporting in the IA and ACI performance categories for performance year 2017 and future years.[10] The Coalition also appreciates that the

[4] Physician Clinical Registry Coalition, Comment Letter on CMS-5517-P-Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models, CMS-2016-0060-2959 (June 27, 2016).
[5] Final Rule at 77157, 77370-71.
[6] *Id*. at 77104. *See also* 42 C.F.R. § 414.1335(a)(1)(i).
[7] Final Rule at 77298-99.
[8] *Id*. at 77281-82.
[9] *Id*. at 77124. *See also* 42 C.F.R. § 414.1340(a).
[10] *See* Final Rule at 77369-70.

Final Rule increases the bonus score for the optional Public Health Registry Reporting and Clinical Data Registry Reporting measure in the ACI performance category to five percent and clarifies that clinicians may submit data through attestation.[11]

Despite the above changes and clarifications, the Coalition still has significant concerns about several issues relating to QCDRs and other clinical outcomes data registries that were either rejected or ignored in the Final Rule. The Coalition is concerned that some of CMS's final proposals limit the broader use of registries as data collection platforms. We urge CMS to implement the following changes and clarifications to the Final Rule to encourage the use of QCDRs and other clinical outcomes data registries:

1) Recognize that QCDRs need access to Medicare claims data contemplated by Section 105(b) of MACRA through separate mechanisms from the Qualified Entity Program;

2) Clarify that QCDRs that involve multiple organizations should be led and controlled by clinician-led professional organizations or similar entities that are focused on quality improvement relating to particular types of medical procedures, conditions, or diseases;

3) Issue subregulatory guidance on MIPS data submission standards;

4) In the IA performance category, assign all registry-related IAs a high weight and apply IAs to other clinical outcomes data registries beyond QCDRs;

5) In the Quality performance category,

    - Allow for a three-year period of automatic measure approval through the QCDR self-nomination process,
    - Exclude the submission of cross-cutting measures for future performance years,
    - Award points above the three-point floor for reporting on first year QCDR measures and measures without benchmarks,
    - Retain reporting of measures groups and further reduce the reporting threshold to a 20-patient minimum for clinicians who opt to use measures group reporting under MIPS, and
    - Retain the 50% reporting threshold for future performance years and establish a 30-patient threshold for patient-reported outcomes;

6) In the ACI performance category, assign full ACI credit for MIPS participants utilizing a QCDR or clinical data outcomes registry.

[11] *Id*. at 77221, 77214. *See also* 42 C.F.R. § 414.1380(b)(4)(i)(C).

1. CMS Should Create a Separate Process for Providing QCDRs with the Continuous, Timely, and Affordable Access to Medicare Claims Data Contemplated by Section 105(b) of MACRA

The Final Rule reiterates the agency's recently-finalized regulations on the Qualified Entity Program that allow QCDRs to serve as quasi-qualified entities for purposes of obtaining access to Medicare Claims data.[12] However, we strongly disagree with CMS's statement in the Final Rule that "the requirements of the qualified entity program create an appropriate framework for QCDRs to conduct analyses to support quality improvement and patient safety and to work directly with providers and suppliers on issues related to quality improvement and patient safety."[13] While we appreciate CMS's effort to provide QCDRs with an alternative means of accessing Medicare data, treating QCDRs as quasi-qualified entities will not provide them with the type of access they need or contemplated by Section 105(b) of MACRA.[14]

To perform data analysis for quality improvement and patient safety purposes, QCDRs require regular, continuous, and sometimes long-term access to large Medicare data sets to better track clinical outcomes over time. In drafting Section 105(b) of MACRA, Congress was aware of this need and as such specifically directed CMS to provide QCDRs with Medicare claims data "for purposes of linking such data with clinical outcomes data." Significantly, if Congress had wanted CMS to treat QCDRs as qualified entities for purposes of data access, it easily could have said so in Section 105(a), which addresses data access issues for qualified entities. Instead, it created a completely separate section and mandate for CMS to provide QCDRs with access to Medicare data.

Moreover, offering QCDRs the opportunity to apply for quasi-qualified entity status does little to give QCDRs the continuous and timely access to Medicare claims data required under Section 105(b). Qualified entity status only lasts for three years and continued participation in the program requires re-application by submitting documentation of any changes to the original application. In addition, Medicare Fee-For-Service files are released quarterly on an approximate 5.5 month lag. Qualified entities must pay for each set of data they receive, which can become cost prohibitive over time. In addition, the data provided under the Qualified Entity Program is both over- and under-inclusive. The data available to qualified entities is provider-wide and state-specific. In fact, QCDRs generally need national data sets that are either procedure- or specialty-specific. In order to receive nationwide data, QCDRs will have to pay for the entire set of data across all providers and then narrow down the data itself to the particular clinical specialty.

The onerous requirements and lengthy application process required to become a qualified or quasi-qualified entity also stands as a substantial barrier for QCDRs to gain access to the data mandated by Section 105(b). CMS seems intent on keeping the Qualified Entity Program

[12] Final Rule at 77373. *See also* 81 Fed. Reg. 44456 (July 7, 2016).
[13] Final Rule at 77373.
[14] Section 105(b) explicitly directs CMS to provide Medicare claims data to QCDRs "for purposes of linking such data with clinical outcomes data and performing risk-adjusted, scientifically valid analyses and research to support quality improvement or patient safety."

extremely small. In the Qualified Entity Final Rule, CMS estimated that five new qualified or quasi-qualified entities will join the program under the new rules, increasing the total number of qualified entities from 15 to 20.[15] This suggests that it will be very difficult for QCDRs to qualify for quasi-qualified entity status. Yet, the intent of Section 105(b) is for all QCDRs to have continuous and timely access to Medicare data to support their quality improvement, patient safety, and research efforts. Therefore, we request that CMS consider other mechanisms for QCDRs to obtain access to Medicare claims data other than as a quasi-qualified entity.

We are attaching to these comments a copy of our Qualified Entity Final Rule comments with respect to offering QCDRs quasi-qualified entity status, as well as a separate document the Coalition has prepared outlining the type of data access program that would meet the needs of QCDRs and the intent of Section 105(b).

2. CMS Should Clarify that QCDRs that Involve Multiple Organizations Should Be Controlled by Clinician-Led Organizations or Similar Entities Focused on Quality Improvement

The Coalition greatly appreciates CMS's efforts to ensure smaller societies can form QCDRs. In the Coalition's Proposed Rule comments, we discussed our concerns with the broad language at 42 C.F.R. § 414.1400(d) that would allow entities that do not meet the QCDR requirements on their own to collaborate with external organizations to qualify as a QCDR. While CMS described and responded to our comment in the Final Rule, it did not address our specific concerns about health information technology (HIT) vendors and other commercial entities qualifying as QCDRs without participation of clinician-led professional organizations focused on quality improvement. In fact, CMS may have misunderstood our concern. In the Final Rule, CMS states "many specialty societies including subspecialty groups may not have the resources… to be a QCDR and thus partner with outside entities to support their QCDR. We believe that prohibiting specialty groups from partnering with outside entities would only serve to harm smaller societies…"[16]

We agree with CMS that small specialty groups should be able to partner with outside entities to become a QCDR. Instead, we seek narrower language to require that clinician organizations or similar entities focused on quality improvement lead QCDRs. The current 42 C.F.R. § 414.1400(d) is too broad and may allow commercial organizations to collaborate to form a QCDR, or commercial organizations that collaborate with specialty groups to control the priorities of the QCDR. If this occurs, a QCDR could be focused on an external organization's commercial interest and not prioritize clinical interests and quality improvement. This language could also impede the development of specialty-wide or procedure/disease-based registries if commercial entities control the QCDRs. We, therefore, again ask that CMS adopt narrower language that requires QCDRs to be controlled by clinician-led professional organizations or similar entities that are focused on quality improvement. This change should not adversely

[15] 81 Fed. Reg. 44456, 44473 (July 7, 2016).
[16] Final Rule at 77377.

affect HIT vendors, which have numerous other ways in which they can submit MIPS data to CMS on behalf of eligible clinicians.

3. The Coalition Requests Guidance on MIPS Data Submission Standards

We greatly appreciate CMS's acknowledgement of the Coalition's request in its Proposed Rule comments for guidance on MIPS data submission standards.[17] While we are pleased that CMS plans to issue subregulatory guidance, the Coalition urges CMS to publish such guidance as soon as possible, including specific guidance for registries. We also request that the guidance contain specific details on the standards registries must use to report MIPS data for all three performance categories (*i.e.*, through XML reporting, QRDA reporting, or both) and the documentation registries must provide participants who attest to registry-related IAs.

4. The IA Performance Category Should Give Greater Weight for Registry-Related Measures and Apply IAs to Clinical Outcomes Data Registries

The Coalition requests that CMS consider making several additional changes originally requested within our Proposed Rule comments. In those comments, we requested that CMS assign high weights for registry-related IAs. Specifically, the Proposed Rule assigned medium weight (10 points) for all but two of the registry-related IAs.[18] We requested that CMS assign high weights (20 points) for registry-related IAs such as those that involve participation in a QCDR for quality improvement, to demonstrate performance of activities that promote implementation of shared clinical decision making capabilities, to promote use of patient engagement tools, and for those ongoing practice assessment and improvements in patient safety.[19]

While we understand CMS's response to our request for registry-related IAs to be assigned a high weight, we disagree with CMS's reasoning.[20] In the Final Rule, CMS states that it considered whether an activity was critical for supporting certified patient-centered medical homes in proposing whether an improvement activity would be a high-weighted activity, and also that QCDR participation does not require multiple actions.[21] Many of the IAs assigned high weights do not appear to be critical for supporting certified patient-centered medical homes. Also, QCDR and other registry participation allow clinicians to participate in more improvement activities due to ease in reporting. Clinicians must also make significant investments of time and money in order to participate in a QCDR and other clinical outcomes registries. Such investments are similar to an activity that requires multiple actions. The Coalition strongly believes participation in a QCDR and other clinical outcome data registries highly encourages

[17] *Id*. at 77372, 77376.
[18] The only registry-related IAs with a proposed high weight are the "use of a QCDR to generate regular feedback reports that summarize local practice patterns and treatment outcomes, including for vulnerable populations" and "use of a registry or certified health information technology functionality to support active care management and outreach for patients" in treatment for behavioral health needs, dementia, and poorly controlled behavioral health conditions. *See* Final Rule at 77820, 77831.
[19] *See id*. at 77817-77831.
[20] *See id*. at 77183.
[21] *Id*.

performance of multiple improvement activities. In addition, assigning a high weight to registry-related IAs will create increased participation in QCDRs and other clinical outcome data registries, which helps achieve the basic premise of MIPS to tie physician payment to quality through the increased reporting of measures and tracking of performance.

In our Proposed Rule comments, we also asked CMS to consider applying other types of clinical outcome registries to IAs that apply to QCDRs. We do not see any mention of our comments on this issue in the Final Rule and CMS has not made any changes regarding this request. As stated in our Proposed Rule comments, the majority of registry-related IAs do not apply to clinical outcome registries other than QCDRs. Of the fifteen IAs that apply to QCDRs, only three IAs also apply to other types of registries.[22] The Coalition urges CMS to apply the QCDR IAs to other types of clinical outcomes data registries. Many organizations that run QCDRs have other non-QCDR clinical data outcomes registries that should be recognized as improving clinical practice. CMS is discouraging the use of other registries by only creating a few IAs that can be reported through non-QCDR registries. For purposes of identifying other kinds of clinical outcomes data registries, we recommend that CMS adopt the definition of Clinician Led Clinical Data Registry found in the 21st Century Cures Act.[23]

5. CMS Should Further Modify the Quality Performance Category to Create Greater Incentives for Registry Reporting

The Coalition urges CMS to consider making several changes to greater incentivize the use of QCDRs to report measures in the Quality performance category.

A. The Coalition Recommends a Three-Year Period of Automatic Measure Approval Through the QCDR Self-Nomination Process

In its Proposed Rule comments, the Coalition requested modification of the QCDR self-nomination process to allow quality measures that have been approved in prior years to receive automatic approval for a period of three years. In the Final Rule, CMS responded to our comment by stating that the measures are reviewed annually to ensure they are appropriate for use in the program and that CMS will consider automatic approval in future years.[24] We ask that CMS reconsider our request for a three-year automatic approval period during this comment period. As QCDRs require nine to twelve months to code and develop software updates for new measures, and additional time to train staff to utilize these measures, an annual approval period makes it difficult for QCDRs to justify the development of new measures and thus stifles the reporting of such measures. With a three-year approval period, QCDRs are much more likely to invest in the creation of new measures, which will advance the collection of quality measures and the evolution of MIPS.

[22] *See id*. at 77820, 77826-27, 77831.
[23] *See* Coalition comments on Proposed Rule at 4.
[24] Final Rule at 77157.

B. CMS Should Not Require the Submission of Cross-Cutting Measures for Future Performance Years

As stated above, the Coalition greatly appreciates CMS's removal of the proposal requiring QCDR submission of cross-cutting measures during the 2017 transition year.[25] However, the Coalition requests that CMS also not require the submission of cross-cutting measures in future performance years. As many QCDRs are specialty and procedure-specific, requiring the reporting of cross-cutting measures will force these QCDRs to collect data and perform analyses on data outside their specialized scope. As QCDRs already operate under tight budgets, a cross-cutting measure reporting requirement would further strain their scarce resources and detract from the performance of the QCDRs. In addition, many QCDRs lack the expertise to collect data in these areas and would also have to invest significant resources to develop the functionality to report cross-cutting measures. A cross-cutting measure reporting requirement might even discourage some clinical data registries and other entities from becoming QCDRs.

In addition, Congress did not intend for clinicians to utilize QCDRs to submit traditional process measures. The Taxpayer Act of 2012 requires the Secretary of HHS to allow individual providers to submit measures via an approved QCDR as an alternative to traditional PQRS measures.[26] Under MACRA, the Secretary must establish an annual final list of quality measures from which MIPS eligible clinicians must choose the measures they will report.[27] The final annual list can include measures endorsed by a consensus-based entity, measures developed by the Secretary's draft quality measures plan, and measures submitted by stakeholders.[28] Any measure selected for inclusion in the annual list that is not endorsed by a consensus-based entity must have a focus that is evidence based.[29] New measures must also be submitted for publication to a specialty-appropriate peer-reviewed journal, which must include the method for developing and selecting the measure.[30] Measures used by QCDRs are exempt from the above requirements.[31] Together, the Taxpayer Act of 2012 and these exceptions reflect a congressional intent to allow specialties to develop and select QCDR measures outside the prescriptive process used to develop and select general quality reporting measures. Any future cross-cutting measure reporting requirement would be inconsistent with this legislative intent.

C. CMS Should Award CMS Eligible Clinicians Additional Points for Reporting of First Year QCDR Measures and Measures Without Benchmarks

The Coalition greatly appreciates CMS's creation of a measure score "floor" of three-points for use of new measures and measures without benchmarks to avoid a negative payment adjustment.[32] However, the Coalition encourages CMS to award clinicians that report on first

[25] *Id*. at 77161.
[26] American Taxpayer Act of 2012, amending SSA § 1848(m)(3).
[27] SSA § 1848(q)(2)(D)(i).
[28] *Id*. § 1848(q)(2)(D)(v).
[29] *Id*.
[30] *Id*. § 1848(q)(2)(D)(iv).
[31] *Id*. § 1848(q)(2)(D)(vi).
[32] Final Rule at 77281-82.

year QCDR measures and measures without benchmarks above the three-point floor whenever clinicians meet the criteria for additional points. If CMS does not have benchmarks for a measure, the Coalition requests that CMS work with QCDRs and other clinical outcomes data registries to provide benchmark information to more accurately assign points to a measure.

D. CMS Should Reinstate Measures Groups Reporting and the Reduce the 50% Reporting Threshold to a 20-Patient Minimum for Clinicians Utilizing Measures Group Reporting

While we appreciate CMS's attempts to simplify reporting for specialists through specialty measure sets, we still believe measure group reporting is a more appropriate reporting mechanism. Therefore, we disagree with CMS's assertion in the preamble to the Final Rule that specialty measure sets are "a more appropriate way for MIPS to incorporate measures relevant to specialists than measures groups."[33] The specialty measure sets still require submitting necessary data for multiple individual measures and require more resources than the measures groups. Physicians at small practices without an EHR will have increased difficulty with reporting specialty measure sets and will likely have decreased reporting under MIPS due to this policy. If CMS decides to reinstate measures group reporting, the Coalition recommends that both QCDRs and qualified registries have the ability to report using measures groups.

The removal of measures group reporting has also affected the reporting threshold for submitting quality measures through a QCDR, qualified registry, or EHR submission mechanisms. As we stated above, we are pleased that CMS decreased the reporting threshold in the Final Rule from 90% to 50% of patients that meet a measure's denominator criteria. However, a 50% reporting threshold is still much higher than the threshold many clinicians must currently meet under PQRS. Under PQRS measures group reporting, clinicians must report on a minimum of twenty patients. The new 50% threshold represents a large increase in reporting requirements for clinicians currently reporting through measures groups to satisfy PQRS. Therefore, we anticipate this threshold will create a barrier for these clinicians to use QCDRs, qualified registries, and other EHR submission mechanisms. At a time when CMS is trying to move clinicians away from claims-based reporting, this policy will further encourage clinicians to utilize the claims-based reporting mechanism since it requires reporting on Medicare patients only rather than all patients. The Coalition requests that CMS institute a 20-patient minimum for QCDR, qualified registry, and EHR submission mechanisms for clinicians who utilize measures group reporting under PQRS.

E. The Coalition Recommends Retention of the 50% Reporting Threshold for Future Performance Years and a 30-Patient Threshold for Patient-Reported Outcomes

The Coalition strongly disagrees with CMS's proposal to increase the reporting threshold to 60% in the 2018 performance year and to continue to increase the threshold in future years.[34] For clinicians who do not utilize measure groups reporting, the Coalition urges CMS to retain the

[33] *Id*. at 77140.
[34] *Id*. at 77121.

50% reporting threshold for future performance years. As stated above, clinicians will struggle to meet the 50% reporting threshold and many do not have the time or financial resources to report on a greater percentage of patients. While clinicians will gain experience with MIPS over time and may develop efficiencies to meet the current reporting threshold, a higher threshold will require increased time and resources. Therefore, we are concerned that incremental increases in the reporting threshold will discourage clinicians from using registry, QCDR, and EHR submission mechanisms.

In addition, the Coalition requests that CMS establish a separate reporting threshold of 30 patients for patient-reported outcomes measures. These measures require the administration and collection of patient surveys, which is extremely time and labor intensive. In fact, it is unrealistic that many clinicians can meet a 50% reporting threshold for patient-reported outcomes. The Coalition believes that a 30 patient reporting requirement is an appropriate balance that allows for a sufficient number of samples but does not create burdensome requirements on clinicians.

6. The ACI Performance Category Should Assign Full Credit for Participation in a QCDR or Clinical Data Outcomes Registry

As stated above, we greatly support CMS's decision to increase the bonus score available for the Public Health Registry Reporting and Clinical Data Registry Reporting measure to five percent.[35] However, in the Coalition's Proposed Rule comments, we requested that CMS consider assigning full credit or full base score points in the ACI category for electronic participation in a QCDR.[36] CMS did not mention our recommendation in the Final Rule. We again urge CMS to reward electronic participation in either a QCDR or clinical outcomes data registry by assigning full credit or full base score points. As we also described in our comments on the IA performance category, awarding full credit or base score points in the ACI performance category will incentivize electronic reporting and the use of registries. Clinicians must invest significant time and money to use electronic reporting and registries, and are therefore much more likely to pursue these means when there are more significant benefits to making the investment.

Conclusion

The Coalition appreciates this opportunity to comment on the Final Rule. We strongly support the expansion of the use of QCDRs and other clinical outcomes data registries to help ease clinicians' burdens for submitting data under MIPS. While the Coalition greatly appreciates CMS's efforts with the Proposed Rule and subsequent Final Rule, the additional changes that we have proposed will increase QCDRs' access to Medicare claims data, create further incentives to use third-party submission mechanisms, and remove some proposals that would create barriers to the development of QCDRs in particular. We urge CMS to adopt the Coalition's suggested changes and continue to facilitate the use of QCDRs and other clinical outcomes data registries.

[35] *Id*. at 77221, 77235.
[36] *See* Coalition Comments on Proposed Rule at 9.

These changes will allow the use of registries to grow and ultimately result in even greater improvements in the quality of patient care.

Thank you for the opportunity to submit these comments. If you have any questions, please contact Rob Portman at Powers Pyles Sutter & Verville PC (Rob.Portman@ppsv.com or (202)-872-6756).

Respectfully submitted,

AMERICAN ACADEMY OF DERMATOLOGY ASSOCIATION
AMERICAN ACADEMY OF OPHTHALMOLOGY
AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY
AMERICAN ACADEMY OF PHYSICAL MEDICINE AND REHABILITATION
AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS/ NEUROPOINT ALLIANCE
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
AMERICAN COLLEGE OF GASTROENTEROLOGY/GIQUIC
AMERICAN COLLEGE OF RHEUMATOLOGY
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AMERICAN GASTROENTEROLOGICAL ASSOCIATION
AMERICAN JOINT REPLACEMENT REGISTRY
AMERICAN SOCIETY OF ANESTHESIOLOGISTS/ANESTHESIA QUALITY INSTITUTE
AMERICAN SOCIETY FOR GASTROINTESTINAL ENDOSCOPY/GIQUIC
AMERICAN SOCIETY FOR RADIATION ONCOLOGY
AMERICAN SOCIETY OF CLINICAL ONCOLOGY
AMERICAN SOCIETY OF PLASTIC SURGEONS
AMERICAN UROLOGICAL ASSOCIATION
NORTH AMERICAN SPINE SOCIETY
SOCIETY FOR VASCULAR SURGERY
SOCIETY OF NEUROINTERVENTIONAL SURGERY
THE SOCIETY OF THORACIC SURGEONS