American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

September 6, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
PO Box 8016
Baltimore, MD 21244-8016

**Re: CMS-1770-P**

**Re: Medicare and Medicaid Programs; CY 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicare and Medicaid Provider Enrollment Policies, Including for Skilled Nursing Facilities; Conditions of Payment for Suppliers of Durable Medicaid Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); and Implementing Requirements for Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts Proposed Rule**

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Dear Administrator Brooks-LaSure:

On behalf of our 40,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to comment on the Calendar Year (CY) 2023 Medicare Physician Fee Schedule (PFS) and Quality Payment Program (QPP) Proposed Rule, as many of the proposed policies have a significant impact on our members and the patients we serve. A summary of our comments follows, with each section linked to our more in-depth comments that begin on page 11.

## Summary of Comments

### Physician Fee Schedule

***Overview:*** In this proposed rule, the Centers for Medicare & Medicaid Services (CMS) proposes a physician fee schedule (PFS) conversion factor of $33.08, a decrease of $1.53 from the CY 2022 PFS conversion factor of $34.61. The conversion factor reflects the expiration of a 3.0 percent bump that Congress added to the conversion factor in 2022. There is also an additional cut of 1.4 percent due to the budget neutrality requirement. The total cut to the conversion factor is roughly 4.4 percent. Emergency medicine clinicians will experience this across-the-board reduction to their reimbursement in 2023. ***This cut to emergency medicine, if finalized, would jeopardize the nation's critically needed safety net and leave emergency physicians in an untenable financial situation; and we therefore request that CMS do everything within its authority to mitigate the reduction.***

***ACEP urges CMS and the Department of Health and Human Services (HHS) to utilize its 1135 waiver authority under the COVID-19 public health emergency (PHE) to waive the budget neutrality requirement for all of CY 2023. We also strongly urge CMS to work with Congress to enact meaningful physician payment reform that will add more stability to the PFS.***

- ***Evaluation and Management Services***
  - *AMA CPT Documentation Requirements:* In the rule, CMS discusses the American Medical Association (AMA) Current Procedural Terminology (CPT) documentation changes and proposes to adopt most of these changes in coding and documentation. However, CMS is proposing to maintain the current billing policies that apply to the evaluation and management (E/M) codes while the agency considers potential revisions that might be necessary in future rulemaking. ACEP supports the stated goals of reducing the unnecessary documentation burden and bringing CPT and CMS into better alignment while maintaining a resource-based system that also decreases the need for audits.

  - *Emergency Department (ED):* CMS is proposing to reject the AMA Relative Value Scale Update Committee (RUC) recommendation for CPT 99284 and keep the value at 2.74. **ACEP strongly supports this proposal** and appreciates CMS' recognition that it is appropriate to retain the historic relativity between the new patient office or other outpatient codes and the ED E/M codes.

  - *Critical care:* CMS is proposing to change the threshold for reporting CPT 99292 in addition to the base code of CPT 99291 from 75 minutes to 104 minutes. **ACEP notes that this proposed critical care policy differs from long-standing CPT policy,** and we believe will therefore increase provider confusion and administrative burden. We also believe that if CMS adheres to this policy, the value of the first hour of critical care should be increased commensurately, since it is currently based on 60 minutes of critical care.

  - *Observation Services*
    - Overall concerns: ACEP is generally concerned with the overall ability of emergency physicians to adopt all the changes that CMS is proposing for 2023 due to staffing shortages and complications in workflow implementation. Thus, we believe CMS should consider delaying or phasing in some of the changes to the observation codes and billing requirements, **specifically the enforcement of the 8-to-24-hour rule related to observation encounters that transcend the calendar date.**
    - Valuation of New Combined Codes: ACEP notes that CMS' proposed revisions to the values for inpatient and observation E/M visits create an inconsistent relativity across the code family as compared to office and outpatient E/M services.
    - Billing For Both an ED Service and an Observation Service: CMS proposes to retain the policy that a billing provider may only bill initial hospital or observation care service if the physician sees a patient in the ED and decides to either place the patient in observation status or admit the patient as a hospital inpatient, in contradiction to the new CPT policy. Therefore, ACEP requests that CMS provide language in the final rule to clarify how to appropriately bill for these services.
    - 8-to-24Hour Rule: ACEP is concerned about the application of the 8-to-24-hour rule with the elimination of the inpatient hospital and observation code sets due to the contradictions between CPT and CMS policy. We would appreciate direction on how to report this type of interaction between providers of different groups in the transition from observation to inpatient care and reiterate our request for CMS to delay enforcement of the 8-to-24-hour rule related to observation encounters that transcend the calendar date.

- Prolonged Services: CMS establishes new Healthcare Common Procedure Coding System (HCPCS) prolonged services codes (GXXX1- GXXX3) based on their refutation that "there is inherently greater complexity of patient need or intensity of work for E/M visits furnished in non-office settings (for example, inpatient, ED, and home settings) compared to the office settings." ACEP strongly disagrees that the complexity and intensity of E/M visits delivered in office settings are the same as they are in facility-based settings such as the ED. We also question the need to create the new CMS prolonged service code GXXX1 when CPT has a code that describes this same service, namely CPT 993X0, which will become available in 2023. We ask CMS to recognize the code CPT 993X0 with values of 0.81 work, 0.31 practice expense (PE), and 0.03 personal liability insurance (PLI) for a total facility relative value unit (RVU) of 1.15.

- *Split/Shared Services:* In this year's rule, CMS is proposing to delay the implementation of the full transition to using only time to determine the substantive portion of a split/shared E/M service until 2024. ***ACEP supports the CMS proposal to delay the implementation of the full transition to time, and we continue to support the current policy to use the history, physical exam, medical decision making (MDM), or more than half of the total time spent with a patient to determine the substantive portion of the split/shared visit***. We believe that the time a physician and non-physician practitioner each spend with a patient does not necessarily dictate which clinician actually provided the "substantive" portion of a service. Thus, **we strongly urge CMS to revise the split or shared visit policy to allow the physician or non-physician practitioner who is managing and overseeing the patient's care to bill for the service, thereby preventing the disruption of team-based care.**

- ***Valuation of Specific Codes***
  - *Chronic Pain Management:* ACEP believes that the new payment policies CMS implements should not be limited to management of chronic pain but should also focus on providing support for acute pain. We also support Medicare improving affordable access to non-opioid options.

- ***Telehealth Services***
  - *Telehealth Background:* ACEP continues to support CMS' decision to include all five ED E/M code levels 1-5 (CPT codes 99281-99285), the critical care codes, and some observation codes on the list of approved telehealth services on a "Category 3" basis. Emergency physicians have provided vital telehealth services during the COVI9-19 PHE which would be beneficial even after the end of the PHE.

  - *Observation Codes:* **ACEP remains disappointed that initial observation care will be removed from the telehealth list 151 days after the PHE ends**. It is clinically inconsistent to only have some observation codes on the list of approved telehealth services, and **we urge CMS to add all observations codes to the list on a Category 3 basis.**

  - *Direct Supervision:* ACEP is supportive of the current modified policy of the direct supervision requirement to allow for the virtual presence of the supervising physician using interactive audio/video real-time communications technology and is supportive of extending this policy past the end of the pandemic.

  - *Category 2 Criterion:* ACEP is concerned that the Category 2 criterion is unreasonable and makes it extremely difficult to add services to the list of approved telehealth services. We therefore suggest that CMS consider revising its Category 2 criterion in future rulemaking.

- ***Rebasing and Revising the Medicare Economic Index:*** In this rule, CMS proposes to rebase and revise the Medicare Economic Index (MEI) using data from 2017 to reflect more current market conditions faced by physicians in furnishing physicians' services. ACEP supports CMS' proposal to the delay in implementation of the MEI cost share weights for purposes of the CY 2023 Geographic Practice Cost Indices (GPCIs) and PFS rate-setting.

- ***Geographic Practice Cost Indices (GPCIs):*** CMS proposes to phase in half of the proposed GPCI adjustments in CY 2023 and the remaining half in CY 2024. ACEP supports CMS' approach to updating the GPCIs and believes that it is appropriate to use more updated data sources to determine the GPCI relative values for work, practice expense, and malpractice.

- ***Medicare Payments for Dental Services:*** CMS is proposing to clarify and codify certain aspects of the current Medicare fee-for-service (FFS) payment policies for dental services and is seeking comment on payment for other dental services that are substantially related and integral to the clinical success of an otherwise covered medical service. ACEP supports this effort from CMS to expand coverage for dental conditions which are inextricably linked to progressive infections and other conditions covered by Medicare.

- ***Modifications Related to Medicare Coverage for OUD Treatment Services Furnished by OTPs:*** CMS is allowing Opioid Treatment Programs (OTPs) to initiate treatment of buprenorphine via two-way audio/video communications technology, as long as that method of providing care is authorized by the Drug Enforcement Administration (DEA) and Substance Abuse and Mental Health Services Administration (SAMHSA). ACEP believes CMS should continue to make it a priority to promote the initiation of medication-assisted treatment (MAT) both by OTPs and outside of OTPs, including the ED. Additionally, we believe CMS should work to improve access to and use of MAT for the treatment of other substance abuse disorders beyond opioid use disorder (OUD), and one way of accomplishing these goals is to expand the G2213 code to cover the initiation of MAT in the ED for the treatment of alcohol use disorder and other substance use disorders.

- ***Medicare Shared Savings Program***
  - *Overview:* CMS is proposing to make numerous changes to the program, including allowing for upfront advanced payments to be made to certain new Medicare Shared Savings Program (MSSP) accountable care organizations (ACOs) that could be used to address Medicare beneficiaries' social needs; giving smaller ACOs more time to transition to downside financial risk; creating a health equity adjustment to an ACO's quality performance category score to reward excellent care delivered to underserved populations; and adjusting the benchmark methodology to encourage more ACOs to participate. CMS states that these adjustments would help the agency achieve the goal of having all people with traditional Medicare be in an accountable care relationship with a health care provider by 2030.

  - *Overarching Comments:* ACEP overall supports these proposals, but **we urge CMS to create additional incentives for specialists like emergency physicians to get engaged in the MSSP and other ACO initiatives,** including alternative payment models (APMs). ACEP created an emergency medicine APM called the Acute Unscheduled Care Model (AUCM), which CMS could consider incorporating into the MSSP and other ACO initiatives.

  - *Screening for SDOH and Screen Positive Rate for SDOH and Future Measures Development RFI:* CMS is seeking comment on two new measures: Screening for Social Drivers of Health (SDOH) and Screen Positive Rate for Social Drivers of Health. Overall, ACEP believes that quality measures should account for risk factors such

as lack of access to food, housing, and/or transportation that affect patients' ability to adhere to treatment plans.

- *Addition of New Consumer Assessment of Healthcare Providers & Systems (CAHPS) for MIPS Survey Questions RFI:* CMS seeks input on potential modified questions in the CAHPS for Merit-based Incentive Payment System (MIPS) survey pertaining to health disparities and price transparency.
    - Discrimination Question: CMS is considering adding a question about insensitive treatment based on social demographics. ACEP reaffirms that denial or delay of the provision of emergency care on the basis of race, religion, sexual orientation, gender identity, ethnic background, social status, type of illness, or ability to pay is unethical.
    - Price Transparency: CMS is seeking input on adding a question to CAHPS about the discussion of cost with their health care team. ACEP appreciates the effort in ensuring price transparency, but notes that it is nearly impossible for emergency clinicians to approximate costs initially, and therefore, emergency care should be excluded from this question.
    - Revisions for Specialties: CMS requests public comment on shortening the survey to remove survey items that are relevant only to primary care providers. ACEP offers a patient engagement module for all participants of our qualified clinical data registry (QCDR), the Clinical Emergency Data Registry (CEDR), and we believe this module is superior to ED CAHPS.

- ***Medicare Part B Payment for Preventive Vaccine Administration Services:*** ACEP supports CMS' overall goal to revise the payment rates to ensure that they reflect the most up-to-date practice costs and agrees with CMS' assertion that the payment amount for the administration of preventive vaccines should be based upon the annual increase to the MEI.

- ***Requirement for Electronic Prescribing for Controlled Substances for a Covered Part D Drug under a Prescription Drug Plan or MA-PD Plan:*** CMS is proposing to delay compliance of the electronic prescribing for controlled substances (EPCS) requirement by another year, until January 1, 2024, but is seeking comment on what penalties to implement going forward starting in 2025. ***ACEP supports the proposal to delay the EPCS requirement until 2024*** but is disappointed that CMS did not consider factors unique to emergency medicine when establishing the final exceptions and requirements.

- ***Appropriate Use Criteria Program:*** Although the Appropriate Use Criteria (AUC) program has been delayed indefinitely due to the COVID-19 PHE, ***we believe that at the program is unnecessary and could harm patient care by postponing vital treatment.***

## The Quality Payment Program

- ***Continuing to Advance to Digital Quality Measurement and the Use of Fast Healthcare Interoperability Resources (FHIR) in Physician Quality Programs—Request for Information:*** CMS is revising their potential future definition such that a digital quality measure (dQM) is a quality measure, organized as self-contained measure specification and code package, that uses one or more sources of health information that is captured and can be transmitted electronically via interoperable systems. ACEP believes that if CMS wishes to promote the transition to "digital quality measurement," then the agency must provide financial incentives to help achieve that goal. If clinicians can continue to easily and inexpensively use manual processes to successfully report under MIPS, the transition to digital quality measures will be hampered. As of now, there are no real incentives for hospitals to adopt FHIR.

- ***Advancing the TEFCA: Request for Information:*** HHS has established a framework for a "Trusted Exchange Framework and Common Agreement (TEFCA)." CMS is looking to incentivize exchange under TEFCA through programs that incentivize high quality care, or through program features in value-based payment models that encourage certain activities that can improve care delivery. ACEP has created a next-generation digital platform, the Emergency Medicine Data Institute (EMDI), that currently aggregates about 30 million ED visits annually, and projects this to expand to more than 75 million within five years. ACEP believes that CMS must create appropriate incentives for hospitals to both cooperate and provide data to data aggregators such as ACEP's EMDI. Doing so would help advance the goals of TEFCA.

- ***MIPS Value Pathways (MVPs)***

    - *ACEP Recommendations for Modifying MVPs*
        - Create More Incentives for Participating in MVPs: ***ACEP continues to believe that there should be some additional incentives for initially participating in an MVP over traditional MIPS.*** ACEP strongly recommends that CMS include at least a five-point bonus for participating in an MVP initially. Clinicians who participate in MVPs should also be held harmless from any downside risk for at least the first two years of participation.
        - Eliminate the Foundational Layer: ACEP believes that measures that should be included in MVPs are only those that have been developed by specialty societies to ensure they are meaningful to a physician's particular practice and patients and measure things a physician can actually control.

    - *MVPs and APM Participant Reporting Request for Information*: ACEP supports the long-term goal of MVPs to transition clinicians to participate in APMs, and created an emergency medicine APM, the Acute Unscheduled Care Model (AUCM), to integrate emergency physicians into APM participation. **CMS must make it a priority to create additional APM opportunities for emergency physicians and other specialists—or figure out how to modify current APMs in order to better engage specialists and allow them to actively participate.**

    - *Process for Developing New MVPs:* CMS is proposing a streamlined process for adding new MVPs to the program. However, we are concerned that CMS still does not plan on notifying the parties that submit MVPs of any changes in advance of the rulemaking process.

    - *MVP Maintenance Process and Engagement with Interested Parties*: CMS is proposing to modify the MVP maintenance process on a rolling basis. ACEP appreciates the flexibility to propose revisions to existing MVPs throughout the year and recognizes the importance of regular updates to the list of quality measures and improvement activities to ensure that they reflect the most up-to-date clinical standards and practice patterns.

    - *Emergency Medicine-focused MVP:* CMS is proposing to remove two improvement activities based on updates to the improvement activities inventory and to add one improvement activity. ACEP opposes the deletion of the two measures, PSPA 6: Consultation of the Prescription Drug Monitoring Program and PSPA 20: Leadership engagement in regular guidance and demonstrated commitment for implementing practice improvement change.

- *Subgroup Reporting:* ***ACEP believes that subgroup reporting should continue to be optional for the foreseeable future.*** Subgroup reporting adds to administrative complexity and burden and will disincentivize MVP participation.

- ***Quality Performance Category***
  - *High Priority Measure:* ACEP agrees with CMS that health equity focused measures should be one of the major focuses going forward and therefore should have the high priority status.
  - *Data Completeness:* CMS is proposing to maintain the current data completeness threshold at 70 percent for the 2023 performance period but is proposing to increase the data completeness threshold to at least 75 percent for the 2024 and 2025 performance period. **ACEP opposes the proposed increase in the threshold for the 2024 and 2025 performance periods** because it would increase administrative burden and overall cost of complying with MIPS requirements.
  - *Modify the MIPS Quality Measure Set:* CMS is proposing to add five quality measures to the emergency medicine specialty set. ACEP supports the addition of the Appropriate Treatment for Upper Respiratory Infection (URI) measure, but opposes the following proposed additions: Preventive Care and Screening: Screening for Depression and Follow-Up Plan; Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention; and Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling. We also have concerns about the Screening for Social Drivers of Health measure in terms of its applicability to emergency physicians.

- ***Cost Performance Category:*** ***ACEP encourages CMS to continue to develop episodes that capture the clinical screening, diagnostic testing, and stabilization work done by emergency physicians before a patient is admitted to the hospital.***

- ***Improvement Activities Performance Category***
  - *Removals:*
    - PSPA 6: Consultation of the Prescription Drug Monitoring Program: ACEP believes that it is imperative that this improvement activity continue to be utilized in light of our nation's opioid epidemic, as it allows emergency physicians to identify and protect patients at risk of opioid addition.
    - PSPA 20: Leadership engagement in regular guidance and demonstrated commitment for implementing practice improvement change: ACEP believes this improvement activity institutionalizes quality improvement within organizations by making it an explicit component of the leadership's role and responsibility and therefore opposes deletion of the measure.

  - *Additions:*
    - IA_PCMH: Electronic submission of Patient Centered Medical Home accreditation: ACEP supports the addition of this measure as Patient Centered Medical Home certification can lead to significant and sustainable practice improvements.
    - Create and implement a plan to improve care for lesbian, gay, bisexual, transgender, and queer patients: ACEP recognizes that marginalized populations are more likely to experience social inequalities and healthcare disparities and therefore believe that it is important to improve care for this population.
    - Create and implement a Language Access Plan: ACEP supports the addition of this measure.

- ***Promoting Interoperability***
    - *Reporting Period:* ACEP supports CMS' proposal to maintain the 90-day performance period for the Promoting Interoperability category for CY 2023. We also urge CMS to consider the long-term impact of the COVID-19 pandemic on physician medical practices, particularly those in small and rural settings, and to maintain the 90-day performance period going forward.

    - *Changes to the Query of Prescription Drug Monitoring Program Measure under the Electronic Prescribing Objective:* CMS is proposing to require MIPS eligible clinicians to report the Query of Prescription Drug Monitoring Program (PDMP) measure for the Promoting Interoperability performance category beginning in CY 2023 and proposing to expand the Query of PDMP measure to include Schedule III and IV drugs in addition to Schedule II opioids. ACEP is concerned with CMS' proposal to mandate and expand this measure simultaneously as best practices for PDMPs are still being established.

    - *Promoting Interoperability Scoring*: ACEP supports CMS' proposals regarding the scoring of objectives and measures in performance period CY 2023, with the exception of the requirement to report the Query of PDMP measure.

    - *Patient Access to Health Information Measure – Request for Information (RFI):* CMS is seeking comments on how to further promote equitable patient access and use of their health information without adding unnecessary burden on clinicians. While ACEP supports patients' access to their health information, we are concerned about the complications to the physician-patient relationship caused by the timing of data sharing and the ability of patients to alter their health records without physician consultation.

- ***MIPS Final Scoring Methodology***
    - *Scoring Administrative Claims Measures in the Quality Performance Category Using Performance Period Benchmarks:* CMS is proposing to score administrative claims measures using benchmarks calculated using performance period benchmarks to allow for scores that are more reflective of current performance while adding no additional burden to clinicians. ACEP is concerned that using performance year benchmarks would make it impossible for clinicians to know ahead of time what each measure's performance benchmark is.

    - *Assigning Measure Achievement Points for Topped Out Measures:* ACEP appreciates CMS' clarification that when a measure is suppressed or had its performance period truncated because of a substantive change or a change in clinical guidelines, the topped-out measure resets entirely the year following the change.

    - *Cost Performance Score*: CMS is proposing to establish a maximum cost improvement score of one percentage point for the Cost performance category beginning with the CY 2022 performance period/2024 MIPS payment year. ACEP does not support this proposal and believes that CMS should increase the maximum cost improvement score to at least five percent due to the Cost category's significant impact on a clinician's MIPS score.

    - *Calculating the Final Score*
        - Complex Bonus: **ACEP strongly supports the proposal that a facility-based MIPS eligible clinician would be eligible to receive the complex patient bonus, even if they do not submit data for at least one MIPS performance category. We urge CMS to finalize the proposal.**

- Facility-based Scoring Option: CMS is proposing to make facility-based MIPS eligible clinicians eligible for the complex bonus and expand eligibility to include virtual groups. ACEP supports this effort but believes that more action needs to be taken to support hospital-based clinicians.
- Performance Threshold: CMS is proposing to set the performance threshold in 2023 at 75 points and believes that a third of MIPS eligible clinicians would receive a negative payment adjustment at this threshold. ACEP supports this proposal.

- ***Qualified Clinical Data Registries (QCDRs):*** QCDRs are third-party intermediaries that help clinicians report under MIPS. ***ACEP is proud to be an ongoing certified QCDR and have helped tens of thousands of emergency physicians participate successfully in MIPS.*** Further, we believe that ***CMS should continue to refine the QCDR option under MIPS to streamline the self-nomination process and provide better incentives for organizations, including medical associations such as ours, to continue to invest in their QCDRs and develop new, meaningful measures for specialists to use for MIPS reporting and other clinical and research purposes. Conversely, CMS should refrain from finalizing proposals that would impose significant and unreasonable burdens on QCDRs.***

  - *QCDR Measure Self-Nomination Requirements:* CMS is proposing to clarify the requirements for publicly posting the approved measure specifications. ACEP appreciates the clarification and supports this proposal.

  - *QCDR Measure Approval Criteria:* CMS proposes to revise its QCDR measure approval requirements by delaying the requirement for a QCDR measure to be fully developed and tested until the CY 2024 performance year. ACEP supports this proposal and requests that CMS also delay the testing requirements for measures in MVPs.

  - *Remedial Action and Termination of Third-Party Intermediaries:* In the rule, CMS proposes one revised and one new requirement for Corrective Action Plans (CAPs) and proposed termination of certain approved QCDRs and Qualified Registries that continue to fail to submit performance data. ACEP does not support these proposals and believes it is premature to institute such a policy given the impact COVID-19 has had on MIPS participation and QCDR stewards.

  - *Request for Information on Third-Party Intermediary Support of MVPs:* ACEP believes that QCDRs should have the capability of supporting all the QPP measures within the MVP and all the QCDR measures that they own, or for which they have a licensed agreement with the measure owner. Additionally, we feel that maintaining and operating a QCDR is expensive and smaller QCDRs may find it cost-prohibitive to support all measures within an MVP. Further, we urge CMS going forward to streamline the self-nomination process and refrain from placing significant and unreasonable burdens on QCDRs.

  - *Request for Information on National Continuing Medical Education (CME) Accreditation Organizations Submitting Improvement Activities:* CMS is considering approaches to including CME accreditation organizations as third-party intermediaries. ACEP supports this option, but believes that if it is added, clinicians should be aware that CME accreditation organizations can only help them meet the Improvement Activities performance category.

- ***Public Reporting:*** ACEP continues to be concerned that all quality measures reported by clinicians are included in the Compare rating. We are also concerned that clinicians will only report on measures they perform well on due to the disincentive to report more than six measures.

- ***Advanced APMs:*** ACEP developed the emergency medicine-specific APM, the Acute Unscheduled Care Model (AUCM). Since CMS has not incorporated elements of this model into existing APMs, most emergency physicians participate in MIPS rather than Advanced APMs.
    - *RFI on QPP Incentives beginning in PY 2023:* CMS is concerned that there may be more of an incentive to participate in MIPS than Advanced APMs because they believe that after CY 2026, clinicians who participate in MIPS and receive a positive MIPS adjustment may actually receive a higher overall payment under the PFS than those who participate in Advanced APMs and only receive a 0.75 percent conversation factor increase. While ACEP shares CMS' concerns about the relative incentive between participating in MIPS and being in Advanced APMs, we believe it is important to reiterate that many specialists do not have an opportunity to participate in Advanced APMs in the first place.

    - *Request for Information: Potential Transition to Individual QP Determinations Only*: CMS is requesting public comment on the idea of transitioning away from an entity-level Qualifying APM Participant (QP) determination and instead calculating Threshold Scores and making QP determinations at the individual eligible clinician level for all eligible clinicians in Advanced APMs and Other Payer Advanced APMs. ACEP is concerned about the impact of such a methodology change on the ability for specialists to become QPs. If the goal is to eventually create more opportunities for specialists to participate in APMs, any QP methodology that CMS implements must ensure that it does not disadvantage specialists and thereby discourage them from participating in APMs.

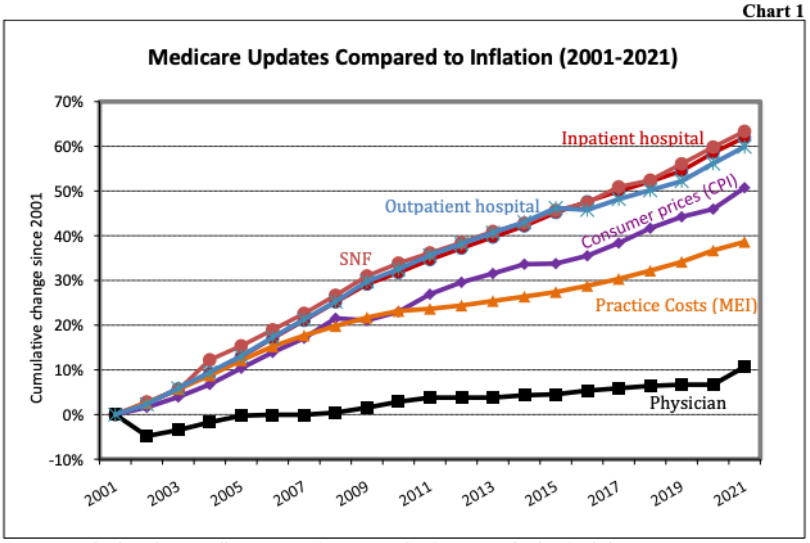
# The Physician Fee Schedule

## Overview

In this proposed rule, the Centers for Medicare & Medicaid Services (CMS) proposes a physician fee schedule (PFS) conversion factor of $33.08, a decrease of $1.53 from the CY 2022 PFS conversion factor of $34.61. The conversion factor reflects the expiration of a 3.0 percent bump that Congress added to the conversion factor in 2022. These reductions stem from CMS' decision to increase the office and outpatient evaluation and management (E/M) services in 2021. There is also an additional cut of 1.5 percent due to the budget neutrality requirement. As required by law, CMS must preserve budget neutrality in cases where relative value unit (RVU) changes may cause PFS spending to increase or decrease by more than $20 million. The total cut to the conversion factor is roughly 4.4 percent.

Physicians must continue to deal with annual updates to Medicare payments that do not cover the increased costs due to inflation of providing care. Along with the 3.0 percent across-the-board reduction and an additional reduction of 1.4 percent to preserve budget neutrality, the 2.0 percent sequestration reduction continues to apply year after year. Furthermore, there is another "Pay-Go" sequester of 4.0 percent that is scheduled to begin at the start of 2023—making the total overall projected cut starting January 1 at 10.4 percent. In short, Medicare payment to physicians is simply inadequate. An analysis conducted by ACEP found that ***Medicare payments have decreased by 53 percent when comparing Medicare payments to inflation*** between the start of the Resourced-based Relative Value Scale (RBRVS) in 1992 and 2016.[1] As seen in the chart below, over the last 20 years, the payment systems for other Medicare provider types like hospitals and skilled nursing facilities (SNF), as well as actual practice costs that are reflected in the Medicare Economic Index (MEI), have far exceeded Medicare payments under the PFS.

**Chart 1**




Sources: Federal Register, Medicare Trustees' Reports and U.S. Bureau of Labor Statistics

Even the 2022 Medicare Trustees Report acknowledges that updates for physician reimbursement are not sufficient. The Trustees believe that, absent a change in the delivery system, access to Medicare-participating physicians will become a significant issue in the long term.[2] Given the fact that annual updates to physician payments are already not

[1] The ACEP analysis is available at:: https://www.acep.org/globalassets/uploads/uploaded-files/acep/advocacy/state-issues/medicare-versus-inflation.pdf.

[2] The 2022 Medicare Trustees Report is available at: https://www.cms.gov/files/document/2022-medicare-trustees-report.pdf.

keeping up with the cost of providing physician services, adding large-scale payment reductions would make it even more difficult for a number of physician specialties including emergency medicine to continue providing care.

**Emergency physicians will experience this across-the-board reduction to their reimbursement in 2023. This cut to emergency medicine, if finalized, would jeopardize the nation's critically needed safety net and leave emergency physicians in an untenable financial situation. We therefore request that CMS do everything within its authority to mitigate the reduction.**

A 4.4 percent reduction to Medicare reimbursement for emergency physicians and other emergency medicine health care professionals on top of the pending sequestration cuts would have rippling effects across the health care system and have a detrimental impact on access to care. During the COVID-19 public health emergency (PHE), it has been more expensive than usual to provide appropriate care to the patients who do come to the emergency department (ED). Most emergency physicians are not employed by hospitals, but rather work for independent groups that contract with the hospital to provide emergency services in the ED. ACEP conducted a survey in 2020 that showed that the majority of hospitals have not provided any financial support to these independent groups during the COVID-19 pandemic to help cover any losses or increased expenses. Instead, the groups had to incur additional expenses for treatment, such as developing and implementing protocols for alternative sites of care, enhancing telehealth capabilities, purchasing their own personal protective equipment (PPE), and taking on other new administrative costs due to staffing shortages (such as taking over nursing functions including triaging, treating, and performing nurse discharge responsibilities for patients with potential COVID symptoms in ways that limit possible exposure to the disease).

Medicare does not include permanent mechanisms to reimburse for critical activities and additional costs that are associated with managing infectious disease outbreaks. Given lessons learned during the COVID-19 PHE and other infectious disease outbreaks, CMS should consider reimbursing for certain direct and indirect activities that physicians typically take on during these pandemics or other extreme circumstances.

In all, CMS has an obligation to health care professionals and patients to do everything in its power to stabilize reimbursement to providers. While we understand that Congress has the authority to waive budget neutrality under most circumstances, we want to reiterate organized medicine's previous request3 that ***CMS and the Department of Health and Human Services (HHS) utilize its 1135 waiver authority under the COVID-19 PHE to waive this requirement for all of CY 2023. We also strongly urge CMS to work with Congress to enact meaningful physician payment reform that will add more stability to the PFS.***

**Evaluation and Management Services**

***AMA CPT Documentation Requirements***

The American Medical Association (AMA) released 2023 Documentation Guideline changes to the Current Procedural Terminology (CPT) on July 1, 2022. In the rule, CMS discusses these documentation changes and proposes to adopt most of these changes in coding and documentation. However, CMS is proposing to maintain the current billing policies that apply to the evaluation and management (E/M) codes while the agency considers potential revisions that might be necessary in future rulemaking.

[3] American Medical Association and Other Specialty Societies Letter to HHS Secretary. July 1, 2020. https://searchlf.ama-assn.org/undefined/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2FE-M-Sign-on-letter-to-HHS-Budget-Neutrality.pdf.

ACEP appreciates CMS working closely with the AMA Joint CPT/Relative Value Scale Update Committee (RUC) Documentation Guidelines workgroup over the past few years to make these meaningful changes beginning in 2023. We support the stated goals of reducing the unnecessary documentation burden and bringing CPT and CMS into better alignment while maintaining a resource-based system that also decreases the need for audits. Although the new guidelines are significantly better, especially including robust definitions of included terms, ACEP has submitted a Code Change application to the CPT Editorial Panel asking for small changes in the medical decision making (MDM) grid to better reflect patient care in the ED setting, which are not captured in a document originally designed for office-based service, especially as they relate to escalation of care and social determinants of health.

***Emergency Department (ED)***

The current work relative value unit (RVU) for the ED E/M Level 4 service (CPT 99284) is 2.74. CMS had increased the work RVU to 2.74 from 2.60 in 2021 in order to maintain the relativity in service levels between the ED E/M codes and the office and outpatient E/M codes. However, based on an AMA RUC survey, the AMA RUC recommended that the work RVU should drop back down to 2.60 starting in 2023. CMS is proposing to reject the AMA RUC recommendation and keep the value at 2.74.

**ACEP strongly supports this proposal.** ACEP has previously argued that the ED E/M codes should retain their relative values as compared to the office and outpatient E/M codes. Our argument was in line with previous statements from the RUC. In fact, the RUC has three times (1997, 2007, and 2018) recommended that the ED E/M codes should be the same value as the new patient office or other outpatient E/M codes for levels 1 through 3 and that levels 4 and 5 should be higher. We appreciate that CMS continues to give credence to this argument and believes that it is appropriate to retain the historic relativity between the new patient office or other outpatient codes and the ED E/M codes.

***Critical Care***

CMS is proposing a correction to a "technical error" regarding time thresholds for critical care when reporting 99291 and for when an additional 30 minutes of critical care is justified. AMA CPT has long established the threshold as at least 15 minutes in addition to the 60 minutes captured by 99291. Thus, when 75 minutes of critical care were performed, it was appropriate to report 99292 as well as the base code of 99291. CMS is proposing to change that time threshold to 104 minutes based on the principle that 74 minutes plus 30 minutes equals 104 minutes. Initially, this proposal was characterized as only applying to split or shared services in teaching settings. However, in the rule, CMS clarifies that the policy "is the same for critical care whether the patient is receiving care from one physician, multiple practitioners in the same group and specialty who are providing concurrent care, or physicians and NPPs who are billing critical care as a split (or shared) visit."[4]

**ACEP notes that this proposed critical care policy differs from long-standing CPT policy**. One of the stated goals of the new documentation guidelines was that CPT and CMS would more closely align. Furthermore, another important goal was to decrease provider confusion and administrative burden. This proposed policy contradicts the time section instructions in the introduction to all CPT codes found on page xviii of the code set. The instructions state that the concept of "a unit of time is attained when the midpoint is passed"—which is typically one minute

[4] Medicare and Medicaid Programs; CY 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicare and Medicaid Provider Enrollment Policies, Including for Skilled Nursing Facilities; Conditions of Payment for Suppliers of Durable Medicaid Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); and Implementing Requirements for Manufacturers of Certain Single-Dose Container or Single-Use Package Drugs To Provide Refunds With Respect to Discarded Amounts Proposed Rule. 87 Fed. Reg. 46003. (July 29, 2022).

greater than the midpoint time. However, this policy does not apply when there are specific code- or code range-specific instructions in the CPT guidelines, as there are in the critical care codes. The guidelines for critical care codes specifically note that 30 minutes (not 31) is the minimal time threshold for reporting 99291. It is also in contradiction to the Total Duration of Critical Care Code chart on page 33 of the 2022 CPT code set, in which 75 to 104 minutes of critical care time would be reported as one unit of 99291 and an additional unit of 99292. CMS proposes this new policy will apply regardless of whether one or more clinicians are included in the provision of the service, such as in a split or shared visit. In all, deviating from a long-held CPT principle related to the minutes required for 99292 will increase clinician confusion and administrative burden as it leads to two sets of coding rules that are not harmonized.

We also believe that if CMS adheres to this policy, the value of the first hour of critical care should be increased commensurately, since it is currently based on 60 minutes of critical care.

***Observation Services***

Overall Concerns

CMS is proposing to accept the CPT coding changes that merge the codes previously describing observation services into the inpatient E/M code set. ACEP is generally concerned with the overall ability of emergency physician practices to adapt to all the changes that are coming in 2023. Specifically, CMS is expecting practices to adapt their electronic health record (EHR) systems and workflows to implement the following:

- Overall changes to the documentational guidelines for E/M services;
- Full restructuring of the observation codes; and
- Potentially juggling different time intervals for the individual critical care codes with discordance between CMS and CPT (as described above).

Many of the changes to the observation codes and billing rules are complicated and will take time to fully incorporate into workflows. Emergency physicians and other hospital-based clinicians are currently dealing with significant staffing shortages in their hospitals, which will make these changes even harder to implement. CMS should consider delaying or phasing in some of the changes to the observation codes and billing requirements to make it easier for emergency physicians to appropriately implement them all.

**As discussed below, ACEP requests that CMS specifically delay enforcement of the 8-to-24-hour rule related to observation encounters that transcend the calendar date.** On top of adapting to a new code family with new coding rules, as well as the landmark changes of the 2023 Documentation Guidelines, the 8-to-24-hour rule adds an extra layer of complexity that represents excessive change in a single year for even the most engaged clinicians to understand and implement.

Valuation of New Combined Codes

ACEP notes that CMS' proposed revisions to the values for inpatient and observation E/M visits create an inconsistent relativity across the code family as compared to office and outpatient E/M services. The most complex observation services relate to the initial day admission, but under CMS' proposed RVU changes, those services are declining in value while the subsequent discharge day code values increase. This inconsistency creates a rank order anomaly across the code family. We have previously argued that CMS should apply an equitable approach that maintains the longstanding relativity across different E/M code sets.

Billing For Both an ED Service and an Observation Service

CPT released a policy applying to 2023 that is related to billing for both an ED and observation service which differs from historic CPT instructions. The new CPT language states, "When the patient is admitted to the hospital as an inpatient or to observation status in the course of an encounter and another site of service (e.g., hospital, ED, office, nursing facility), the services in the initial site may be separately reported. Modifier 25 may be added to the other evaluation and management service to indicate a significant, separately identifiable service by the same physician or qualified health care professional was performed on the same date." However, CMS proposes to retain its current policy that a provider may only bill initial hospital or observation care service if the physician sees a patient in the ED and decides to either place the patient in observation status or admit the patient as a hospital inpatient. In contrast, CPT reporting instructions do not place any limitations on the number of visits that can be billed. By deviating from CPT policy, CMS is creating contradicting guidance—leading to an increase in clinician burden in an already complex area.

This policy also results in some confusion in how to appropriately bill for separate services provided over a span of a few days. To demonstrate the uncertainty such a policy would create, CMS should consider the example of a patient that presents to the ED on day 1 at 6:00 pm with chest pain. The emergency physician recognizes this patient will require prolonged monitoring and treatment but may be stabilized enough to prevent inpatient admission. The patient is placed in observation status in the ED and kept overnight. At 8:00 am the following morning (i.e., 14 hours later), the patient fails to respond to the treatment plans and is transferred to inpatient admission under the care of the separate hospitalist group. Under this scenario, it is unclear how the emergency physician would now report the care provided on the two calendar dates. Would the emergency physician report CPT 99221-99223 for the first date and a discharge or subsequent code on day 2? What code then would the hospitalist providing the inpatient admission report on that second calendar day, another CPT 99221-99223 since it is an initial visit for that provider and group? CMS should provide some language in the final rule to clarify how to appropriately bill for these services.

8-to-24-Hour Rule

ACEP also has some significant concerns about the application of the 8-to-24-hour rule with the elimination of the inpatient hospital and observation code sets. This is an area where CPT and CMS policy differ with CPT code selection being based on calendar date, and CMS code selection being based on clock time of service. Documentation revisions for 2023 were guided by a stated attempt of eliminating discrepancies between CPT and CMS and reducing administrative burden and confusion. The 8-to-24-hour policy accomplishes neither. We will appreciate direction on how to report this type of interaction between clinicians of different groups in the transition from observation to inpatient care.

**As stated above, we specifically request CMS to specifically delay enforcement of the 8-to-24-hour rule related to observation encounters that transcend the calendar date.** Even expert coders have difficulty understanding and implementing this concept in code assignment under this scenario. We understand the rationale for requiring at least eight hours of service to report the same day inpatient admission or observation and discharge code set 99234-99236 but fail to see the fairness of disallowing a visit to be billed on the following calendar day if less than 24 hours of total care are achieved using the CPT construct of now 99221-99223 and 99231-99233. The chances of 23 hours of inpatient or observation care all occurring on the same calendar date seem remote and thereby create an unfair standard. The initial day CPT codes were certainly not valued by the RUC with an understanding that up to 23.5 hours of time was spent in patient care.

Prolonged Services

CMS also establishes new Healthcare Common Procedure Coding System (HCPCS) prolonged services codes (GXXX1- GXXX3) and states that "we do not agree that there is inherently greater complexity of patient need or intensity of work for E/M visits furnished in non-office settings (for example, inpatient, ED, and home settings) compared to the office settings. Therefore, we believe it would be more accurate to make payment based on the same time increment of physician work in these various settings. We are proposing that the three prolonged visit HCPCS G codes GXXX1 - GXXX3 (discussed above under each applicable family) be valued identically across settings, based on the RUC recommended value for CPT code 99417 or 0.61 RVUw."[5] **ACEP strongly disagrees that the complexity and intensity of E/M visits delivered in office settings are the same as they are in facility-based settings such as the ED.** Patients experiencing possible medical emergencies are often told by their office-based clinician to go to the ED since the acuity and complexity of the patient's condition requires a higher level of care than can be provided in an office-based setting. Therefore, the position that high-level office-based E/M services require the same complexity of patient need or intensity of work as high-facility-based services is flawed.

We also question the need to create the new CMS prolonged service code GXXX1 (Prolonged hospital inpatient or observation care evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician) when CPT has a new code that describes this same service, namely 993X0 (Prolonged inpatient or observation evaluation and management service(s) with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the inpatient and observation evaluation and management service)). This code will become billable in 2023. We ask CMS to instead recognize the CPT code 993X0 with values of 0.81 work, 0.31 practice expense (PE), and 0.03 personal liability insurance (PLI) for a total facility RVU of 1.15.

We believe this proposal for code GXXX1 creates administrative complexity, which is counter to all of the work of the AMA Joint CPT RUC Workgroup over the past three years. Having both a CPT code and a HCPCS II G code for the same service creates unnecessary complexity. Furthermore, having to reference a separate table embedded in CMS rulemaking adds burden over simply having the time ranges included in the CPT codes themselves. Without the table, it is unclear what "total time for the primary service" means. The base code selection method is clear and familiar, and thus why CPT chose it.

***Split/Shared Services***

In the CY 2022 PFS and QPP final rule, CMS finalized a policy for determining whether a physician or non-physician practitioner should bill for an E/M service that they both were involved in delivering (called split/shared services). ACEP, the AMA, and many other specialty societies have strongly opposed using only time to determine the substantive portion of a split/shared E/M service and formally requested that CMS reverse its 2023 policy and instead modify it to allow the determination to be made based on time OR MDM.

In this year's rule, CMS is proposing to delay the implementation of the full transition to time-only until 2024. CMS will continue to allow providers to use the history, physical exam, medical decision making (MDM), or more than half of the total time spent with a patient to determine the substantive portion of the split/shared visit in 2023. CMS states in the rule that the agency still believes that it is appropriate to define the substantive portion of a split (or shared)

[5] 87 Fed. Reg. 46001. (July 29, 2022).

service as more than half of the total time. However, delaying implementation of this policy until 2024 will allow providers to get accustomed to the new changes and adapt their workflow in practice. Additionally, this delay allows interested parties another opportunity to comment on this policy and gives CMS time to consider more recent feedback and evaluate whether there is a need for additional rulemaking on this policy.

***ACEP supports the CMS proposal to delay the implementation of the full transition to time, and we continue to support the current policy to use the history, physical exam, MDM, or more than half of the total time spent with a patient to determine the substantive portion of the split/shared visit***. Time is extremely difficult to measure in the ED. Emergency physicians manage multiple patients at once and keeping track of the specific time spent with an individual patient is nearly impossible. In other words, we cannot appropriately document time increments that are spent with individual payments. Electronic health records (EHRs) do not routinely track this information and there are no reasonable ways to incorporate the tracking of time into physician workflows. Attempting to do so would significantly reduce the efficiency of an already strained system and significantly increase administrative burden.

Further, we believe that the time a physician and non-physician practitioner spends with a patient does not necessarily dictate which clinician actually provided the "substantive" portion of a service. If a physician for example makes a critical decision that leads to a diagnosis or treatment plan for the patient, then we argue that should count as the "substantive" portion of the service, regardless of how much time the physician spent with a patient compared to a non-physician practitioner.

In all, the time physicians spend treating patients is not equivalent with the time that non-physician practitioners spend with patients. A physician's time is most frequently spent in significant medical decision-making; consideration of differential diagnoses; assuring that evaluations, treatments, and recommendations optimize patient safety; and review of comorbidities and the potential for medication interaction. Thus, the policy of simply adding up minutes or hours spent by physicians and non-physician practitioners and comparing whoever spent more time is inherently flawed and perversely encourages inefficiency, especially for time-consuming but low-value activities. For example, if a non-physician practitioner spent 40 minutes gathering a history, recording current medications, and documenting the patient encounter in the electronic health record, and the physician did the physical exam, reviewed key lab and x-ray results, performed significant medical decision-making, and determined appropriate treatment – but only took 30 minutes – the "substantive portion" would be attributed to the non-physician practitioner, who would then bill for the service. Not allowing the physician to bill for the service in this common scenario creates a large disincentive for the continuation of physician-led team-based care, where patients benefit from the collaboration of physicians and non-physician practitioners who care for them.

**We strongly urge CMS not to disrupt team-based care and to revise the split or shared visit policy to allow the physician or non-physician practitioner who is managing and overseeing the patient's care to bill for the service.**

**Valuation of Specific Codes**

***Chronic Pain Management***

CMS is proposing new codes to better account for the time needed to manage patients with chronic pain. ACEP appreciates CMS' goal to develop payment systems that better support management of patients' pain. However, as emergency physicians, we mostly treat patients with acute pain and believe that the new payment policies CMS

implements should not be limited to management of chronic pain, but should also focus on providing support for acute pain. Patient outcomes will be improved and overall Medicare spending could decrease if CMS provides physicians with the resources they need to help prevent patients from developing chronic pain, rather than only paying for treatment after patients' medical diagnoses and treatments become more severe.

In addition, to help with the management of acute pain, Medicare should work to significantly improve affordable access to the many different non-opioid options. ACEP is extremely supportive of the use of non-opioid alternatives for pain management. Innovative alternative treatments to opioids (ALTO) programs implemented in states such as New Jersey and Colorado have dramatically and quickly reduced opioid prescriptions in the ED. ALTO uses evidence-based protocols like nitrous oxide, nerve blocks, trigger point injections, and other non-opioid pain management tools to treat a patient's pain in the ED.

**Telehealth Services**

***Telehealth Background***

In previous PFS rules, CMS has examined which of the codes that are temporarily on the list of approved Medicare telehealth services during the COVID-19 PHE would remain on the list for an extended period or permanently. ACEP continues to support CMS' decision to include all five ED E/M code levels 1-5 (CPT codes 99281-99285), the critical care codes, and some observation codes on the list of approved telehealth services on a "Category 3" basis. We recognize that these services will remain on the list until December 31, 2023, and that in order for the codes to remain permanently on the list of approved telehealth services, CMS needs to see more data and evidence about the benefits of providing these services via telehealth to meet a "Category 2" review.

ACEP for years has strongly supported the delivery of telehealth services by board-certified emergency physicians—and we have seen some extremely positive effects of using telehealth during the pandemic. As described below, meeting the Category 2 criterion is an unreasonably high bar, and it will take a significant amount of time to collect the data needed to meet it; ACEP is still compiling the data needed to make a compelling case to CMS.

During the COVID-19 PHE, emergency physicians provided telehealth services in the following three different clinical situations, all of which added clinical value to patients:

1. ***Preventing Medicare beneficiaries from making unnecessary visits to the ED.*** Medicare beneficiaries who had urgent medical needs, but were unsure if they were having a medical emergency, were able to contact their EDs and have a telehealth visit with an emergency physician to assess whether the patient could stay at home, go to an urgent care clinic, or visit the ED. While Medicare beneficiaries previously had the opportunity to go to the ED if needed, this type of telehealth visit has now provided Medicare beneficiaries with a safe way of getting their condition evaluated before making that decision. Emergency physicians are trained in rapid diagnosis and evaluation of patients with acute conditions, so they are most capable of providing these type of telehealth services. In many cases, we are able to provide treatment to patients with minor illnesses and injuries completely via telehealth.

2. ***Providing MSEs to patients who came to the ED.*** As alluded to above, CMS released guidance stating that physicians (or other qualified medical persons) can perform medical screening examinations (MSEs) via telehealth and where appropriate meet the MSE requirement without an in-person examination. Hospitals are temporarily allowed to set up alternative locations "on campus" for patients to receive an MSE other than in

the ED. For example, patients presenting with possible symptoms of COVID-19 and meeting certain criteria (i.e., vital sign parameters) can be sent to a negative-pressure tent, where they are seen by an in-person nurse and a physician via telehealth (video and audio) who determines if the patient can be discharged from the tent or needs to be seen in the ED. After completing this process, a low percentage of patients need ED evaluation.

3. ***Ensure appropriate follow-up care after ED discharges.*** Emergency physician groups have set up systems and protocols to follow up with patients once they are discharged from the ED, ensuring that patients are taking their medications appropriately or are seeing their primary care physician or specialist if needed. These follow-up services have helped enhance care coordination efforts and avoid trips back to the ED or inpatient admissions. In addition, for patients under investigation for COVID-19, the treating ED group has been able to follow up with the patient to make sure their COVID symptoms are not progressing. Some groups have sent patients home with portable pulse oximeters and followed up to check their general status and oxygen levels.

Some EDs have been able to track data that could be used to evaluate clinical outcomes, such as monitoring whether a patient required an additional medical visit after the telehealth visit and determining the percentage of patients who avoided an ED or urgent care visit for the illness or injury.

Preliminary, anecdotal evidence has suggested that the use of telehealth services has resulted in improved health outcomes and helped limit avoidable trips to the ED or hospital. It has also improved access to care for beneficiaries, a clear clinical benefit, by connecting patients with clinicians from any location in a timely manner. Finally, some systems have shown overall cost savings by diverting patients from expensive care settings and by averting transfers to inpatient facilities.

***Observation Codes***

**ACEP remains disappointed that initial observation care will be removed from the telehealth list 151 days after the PHE ends**. Other observation codes—Subsequent Observation and Observation Discharge Day Management—are already in Category 3. It is clinically inconsistent to only have some observation codes on the list of approved telehealth services, and **we urge CMS to add all observations codes to the list on a Category 3 basis.**

The COVID-19 pandemic has allowed physicians to maximize staffing of ED observation units with dedicated "observationists" covering more than one observation unit via telehealth for "virtual rounds." EDs have implemented protocol driven ED observation units which been shown to lower the cost of care for payors, with fewer admissions, fewer readmissions, and improved patient satisfaction.[6] [7] Further, this model of care can reduce costs for hospitals, decrease observation length of stays, and improve inpatient bed utilization—which is extremely beneficial for rural hospitals.[8] Previous work has shown that these units can save the country $3.1 billion in annual health care costs.[9] Despite this potential, many hospitals struggle to open and staff these units, particularly rural hospitals.

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[6] Ross MA, Hockenberry JM, Mutter R, Wheatley M, Pitts S. Protocol-Driven Emergency Department Observation Units Offer Savings, Shorter Stays, And Reduced Admissions. Health Affairs. 2013 Dec; 32(12):2149-2156.

[7] Hockenberry JM, Mutter R, Barrett M, Parlato J, Ross MA Factors associated with prolonged observation services stays and the impact of long stays on patient cost. Health Services Research. 2014 Dec;49(3):893-909.

[8] Perry M, Franks N, Pitts SR, Moran TP, Osborne A, Peterson D, Ross MA, The impact of emergency department observation units on a health system, Am J of Emerg Med. 2021 Volume 48; 231-237. https://doi.org/10.1016/j.ajem.2021.04.079.

[9] Baugh CW, Venkatesh AK, Hilton JA, Samuel PA, Schuur JD, Bohan JS. Making greater use of dedicated hospital observation units for many short-stay patients could save $3.1 billion a year. *Health Aff (Millwood)*. Oct 2012;31(10):2314-23. doi:10.1377/hlthaff.2011.0926.

There is great potential for cost savings if all observation services can be delivered via telehealth. A recent study of 20,861 ED observation patients evaluated the impact virtual care with usual care.[10] Virtual emergency observation unit care had no impact on length of stay, inpatient admit rate, total direct cost, or adverse events. However, the benefit of care in this setting relative to traditional inpatient care remained the same; with shorter hospital stays (19.1 hours vs 37.9 hours), lower costs ($1,890 vs $2,814), lower inpatient admission rates (17.5 percent vs 26.0 percent), and lower adverse event rates (0.7 percent vs 1.7 percent).

Through these virtual rounds, providing both initial observation and subsequent observation services via telehealth has become part of the continuum of care delivered in many EDs across the country. Segmenting these observation services going forward would result in a fragmentation of practice patterns and clinical workflow. It would be extremely confusing, and possibly disruptive to patient care, to have two sets of policies for patients in an observation unit. For example, this policy would require an in-person visit for a patient in one room, yet a virtual visit for a similar patient right next door based on the hour of their arrival into the observation unit. It would significantly increase the administrative burden on clinicians as they scramble to try to determine which patient has to wait for an in-person evaluation versus who can be seen right away by telehealth during virtual rounds. The clinical skills and the efficacy of telehealth is the same for all observation codes. To separate them only creates an artificial, arbitrary separation within the same clinical care group.

***Direct Supervision***

Many services under the PFS can be delivered by auxiliary personnel under the direct supervision of a physician. In these cases, the supervision requirements necessitate the presence of the physician in a particular location, usually in the same location as the beneficiary when the service is provided. During the PHE, CMS temporarily modified the direct supervision requirement to allow for the virtual presence of the supervising physician using interactive audio/video real-time communications technology. CMS has stated that this policy would sunset the later of the end of the calendar year in which the PHE ends, or December 31, 2021.

In this year's rule, CMS is not proposing to make the temporary exception to allow immediate availability for direct supervision through virtual presence permanent, but it continues to seek information on whether the flexibility to meet the immediate availability requirement for direct supervision through the use of real-time, audio/video technology should potentially be made permanent.

ACEP believes this policy has been helpful during the PHE and would therefore be supportive of continuing such a policy past the end of the pandemic. Doing so would extend the reach of board-certified emergency physicians to areas of the country where there may not be any such physicians available. We believe that it is essential to have board-certified emergency physicians directly supervise all care delivered in EDs, and telehealth represents a viable tool to accomplish this goal.

***Category 2 Criterion***

ACEP also would like to comment on the current process for adding new telehealth services to the list of approved telehealth services. Specifically, we are concerned that the Category 2 criterion is unreasonable and makes it extremely difficult to add services to the list of approved telehealth services. The specific definition of Category 2 is below:

[10] Abiri A, Keadey M, Hughes G, Pitts SR, Moran TP, Ross M. The impact of virtual care in an Emergency Department Observation Unit. Ann Emerg Med. 2022. Pub pending: 1-12.

*Category 2: Services that are not similar to the current list of telehealth services. Our review of these requests will include an assessment of whether the service is accurately described by the corresponding code when delivered via telehealth and whether the use of a telecommunications system to deliver the service produces demonstrated clinical benefit to the patient. Requestors should submit evidence indicating that the use of a telecommunications system in delivering the candidate telehealth service produces clinical benefit to the patient. The evidence submitted should include both a description of relevant clinical studies that demonstrate the service furnished by telehealth to a Medicare beneficiary improves the diagnosis or treatment of an illness or injury or improves the functioning of a malformed body part, including dates and findings and a list and copies of published peer reviewed articles relevant to the service when furnished via telehealth. Our evidentiary standard of clinical benefit will not include minor or incidental benefits. Some examples of clinical benefit include the following:*

- *Ability to diagnose a medical condition in a patient population without access to clinically appropriate in person diagnostic services.*
- *Treatment option for a patient population without access to clinically appropriate in person treatment options.*
- *Reduced rate of complications.*
- *Decreased rate of subsequent diagnostic or therapeutic interventions (for example, due to reduced rate of recurrence of the disease process).*
- *Decreased number of future hospitalizations or physician visits.*
- *More rapid beneficial resolution of the disease process treatment.*
- *Decreased pain, bleeding, or other quantifiable symptom.*
- *Reduced recovery time.*

Having to produce ample data and evidence to show that providing certain services adds clinical value is a time-consuming and costly endeavor. It could also take years to gather this amount of evidence. ACEP also believes that CMS should not need to look at whether the act of providing a service via telehealth adds additional clinical value. Telehealth is simply a means by which health care providers deliver services—an extremely useful tool that providers can employ to expand access to care. In other words, if a physician provides a specific high-quality service to a patient, we should expect it to be as effective and add as much clinical value regardless of whether it was delivered in-person or via telehealth. We should not have to prove that providing a service via telehealth adds even *more* clinical value than conducting the service in-person. Rather, we should only be required to demonstrate that a service delivered via telehealth is ***as clinically effective*** as the service would have been if it were performed in-person. Therefore, ACEP suggests that CMS consider revising its Category 2 criterion in future rulemaking.

**Rebasing and Revising the Medicare Economic Index**

The Medicare Economic Index (MEI) reflects the weighted-average annual price change for various inputs involved in delivering physicians' services. While the MEI is no longer used to update the conversion factor, as it was under the Sustainable Growth Formula (SGR), it is still used to determine the relative cost share weights for RVUs and Geographic Practice Cost Indices (GPCIs).

In this rule, CMS proposes to rebase and revise the MEI using data from 2017. CMS believes that the MEI cost weights need to be updated to reflect more current market conditions faced by physicians in furnishing physicians' services. However, CMS proposes to delay the implementation of the proposed rebased and revised MEI cost weights for both PFS rate-setting and the proposed CY 2023 GPCI (discussed below).

ACEP supports CMS' proposal to the delay in implementation of the MEI cost share weights for purposes of the CY 2023 GPCIs and PFS rate-setting. Before any substantive changes to the GPCI and RVU relative rates are implemented, the PFS conversion factor must be stabilized. The annual reductions to the conversion factor, including the proposed 4.4 percent reduction to the CY 2023 conversion factor, are unacceptable. As seen from Table 148 in

the proposed rule,[11] there would be a large negative impact on numerous specialties, including emergency medicine (-8.0 percent). It would be premature to implement a significant change to the PFS that would have a drastic impact on payments when there is such instability already present within the PFS.

**Geographic Practice Cost Indices (GPCIs)**

In the proposed rule, CMS proposes updates to the GPCIs, as the agency is statutorily required to do every three years. CMS proposes to phase in half of the proposed GPCI adjustments in CY 2023 and the remaining half in CY 2024.

Overall, ACEP supports CMS' approach to updating the GPCIs and believes that it is appropriate to use more updated data sources to determine the GPCI relative values for work, practice expense, and malpractice. We also appreciate that CMS took the effect that COVID-19 pandemic has had into account when calculating the new GPCIs. For example, for office rent, CMS used the 2015 through 2019 American Community Survey (ACS) 5-year estimates since the most recent data was not available in time for development and may be invalid due to the pandemic.

As stated above in the MEI section, we also strongly support CMS' proposal to the delay in implementation of the MEI cost share weights for purposes of the CY 2023 GPCIs.

**Medicare Payments for Dental Services**

The traditional Medicare program (also known as Medicare Fee-for-Service or FFS) currently covers a limited set of dental services. In the rule, CMS is proposing to clarify and codify certain aspects of the current Medicare FFS payment policies for dental services. CMS is also proposing and seeking comment on payment for other dental services that are substantially related and integral to the clinical success of an otherwise covered medical service.

As emergency physicians, we frequently see patients that present to the ED with dental pain, swelling, and bleeding. These symptoms can be indicative of many conditions, including periodontal disease and dental infection. If left untreated, a dental infection can spread throughout the body, leading to potential non-dental complications like sepsis, endocarditis, mediastinitis, or brain abscess.[12] Additionally, periodontal disease has been linked to chronic diseases including diabetes, heart disease, and stroke, which can present in urgent, high-acuity events.[13] Dental infections and periodontal disease, along with other dental conditions, can be prevented and treated with early detection, which is performed at routine, yearly dental check-ups. However, because Medicare enrollees do not have access to dental insurance, uninsured dental patients whose symptoms progress untreated and spread throughout the body experience more complex problems and require more complicated (and expensive) appropriate medical care.

ED visits for "preventable dental conditions" are estimated to cost $2 billion per year, with uninsured or publicly insured patients representing 83 percent of visits.[14] These visits, borne from untreated dental issues due to insufficient dental care, cause undue pressure on EDs as emergency physicians are required to treat every patient that comes to the ED. Had patients had access to preventive dental care, these patients would not have conditions progress to

[11] 87 Fed. Reg. 46421. (July 29, 2022).
[12] Bayetto K, Cheng A, Goss A. Dental abscess: A potential cause of death and morbidity. Australian Journal of General Practice. 2020;49(9):563-567. doi:10.31128/ajgp-02-20-5254.
[13] Bensley L, VanEenwyk J, Ossiander EM. Associations of self-reported periodontal disease with metabolic syndrome and number of self-reported chronic conditions. Prev Chronic Dis 2011;8(3):A50.
[14] Akinlotan, MA, Ferdinand, AO. Emergency department visits for nontraumatic dental conditions: a systematic literature review. J Public Health Dent. 2020; 80: 313– 326.

require emergency care. Therefore, ACEP supports this effort from CMS to expand coverage for dental conditions which are inextricably linked to progressive infections and other conditions covered by Medicare.

We do however want to express caution to CMS about how it decides to finance any additional services under Medicare Parts A and B. With respect to Medicare Part B, we previously highlighted the significant concerns that we have with the PFS payment structure, including budget neutrality and the lack of an appropriate annual inflationary update. ACEP believes the Medicare system will be increasingly burdened and challenged in its effort to fit additional dental-related services into the PFS, given that the current system is already facing significant fiscal and operational problems that will only be further exacerbated.

**Modifications Related to Medicare Coverage for OUD Treatment Services Furnished by OTPs**

CMS is allowing Opioid Treatment Programs (OTPs) to initiate treatment of buprenorphine via two-way audio/video communications technology, as long as that method of providing care is authorized by the Drug Enforcement Administration (DEA) and Substance Abuse and Mental Health Services Administration (SAMHSA). The DEA and SAMHSA currently have temporary telehealth policies in place. CMS will also allow the service to be performed via audio-only communication technology if two-way audio/video communications technology is not available. CMS is also clarifying that OTPs can bill Medicare for medically reasonable and necessary services furnished via mobile units.

ACEP supports these proposals and clarifications and encourages CMS to work with the DEA and SAMHSA to reduce regulatory burdens around the initiation of buprenorphine. Buprenorphine is an extremely valuable tool in the ED to help start patients on the path towards recovery. Initiating medication-assisted treatment (MAT) in the ED helps individuals stay in treatment longer, reduces illicit opioid use and infectious disease transmission, and decreases overdose deaths.[15] In addition, the available data demonstrate that patients with opioid use disorder (OUD) who are started on buprenorphine in the ED – and for whom there is a clinic to maintain treatment after treatment in the ED – are twice as likely at 30 days to remain in treatment for OUD than patients who receive a referral alone (78 percent of patients started on MAT in the ED remain in treatment at 30 days, compared to only 37 percent of those who receive a referral alone).[16] Substantially increased participation in MAT after ED buprenorphine initiation has been replicated in additional studies.[17] [18]

Furthermore, studies of patients with OUD in California and elsewhere have demonstrated an instantaneous reduction in mortality after buprenorphine-assisted detoxification, justifying its use in the ED even when access to long-term maintenance and follow-up is not available.[19] A study conducted using a retrospective chart review of 158 patients treated at a single ED with buprenorphine for opioid withdrawal also found a greater than 50 percent reduction (17 percent versus 8 percent) in return-rate to the same ED for a drug-related visit within one month, compared to the return-visit rate after usual care.[20] Finally, a recent article from JAMA Psychiatry showed that the use of telehealth for the treatment of OUD among Medicare beneficiaries significantly increased during the COVID-19

[15] Bao YP, Wang RJ, et al. Effects of medication-assisted treatment on mortality among opioids users: a systematic review and meta-analysis. Mol Psychiatry. 2018 Jun 22.

[16] D'Onofrio G, O'Connor PG, Pantalon MV, et al, JAMA. 2015 Apr 28;313(16):1636-44.

[17] Kaucher K, Caruso E, Sungar G, et al. Evaluation of an emergency department buprenorphine induction and medication-assisted treatment referral program. Am J Emerg Med. 2019 Jul 30.

[18] Hu T, Snider-Adler M, Nijmeh L, Pyle A. Buprenorphine/naloxone induction in a Canadian emergency department with rapid access to community-based addictions providers. CJEM. 2019 Jul; 21(4):492-498.

[19] Elizabeth Evans et al., "Mortality Among Individuals Accessing Pharmacological Treatment for Opioid Dependence in California, 2006-10," Addiction 110, no. 6 (June 2015): 996-1005.

[20] Berg ML, Idrees U, Ding R, Nesbit SA, Liang HK, McCarthy ML. Evaluation of the use of buprenorphine for opioid withdrawal in an Emergency Department. Drug Alcohol Depend. 2007;86:239-244.

pandemic. Beneficiaries who received these services were more likely to stay in treatment and less likely to experience an overdose.[21] In all, research suggests that the sooner we can start patients on the right path, and keep them engaged in treatment, the more successful their recovery can be.

CMS should continue to make it a priority to promote the initiation of MAT both by OTPs and outside of OTPs, including the ED.

ACEP also believes that CMS should consider ways to expand the use of MAT in the ED for other substance abuse disorders beyond OUD, such as for alcohol use disorder (AUD). One way to accomplish this goal is to modify the current add on code for initiating MAT in the ED for the treatment of OUD (G2213) to include treatments for all substance abuse disorders. Excessive alcohol use was responsible for more than 140,000 deaths in the United States each year between 2015 and 2019, and more people die from alcohol-related problems annually than all other drugs combined.[22] In 2020, there were 28.3 million people suffering from AUD,[23] but according to the SAMHSA, less than 15 percent of adults who needed AUD treatment received it,[24] and less than one percent of people with AUD were treated with a Food and Drug Administration (FDA)-approved alcohol dependence medication.[25]

With respect to ED encounters, alcohol-related ED visits are actually nearly three times as common as opioid-related visits.[26] The rate of all alcohol-related ED visits increased around 62 percent between 2006 and 2014,[27] and there were nearly three million alcohol-related visits to the ED in 2021.[28] While alcohol-related ED visits are extremely common, only a small fraction of patients are receiving alcohol use treatments. In fact, although guidelines suggest that patients with AUD should be prescribed medication and brief counseling as initial therapy or referred for more intensive psychosocial intervention, only 1.6 percent reported using medications for AUD (MAUD) according to a national survey conducted in 2019.[29] Many treatments for AUD have proven to be extremely effective. A 2020 study found that by instituting an alcohol medical intervention service (AMIS), the ED was able to reduce over 80 percent the 30-day revisit rates.[30]Among patients who had two or more ED visits in the 30 days prior to instituting the AMIS, 70

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[21] Jones CM, Shoff C, Hodges K, et al. Receipt of Telehealth Services, Receipt and Retention of Medications for Opioid Use Disorder, and Medically Treated Overdose Among Medicare Beneficiaries Before and During the COVID-19 Pandemic. *JAMA Psychiatry*. Published online August 31, 2022. doi:10.1001/jamapsychiatry.2022.2284.

[22] CDC. Morbidity and Mortality Weekly Report: Deaths and Years of Potential Life Lost From Excessive Alcohol Use-United States, 2011-2015, July 31, 2020, https://www.cdc.gov/alcohol/features/excessive-alcohol-deaths.html.

[23] SAMHSA (2021). Key substance use and mental health indicators in the United States: Results from the 2020 National Survey on Drug Use and Health (HHS Publication No. PEP21-07-01-003, NSDUH Series H-56). pages 28, 29 and 30: https://www.samhsa.gov/data/sites/default/files/reports/rpt35319/2020NSDUHFFR1PDFW102121.pdf.

[24] SAMHSA (2021). Key substance use and mental health indicators in the United States: Results from the 2020 National Survey on Drug Use and Health (HHS Publication No. PEP21-07-01-003, NSDUH Series H-56). Table 5.11A https://www.samhsa.gov/data/report/2020-nsduh-detailed-tables.

[25] SAMHSA (2021). Key substance use and mental health indicators in the United States: Results from the 2020 National Survey on Drug Use and Health (HHS Publication No. PEP21-07-01-003, NSDUH Series H-56). https://www.samhsa.gov/data/sites/default/files/reports/rpt35319/2020NSDUHFFR1PDFW102121.pdf.

[26] Substance Abuse and Mental Health Services Administration. (2022). Preliminary Findings from Drug-Related Emergency Department Visits, 2021; Drug Abuse Warning Network (HHS Publication No. PEP22-07-03-001). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/.

[27] White, A. M., Slater, M. E., Ng, G., Hingson, R., & Breslow, R. (2018). Trends in alcohol-related emergency department visits in the United States: results from the Nationwide Emergency Department Sample, 2006 to 2014. *Alcoholism: clinical and experimental research*, *42*(2), 352-359. Page 354.

[28] Substance Abuse and Mental Health Services Administration. (2022). Preliminary Findings from Drug-Related Emergency Department Visits, 2021; Drug Abuse Warning Network (HHS Publication No. PEP22-07-03-001). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/.

[29] Han, B., Jones, C. M., Einstein, E. B., Powell, P. A., & Compton, W. M. (2021). Use of Medications for Alcohol Use Disorder in the US: Results From the 2019 National Survey on Drug Use and Health. *JAMA psychiatry*. Page E2.

[30] Corace, K. et al., Alcohol Medical Intervention Clinic: A Rapid Access Addiction Medicine Model Reduces Emergency Department Visits, Journal of Addiction Medicine: March/April 2020 - Volume 14 - Issue 2 –see p. 166.

percent of patients did not return to the ED in the following 30 days.[31] It has also been reported that when the ED directly transferred patients to a treatment facility for admission, patients were 30 times more likely to enroll in treatment than those who were given an indirect referral and discharged home.[32] Finally, according to SAMHSA, medications can help people reduce their drinking levels and achieve abstinence when used with counseling and other evidence-based techniques.[33]

**In all, we believe CMS should work to improve access to and use of MAT for the treatment of other substance abuse disorders beyond OUD, and one way of accomplishing these goals is to expand the G2213 code to cover the initiation of MAT in the ED for the treatment of AUD and other substance abuse disorders.**

**Medicare Shared Savings Program**

***Overview***

The Medicare Shared Savings Program (MSSP) is the national accountable care organization (ACO) program, which serves over 11 million Medicare beneficiaries. In the rule, CMS is proposing to make numerous changes to the program, including:

- Allowing for upfront advanced payments to be made to certain new MSSP ACOs that could be used to address Medicare beneficiaries' social needs;
- Giving smaller ACOs more time to transition to downside financial risk;
- Creating a health equity adjustment to an ACO's quality performance category score to reward excellent care delivered to underserved populations; and
- Adjusting the benchmark methodology to encourage more ACOs to participate. CMS states that these adjustments would help the agency achieve the goal of having all people with traditional Medicare be in an accountable care relationship with a health care provider by 2030.

***Overarching Comments***

ACEP overall supports these proposals, as we believe that they will help increase participation in ACOs and enable ACOs to focus more on underserved populations—an extremely important step towards helping to reduce disparities in health outcomes and better address the needs of patients with social risk factors. **However, going forward, we urge CMS to create additional incentives for specialists to get engaged in the MSSP and other ACO initiatives.**

Engaging specialists in ACOs will truly help improve quality and reduce costs. Currently, ACOs have not effectively engaged specialists to help meet their cost targets and quality metrics. We believe that there is a lot of potential for ACOs to perform even better if they get specialists more involved in the care of their assigned patients. In fact, in the Center for Medicare and Medicaid Innovation's (CMMI's) strategic plan, the Center states that *specialists must be engaged* in ACO initiatives to help achieve an overarching goal getting all Medicare beneficiaries and the vast majority of Medicaid beneficiaries in "a care relationship with accountability for quality and total cost of care" by 2030. CMMI has stated that it wants to "test incentives to drive coordination between

[31] Id. at Page 168.
[32] D'Onofrio G, Degutis LC. Integrating project ASSERT: a screening, intervention, and referral to treatment program for unhealthy alcohol and drug use into an urban emergency department. Acad Emerg Med. 2010;17(8):903–11.
[33] SAMHSA ADVISORY: Prescribing Pharmacotherapies FOR Patients with AUD https://store.samhsa.gov/product/prescribing-pharmacotherapies-patients-with-alcohol-use-disorder/pep20-02-02-015, page 1.

providers responsible for accountable care relationships and specialty providers accountable for delivering high-cost episodic and/or complex care."

ACEP and others have developed alternative payment model (APM) concepts that CMS should examine to understand how specialists can be integrated into ACOs. In 2017, ACEP created an emergency medicine APM called the Acute Unscheduled Care Model (AUCM). The AUCM, if implemented, would be the first, and only, APM specifically designed for emergency physicians. The model would reward emergency physicians for reducing inpatient admissions and observation stays when appropriate. Emergency physicians would become key members of the continuum of care, as the model focuses on ensuring follow-up care for emergency patients, minimizing redundant post-ED services, and avoiding post-ED discharge safety events.

The AUCM was highly recommended by the Physician-Focused Payment Model Technical Advisory Committee (PTAC) and endorsed by the former Secretary of the U.S. Department of Health and Human Services (HHS).

Although ACEP created the AUCM as a stand-alone APM, the model can be integrated into other population health or disease/procedure specific risk contracts, episode-based models, or ACO initiatives. While much effort has gone into managing readmissions and post-inpatient care, the AUCM focuses on enabling safe discharge and rewards patient-focused care coordination. **ACEP believes that CMS should consider incorporating the AUCM or similar concept into the MSSP and other ACO initiatives.**

***Screening for SDOH and Screen Positive Rate for SDOH and Future Measures Development RFI***

CMS is seeking comment on two new measures: Screening for Social Drivers of Health, and Screen Positive Rate for Social Drivers of Health**.** The measure Screening for Social Drivers of Health assesses the percentage at which providers screen their adult patients for food insecurity, housing instability, transportation problems, utility help needs, and interpersonal safety. The measure Screen Positive Rate for Social Drivers of Health assesses the percentage of patients who screened positive for health-related social needs.

Overall, ACEP believes that quality measures should account for risk factors such as lack of access to food, housing, and/or transportation that affect patients' ability to adhere to treatment plans. As emergency physicians, we see patients from all backgrounds who have various social risk factors. Many interventions are being employed in the ED to help identify barriers to health such as transportation and access to food and housing. One such tool that ACEP supports to help manage care for patients with complex needs is the Collective Medical Technologies' (CMT) Edie™ (a.k.a. PreManage ED) software. Edie™ is an information exchange that provides critical information on patients, such as how many ED visits patients have had in the last year, where they presented, their drug history, other providers who are involved with the patients, and finally, whether there is a patient-specific care management plan that could guide treatment. The platform improves patient care by allowing emergency physicians to make more informed clinical decisions and better direct a patient's follow-up care. It also lowers health care costs through a reduction in redundant tests and through better case management, which reduces hospital readmissions. Through an alliance with CMT, ACEP has seen this system mature in approximately 17 states. Washington state, in the first year alone, experienced a 24 percent decrease in opioid prescriptions written from emergency departments, a 14 percent reduction of super-utilizer visits, and state Medicaid savings of more than $32 million.[34]

Some EDs across the country are attempting to create care coordination and case management programs that help improve follow-up appointment scheduling from the ED and target social interventions and primary medical care to

[34] https://www.acepnow.com/article/emergency-department-information-exchange-can-help-coordinate-care-highest-utilizers/2/.

high ED utilizers. One such program in Maryland applies mobile technology to use paramedics in a community health worker role to follow up on discharged patients at risk for readmission.[35] Many of these patients are Medicare beneficiaries. Another program in the East Bay, California has a help desk for health-related social needs with four integrated medical-legal partnerships, called Health Advocates, to help patients navigate housing and transportation challenges, immigration challenges, and benefit eligibility.[36] ACEP is continuing to explore other innovative ways our physicians can help coordinate care for high-risk patients, including through participation in alternative payment models.

When developing new measures that assess social risk, a critical consideration is measure attribution, or the process of selecting a patient population for which a group or entity will be held accountable for providing appropriate health services and achieving adequate health outcomes. ACEP encourages evaluation at the *clinician group level* in order to ensure that gaps are fairly attributed to entities with adequate agency to be responsible and accountable for outcomes.

There should also be sensitivity, and perhaps an actual formulaic coefficient applied, when evaluating under-resourced facilities to ensure some congruency between their quality performance relative to facilities with more resources. CMS should consider adjusting programmatic requirements to ensure that reporting on quality measures is feasible for all facilities and that under-resourced facilities do not face undue difficulty or burdensome penalties that could affect access to care for vulnerable populations.

***Addition of New Consumer Assessment of Healthcare Providers & Systems (CAHPS) for MIPS Survey Questions RFI***

CMS also seeks input on potential modified questions in the CAHPS for MIPS survey pertaining to health disparities and price transparency.

*Discrimination Question*

CMS is considering adding the following question: "In the last 6 months, did anyone from a clinic, emergency room, or doctor's office where you got care treat you in an unfair or insensitive way because of any of the following things about you?" The potential responses include health condition, disability, age, culture, sex (including sexual orientation and gender identity), and income. CMS seeks feedback on additional or modified potential response categories for this health disparities question.

ACEP understands CMS' rationale for potentially adding this question. However, we want to make it unequivocally clear that emergency physicians have a moral and ethical duty to treat everyone who comes through the doors of the ED. Both by law[37] and by oath, emergency physicians care for all patients seeking emergency medical treatment. Denial of emergency care or delay in providing emergency services on the basis of race, religion, sexual orientation, gender identity, ethnic background, social status, type of illness, or ability to pay, is unethical.[38] We also believe that such a question may benefit from being piloted before being fully implemented in CAHPS. While the implementation of this question likely supports broader awareness of these issues, CMS should evaluate whether the question could result in biases based on the characteristics of the physician providing the care (e.g., women, providers of color).

[35] For more information on the Maryland Mobile Integrated Health Care Programs, please go to https://www.miemss.org/home/LinkClick.aspx?fileticket=w-K7gG-8teo%3D&tabid=56&portalid=0&mid=1964.
[36] For more information on the Health Advocates Program, please go to http://www.levittcenter.org/ed-social-welfare-in-collabor/.
[37] 42 U.S. Code § 1395dd - Examination and treatment for emergency medical conditions and women in labor.
[38] ACEP Code of Ethics for Emergency Physicians; Approved Jan 2017; https://www.acep.org/clinical---practice-management/code-of-ethics-for-emergency-physicians.

Understanding whether these biases could occur and what impact they may have on physician performance must be understood and addressed prior to implementing this question in the CAHPS measure.

*Price Transparency*

CMS also seeks input on the addition of questions to the CAHPS for MIPS survey specific to price transparency. These questions would build upon the goals of the *No Surprises Act* to improve transparency and oversight of drug and medical costs, allowing patients to have more information on which to base their healthcare decisions. Currently, the CAHPS for MIPS survey includes the question "In the last 6 months, did you and anyone on your health care team talk about how much your prescription medicines cost?" CMS is considering adding a question that would be more general in nature and encompass additional areas of a patient's care, such as whether the patient talked with anyone on their health care team about the cost of health care services and equipment.

ACEP appreciates CMS' willingness to improve price transparency and accountability for patients by adding this question to the CAHPS for MIPS survey. However, we urge CMS to keep in mind issues that are unique to emergency medicine and to therefore NOT include ED care in this question. In the ED, minutes and seconds matter and emergency physicians are often required to exercise their best clinical judgement quickly. Patients who have life-threatening illnesses and injuries obviously do not have the ability to shop around for the "lowest cost" provider. Furthermore, in delivering acute care, knowing what patients' total out-of-pocket costs will be before they are diagnosed and stabilized is nearly impossible until a proper course of medical care and progression is followed. A large proportion of emergency care involves the acute diagnosis, treatment, and stabilization of diffuse and undifferentiated clinical conditions. For example, two of the most common patient presentations are "chest pain" and "abdominal pain." These initial symptoms have a large range of ultimate diagnoses and require a large variety of patient-specific lab tests, radiology exams, and other interventions. This is very different from being able to figure out total costs for an urgent care patient with a small, clean, superficial laceration or a sore throat. Further complicating the issue is the fact that emergency care is billed in two separate components, the facility fee and the professional fee. Therefore, patients must sort through costs included in at least two different bills, each of which may have different cost-sharing obligations associated with it.

As emergency physicians, we are bound by Emergency Medical Treatment and Labor Act (EMTALA), which guarantees access to emergency medical care for everyone, regardless of insurance status or ability to pay. EMTALA stipulates that a hospital may not place any signs in the ED regarding prepayment of fees or payment of co-pays and deductibles since they can have the chilling effect of dissuading patients from "coming to the emergency department." To do so could lead patients to leave prior to receiving a medical screening examination and stabilizing treatment without regard to financial means or insurance status, which is a fundamental condition for satisfying EMTALA, and one of the most foundational principles of an important patient protection that was enacted over three decades ago. If we attempt to get pricing information to patients prior to stabilizing them, not only would that constitute an EMTALA violation, but it could also potentially cause the patient's health to deteriorate since it could delay the patient from receiving critical care. The last thing we want to do is put our patients in a position of making life-or-death health care decisions based on costs.

It is also important to note that people who think they are having an emergency have every right to go to the ED without worrying about whether the services they receive will be covered by their insurance. A provision in federal law called the "Prudent Layperson Standard" (PLS) states that payors must cover any medical condition "manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention

to result in: 1) placing the health of the individual (or a pregnant woman or her unborn child) in serious jeopardy; 2) serious impairment to bodily functions, or 3) serious dysfunction of any bodily organ or part." First established under the Balanced Budget Act of 1997, the PLS originally applied to all of Medicare and to Medicaid managed care plans, and then was extended under the Affordable Care Act (ACA) to all insurance plans regulated under the Employee Retirement Income Security Act of 1974 (ERISA) and qualified health plans in the state Exchanges. Furthermore, 47 states (all except Mississippi, New Hampshire, and Wyoming) have passed their own laws making some kind of prudent layperson standard mandatory in their state.

***Revisions for Specialties***

CMS is also considering revisions to the CAHPS for MIPS Survey measure in order to make it more broadly applicable to specialty groups in addition to primary care groups. In particular, CMS requests public comment on shortening the survey to remove survey items that are relevant only to primary care providers. Alternately, CMS may create an alternate shortened survey version for specialty groups while maintaining the existing survey questions for primary care groups.

CMS did create a CAHPS survey that was designed for EDs called ED CAHPS. It was approved for optional use by EDs in 2020. ACEP offers a patient engagement module for all participants of our qualified clinical data registry (QCDR), the Clinical Emergency Data Registry (CEDR), and we believe this module is superior to ED CAHPS. Most current vendors that would administer ED CAHPS do not survey a large enough sample size to allow for statistically valid individual physician attribution, and we believe strongly that performance improvement cannot be accomplished without the capability to give individual clinicians feedback and resultant skills training to improve physician-patient communication.

**Medicare Part B Payment for Preventive Vaccine Administration Services**

In the rule, CMS proposes a number of updates to policies around the administration of preventive vaccines, including the influenza, pneumococcal, and HBV vaccines, and COVID-19 vaccines. ACEP supports CMS' overall goal to revise the payment rates to ensure that they reflect the most up-to-date practice costs. We also agree with CMS that the payment amount for the administration of preventive vaccines should be based upon the annual increase to the MEI. ACEP has argued in the past that the MEI is a good reflection of the increase in practice costs and should also be used to update the PFS conversion factor each year.

**Requirement for Electronic Prescribing for Controlled Substances for a Covered Part D Drug under a Prescription Drug Plan or MA-PD plan**

CMS is implementing a provision of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act, which requires electronic prescribing of controlled substances (EPCS) under Medicare Part D. In this rule, CMS is proposing to delay compliance of the EPCS requirement by another year, until January 1, 2024—but is seeking comment on what penalties to implement going forward starting in 2025.

***ACEP supports the proposal to delay the EPCS requirement until 2024.*** With respect to the exceptions, while we agree with all those listed and with the proposed modifications, we are disappointed that CMS did not consider factors unique to emergency medicine when establishing the final exceptions and requirements. The majority of ED visits fall outside of "business hours," and some of our patients are not connected with a regular pharmacy. Thus,

many e-prescriptions are prone to "failure," meaning the pharmacy hours are not convenient or even accessible for the patient, or the prescribed drug may not be in stock. This usually requires the patient to return to the ED or call the prescriber to cancel the original electronic prescription and re-issue it to a new pharmacy. If the original prescriber's ED shift has ended, a new prescriber must be recruited. This is a limitation of e-prescribing protocols in general and not EPCS in particular, though the additional authentication for EPCS makes this even more cumbersome, and the nature of emergency medicine means this scenario is all too common. Additional state requirements for prescription drug monitoring program (PDMP) logins and checks, and the separate authentication requirements for PDMP, further complicate these scenarios.

Emergency physicians have also faced hurdles getting registered and implementing EPCS into our workflows. For example, when we purchase a new smartphone, we are required to visit the credentialing office of our facility and obtain a new help desk ticket and a new credentialing of the CSP app. Then, that credential must be tied to the EHR for two-factor authentication for EPCS. Further, if we lose a smartphone, we have to re-enroll—and since that process takes time, often we cannot e-prescribe for days to weeks afterwards. These issues have only been exacerbated during the COVID-19 PHE.

In addition, we have had issues getting buprenorphine prescriptions filled through electronic prescribing. Given the effectiveness of using buprenorphine to help treat OUD and the issues some physicians have experienced with electronically prescribing this medication, we believe that buprenorphine prescriptions should be an additional exception to the EPCS requirement.

CMS seeks comments on additional actions that it could take in the future to enforce compliance with the EPCS requirement including possible penalties. ACEP opposes the imposition of penalties, but instead recommends that CMS offer to assist practices that have not yet adopted EPCS. For example, along with the correspondence informing them of the EPCS requirement, CMS could supply information about where physicians can obtain technical support and financial assistance for adopting EPCS. In addition, CMS should urge Medicare Advantage/Part D and standalone Part D plan sponsors to provide positive incentives to physician practices for EPCS adoption, such as waiving prior authorization requirements for controlled substance prescriptions if they are submitted electronically.

**Appropriate Use Criteria Program**

CMS does not include any proposals related to the Appropriate Use Criteria (AUC) program. However, on the AUC website, CMS states that the program has been delayed indefinitely due to the COVID-19 PHE.

As background, the AUC program, created by the Protecting Access to Medicare Act of 2014 (PAMA), will eventually require physicians ordering advanced imaging for Medicare beneficiaries to first consult appropriate use criteria through approved clinical decision support mechanisms in order for the furnishing provider of that advanced imaging to be able to receive payment. PAMA exempts emergency services defined as an "applicable imaging service ordered for an individual with an emergency medical condition" (as defined by EMTALA). ACEP sincerely appreciates that CMS clarified that exceptions granted for an individual with an emergency medical condition include instances where an emergency medical condition is suspected, but not yet confirmed. This may include, for example, instances of severe pain or severe allergic reactions. In these instances, the exception is applicable even if it is determined later that the patient did not, in fact, have an emergency medical condition.

***ACEP strongly supports the continued delay of the program. Overall, we believe that the program is unnecessary and could harm patient care by postponing vital treatment.*** In many ways, MIPS, through the Cost

category, achieves the same ultimate goal as the AUC program does—to manage the utilization of services. Thus, in effect, MIPS has replaced the need to have an AUC program in place. From the emergency medicine perspective, it makes much more sense for emergency physicians to spend their time focusing on improving quality and reducing costs through MIPS rather than having to constantly evaluate whether each Medicare beneficiary who needs advanced imaging would qualify for this exception (and if the beneficiary does not qualify, having to use a clinical decision support tool and adhere to appropriate use criteria that are not applicable to the ED setting).

Further, some hospitals have not appropriately updated their systems to allow emergency physicians to claim the emergency medical condition exception. This has caused confusion and fear that emergency physicians, despite the noted exception, would still have to consult appropriate use criteria even during suspected or confirmed medical emergencies, wasting valuable time. ACEP has tried to educate both our members and hospitals about the emergency medical condition exception, but despite these efforts, we are still hearing these concerning reports. Eliminating the program completely is the only way to ensure that patients are protected and are able to receive immediate treatment when experiencing a suspected or confirmed medical emergency. We therefore request that CMS work with Congress to fully repeal this program.

## The Quality Payment Program

### Continuing to Advance to Digital Quality Measurement and the Use of Fast Healthcare Interoperability Resources (FHIR) in Physician Quality Programs—Request for Information

CMS is revising their potential future definition such that a digital quality measure (dQM) is a quality measure, organized as self-contained measure specification and code package, that uses one or more sources of health information that is captured and can be transmitted electronically via interoperable systems. CMS seeks comment on the following questions:

***Do you have feedback on the potential refined definition of dQMs?***

ACEP suggests one minor clarification in the definition, related to the phrase: "health information that is captured and can be transmitted electronically." As written, there may be confusion as to how health information is captured (i.e., also electronically). For clarity, we suggest that this be reworded to ". . . captured electronically and can be transmitted electronically . . ." We also think that the use of the words "can be" appears to indicate that electronic transfer is optional. Further, we believe electronic transfer should be mandatory. Thus, we suggest that CMS use this definition of dQMs: "dQM is a quality measure, organized as self-contained measure specification and code package, that uses one or more sources of health information that is captured electronically and transmitted electronically via interoperable systems."

***Do you have feedback on potential considerations or challenges related to non-EHR data sources?***

Pre-hospital and telehealth data sources are becoming increasingly important for emergency medicine and often are not integrated into electronic health records (EHRs). Transition of this data to electronic capture and interoperability should be promoted.

Mapping non-EHR data sources to assist with the generation and validation of dQM metrics may suffer similar challenges to what are currently seen within the Social Determinants of Health (SDOH) space. In this area, EHR data only represent a subsection of potential data sources, which may also include care coordination platforms, community referral platforms, long-term services, exchange platforms, and consumer applications. The multi-stakeholder Gravity Project serves as an open collaborative to identify and standardize data elements, and serves as a key leader of the various FHIR Connectathons and Implementation Guides (IGs) to ensure coordination across these various platforms. The lessons learned from the Gravity Project since its inception in 2017 may serve as a roadmap for the development of dQMs in a manner that carefully considers EHR and non-EHR data sources.

***Do you have feedback on the specific implementation guides CMS is considering, additional FHIR implementation guides CMS should consider, or other data and reporting components where standardization should be considered to advance data standardization for a learning health system?***

Within the realm of SDOH and social care referrals, the need to connect EHR and non-EHR data sources is widespread. Data formats may often use data standards and taxonomies that are outside of FHIR or may have yet to be fully mapped to FHIR. For social care referrals, additional data standards include the Human Service Data Standard (HSDS), the Alliance of Information and Referral Systems, the Civic Services Schema, and the AIRS/211 Taxonomy. Efforts such as the FHIR SDOH Clinical Care IG and the FHIR Validated Healthcare Directory (VHDir) may serve as key examples on how to address IGs and directories that work with disparate and non-EHR data.

Specific to qQMs, one may consider the means by which the Structured Data Capture (SDC) IG harnesses expressions —namely queries, FHIRPath, and Clinical Quality Language (CQL)—to define what data elements may be used to satisfy various reporting requirements. A direct example of the SDC workflow is displayed here, which specifically identifies how a FHIR Measure Resource may have a pre-defined FHIRPath expression to generate a FHIR MeasureReport Resource, including scores and sub-scores. Such a method may be directly applicable to various dQMs and reporting components that may take multiple data points into account prior to measure or score generation.

***Are there additional venues to engage with implementors during the transition to digital quality measurement?***

ACEP has invested heavily in a next-generation digital platform (called the Emergency Medicine Data Institute) that will largely accomplish many of these objectives. However, insufficient funding limits our ability to rapidly advance these features. CMS should consider creating incentives for individual clinicians and groups to use Qualified Clinical Data Registries (QCDRs) that strive to meet these objectives.

If CMS wishes to promote the transition to "digital quality measurement," then the agency must provide financial incentives to help achieve that goal. If clinicians can continue to easily and inexpensively use manual processes to successfully report under MIPS, the transition to digital quality measures will be hampered.

***What data flow options should CMS consider for FHIR-based eCQM reporting, including retrieving data from EHRs via FHIR APIs and other mechanisms?***

As of now, there are no real incentives for hospitals to adopt FHIR. The biggest challenge for CEDR, ACEP's QCDR, is garnering the cooperation of hospitals on behalf of our clinician client base. Hospitals have no incentive to build or maintain data feeds to serve their contracted clinicians. In addition, they often charge clinicians groups exorbitant fees to build these data feeds. CMS should therefore consider requiring hospitals to share data with hospital-based clinician groups in a timely and cost-effective manner.

***Are there other critical considerations during the transition?***

This transition may also serve as means to support the new and burgeoning specialty of "Clinical Informatics," which is a boarded specialty of medicine available to all medical specialties. CMS could partner with clinical informaticists to help with the transition from manual quality measures to dQMs and going forward work to expand this workforce as we strive to promote the next generation of high-quality, actionable data on a national scale.

**Advancing the TEFCA: Request for Information**

HHS has established a framework for a "Trusted Exchange Framework and Common Agreement (TEFCA)." CMS is looking to incentivize exchange under TEFCA through programs that incentivize high quality care, or through program features in value-based payment models that encourage certain activities that can improve care delivery.

CMS is seeking comments on the following:

***What are the most important use cases for different groups that could be enabled through widespread information exchange under TEFCA? What key benefits would be associated with effectively implementing these use cases, such as improved care coordination, reduced burden, or greater efficiency in care delivery?***

ACEP's Emergency Medicine Data Institute currently aggregates about 30 million emergency department (ED) visits annually, and projects this to expand to more than 75 million within five years. But even with our current volume, there are numerous opportunities to provide public health surveillance ranging from product safety, disease management trends, adverse drug event (ADE) surveillance, opioid overdose, and emerging biological threats. As noted previously, getting the cooperation of hospitals to share data at all or at a reasonable cost is a major barrier to these vital activities.

***What are key ways that the capabilities of TEFCA can help to advance the goals of CMS programs? Should CMS explore policy and program mechanisms to encourage exchange between different interested parties, including those in rural areas, under TEFCA? In addition to the ideas discussed previously, are there other programs CMS should consider in order to advance exchange under TEFCA?***

CMS must create appropriate incentives for hospitals to both cooperate and provide data to data aggregators such as ACEP's Emergency Medicine Data Institute. Doing so would help advance the goals of TEFCA.

***How should CMS approach incentivizing or encouraging information exchange under TEFCA through CMS programs? Under what conditions would it be appropriate to require information exchange under TEFCA by interested parties for specific use cases?***

One option might be for CMS to designate, certify or somehow sanction data aggregators such as ACEP's Emergency Medicine Data Institute as essential public health data arbiters. Hospitals should be required to share data within scope to meet public health objectives.

***What concerns do commenters have about enabling exchange under TEFCA? Could enabling exchange under TEFCA increase burden for some interested parties? Are there other financial or technical barriers to enabling exchange under TEFCA? If so, what could CMS do to reduce these barriers?***

There are many burdens for data providers. Creating a data feed (FHIR standard or otherwise) has intrinsic costs. There are other barriers, such as security assessment and compliance with the Health Insurance Portability and Accountability Act (HIPAA). If CMS could create a program by which data aggregators such as ACEP's Emergency Medicine Data Institute could be certified once as being secured and HIPAA compliant, data suppliers could then be required to accept it without an additional burdensome security assessment, removing a major challenge for all parties involved.

## MIPS Value Pathways (MVPs)

### *ACEP Recommendations for Modifying MVPs*

The 2023 performance year is the first year of a new reporting option in MIPS called the MIPS Value Pathways (MVPs). MVPs represent an approach that will allow clinicians to report on a uniform set of measures on a particular episode or condition in order to get MIPS credit. ACEP developed an emergency medicine-focused MVP that CMS will be including in the first batch of MVPs starting in 2023. While we are excited about the implementation of this MVP, the Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP, we are generally concerned that not many clinicians will actually report through the MVP next year. Due to the COVID-19 public

health emergency, hardship exemptions have been in place for the 2019, 2020, 2021, and 2022 MIPS performance periods. Therefore, for some clinicians, 2023 may be the first time they participate in MIPS in four years. These clinicians may not be willing to take a risk and try a new method for reporting in MIPS, especially when the potential downside is significant – a nine percent reduction in reimbursement on all Medicare covered professional services. To encourage participation in MVPs, we recommend the following:

Create More Incentives for Participating in MVPs

***ACEP continues to believe that there should be some additional incentives for initially participating in an MVP over traditional MIPS.*** Although we hope that participating in the emergency medicine MVP in 2023 will reduce administrative burden for emergency physicians and allow them to focus on specific quality measures and activities that improve the quality of care they deliver, we also think that many emergency physicians may be hesitant to make any changes to their reporting patterns. ACEP strongly recommends that CMS include at least a five-point bonus for participating in an MVP initially. While we understand that CMS may receive pushback at a later date if and when the agency decides to eliminate such a bonus, we truly believe that an incentive is necessary to maximize participation in MVPs at the start.

Besides creating a bonus, clinicians who participate in MVPs should also be held harmless from any downside risk for at least the first two years of participation while they gain familiarity with reporting the defined measures within the MVP. While the scoring rules for MVPs are slightly more advantageous than they are for MIPS (for example, clinicians are only scored on four quality measures instead of six), they have fewer options and are not able to choose from a broad range of quality measures and improvement activities. Under traditional MIPS, some clinicians report as many quality measures as possible (10-15 measures), with the understanding that CMS will score the top six highest performing measures. If these clinicians were to report under the Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP, they would only be able to report up to nine measures and would be scored on the top four. Therefore, even though clinicians are scored on fewer measures if they choose to report under the MVP, the chances of them receiving high scores on their selected measures may actually be lower.

Eliminate the Foundational Layer

ACEP believes that CMS should eliminate the foundational layer of population-based measures that is included in each MVP. Overall, we believe that measures included in MVPs should be those that have been developed by specialty societies to ensure they are meaningful to a physician's particular practice and patients and measure things a physician can actually control. As hospital-based clinicians, we are concerned about the measure reliability and applicability, case size, attribution, risk adjustment, application at the clinician or group level, and degree of actionable feedback for improvements. Further, many of the existing population claims measures have not been tested at the physician level, are based on a retrospective analysis of claims, and do not provide granular enough information for physicians to make improvements in practice. Physicians do not treat a population, but rather treat patients as individuals tailored to their specific needs.

***MVPs and APM Participant Reporting Request for Information***

One of CMS' goals is to use MVPs as a pathway for clinicians to participate in Advanced Alternative Payment Models (APMs). As CMS moves forward with MVP implementation, the agency continues to seek feedback on ways to better

align clinician experience between MVPs and APMs and to ensure that MVP reporting serves as a bridge to APM participation.

ACEP supports the long-term goal of MVPs to transition clinicians to participate in APMs, but believes we are a long way off from achieving that objective. The Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP was originally constructed based off the Acute Unscheduled Care Model (AUCM)—an emergency medicine APM that ACEP constructed. We describe more about the AUCM in the Medicare Shared Savings Program section above.

Structured as a bundled payment model, the AUCM would improve quality and reduce costs by allowing emergency physicians to accept some financial risk for the decisions they make around discharges for certain episodes of acute unscheduled care. Initial episodes focus on patients with the following symptoms: abdominal pain, altered mental status, chest pain, and syncope. In later years, the AUCM will be expanded to include all ED conditions that have national admission rates less than 90 percent, thereby also capturing headache and back pain. The AUCM would enhance the ability of emergency physicians to reduce inpatient admissions and observation stays when appropriate through processes that support care coordination. Emergency physicians would become members of the continuum of care as the model focuses on ensuring follow up, minimizing redundant post-ED services, and avoiding post-ED discharge safety events that lead to follow-up ED visits or inpatient admissions. The model also allows waivers to promote telehealth, care coordination, and home visit services after discharge to encourage risk sharing for the cost of care and better patient outcomes.

ACEP looks forward to working with CMMI to improve emergency patient care through the implementation of the model. In the meantime, we believe that there is significant synergy between the Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP and the AUCM. However, the transition from this MVP to an APM cannot occur if there are no opportunities for emergency physicians to participate in APMs. **CMS must make it a priority to create additional APM opportunities for emergency physicians and other specialists—or figure out how to modify current APMs in order to better engage specialists and allow them to actively participate.**

Further, ACEP would like to note that we are making a concerted effort to evaluate additional career opportunities for emergency physicians and explore how emergency physicians can use their skills and expertise in treating patients with acute illnesses and conditions outside the four walls of the hospital ED. By better incentivizing care delivered by emergency physicians in urgent care centers and free-standing emergency departments, pre-hospital care delivered in-person or via telehealth (similar to the Emergency Triage, Treat, and Transport, or ET3, Model), and at-home services, CMS could help better meet patient needs. In all, ACEP believes that these alternative approaches to providing emergency care should be tested as part of this transition from MVPs to APMs.

***Process for Developing New MVPs***

CMS proposes to modify the MVP development process such that CMS would evaluate a submitted candidate MVP through the MVP development process, and if CMS determines it is "ready" for feedback, CMS would post a draft version of the submitted candidate MVP on the Quality Payment Program website and solicit feedback for a 30-day period. Interested parties and the general public would have the opportunity to submit feedback on the candidate MVP for CMS' consideration through an email inbox. CMS would review the feedback received and determine if any changes should be made to the candidate MVP prior to potentially including the MVP in a notice of proposed

rulemaking. If CMS determines changes should be made to the candidate MVP, CMS would not notify the interested parties who originally submitted the candidate MVP for CMS consideration in advance of the rulemaking process.

ACEP supports this proposal, as we believe it is important to create a streamlined process for adding new MVPs to the program. However, we are concerned that CMS still does not plan on notifying the parties that submit MVPs of any changes in advance of the rulemaking process. Since these organizations (such as specialty societies) will be the ones who will eventually be helping clinicians participate in the MVP, it is important that there is full transparency in the development process and that CMS fully coordinates with these organizations.

***MVP Maintenance Process and Engagement with Interested Parties***

CMS proposes to modify the MVP maintenance process such that interested parties and the general public would be able to submit their recommendations for potential revisions to established MVPs on a rolling basis throughout the year. CMS would then review the submitted recommendations and determine whether any are potentially feasible and appropriate. If CMS identifies any submitted recommendations that are potentially feasible and appropriate, CMS would host a public-facing webinar, open to interested parties and the general public, through which they may offer their feedback on the potential revisions CMS has identified. CMS would publish details related to the timing and registration process for the webinar through their Quality Payment Program Listserv. If CMS decides to make any revisions to an established MVP based on the recommendations submitted, CMS would adopt such revisions through notice and comment rulemaking.

ACEP supports this proposal. We appreciate the flexibility to propose revisions to existing MVPs throughout the year. It is extremely important to be able to update the list of quality measures and improvement activities on a regular basis to ensure that they reflect the most up-to-date clinical standards and practice patterns. ACEP is already looking forward to considering what proposed measure changes to put forward for the Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP. Again, we do recommend that to the extent possible, CMS work with the organization that originally proposed the MVP to incorporate suggested changes into the MVP.

***Emergency Medicine-focused MVP***

CMS is proposing modifications to the Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP. Specifically, CMS is proposing to remove two improvement activities based on updates to the improvement activities inventory, and to add one improvement activity. CMS is also proposing to add the Office the National Coordinator (ONC) Direct Review attestation requirement that was inadvertently omitted from the Promoting Interoperability performance category in the CY 2022 Physician Fee Schedule (PFS) Final Rule. ACEP opposes the deletion of the two measures, PSPA 6: Consultation of the Prescription Drug Monitoring Program and PSPA 20: Leadership engagement in regular guidance and demonstrated commitment for implementing practice improvement change, for the reasons described below in the Improvement Activities section of the response.

***Subgroup Reporting***

CMS is proposing to (1) modify the definitions of single specialty group and multispecialty group; (2) add subgroup description requirements to the registration process; (3) limit the number of subgroups a clinician may participate in to one subgroup per TIN; (4) establish the subgroup determination period; (5) apply new policies for scoring administrative claims measures and cost measures for subgroups; and (6) not assign a subgroup final score to registered subgroups that do not submit data.

***ACEP believes that subgroup reporting should continue to be optional for the foreseeable future.*** CMS should therefore NOT finalize its proposal to require multispecialty groups to form single specialty subgroups to participate in MVPs beginning in 2026. In all, we are concerned about how CMS defines subgroups, and we do not think that subgroup composition should be based on specialty, geographic location, size, or any other factors. One reason not to constrain the composition of subgroups is that some MVPs are built around conditions. In addition, imposing such limitations will increase the cost and burden of creating a subgroup, thus reducing participation. Further, it is difficult to define a subgroup for clinicians who practice in multiple settings. For example, in rural areas, clinicians can cover the ED, observation unit, and the inpatient floor. If these clinicians have to choose a subgroup that delineates ED versus other settings, they may not have enough patients to meet the measure thresholds. Overall, we have concerns about ensuring that clinicians are placed in the most appropriate subgroup. There should also be a process for rectifying any unintentional mistakes made in the subgroup registration process.

CMS should also not finalize its proposal to use Medicare Part B claims data to determine specialty information. Rather, we urge the agency to allow subgroups to attest to their specialties during the registration process. CMS should create a drop-down for specialty designation as part of the subgroup description. In addition, ACEP does not support the plan to only allow one subgroup to be reported for each TIN-NPI combination since it is contrary to what we believe the intent of MVPs should be—to enable physicians from a group practice to partner with their colleagues in the same or similar specialty or who manage a patient's care during an episode, such as surgeons and anesthesiologists, to report on clinically relevant measures. As a result, CMS should not limit subgroup composition for each TIN-NPI combination.

While creating the concept of subgroups is well-intentioned, it adds to administrative complexity and burden, and in the end will disincentivize MVP participation. **Therefore, again, we urge CMS not to make subgroup reporting mandatory going forward.**

**Quality Performance Category**

***High Priority Measure***

ACEP supports the proposal to modify the definition of the term "high priority measure" to include quality measurement pertaining to health equity. We strongly agree with CMS that health equity focused measures should be one of the major focuses going forward and therefore should have the high priority status. We do note, however, the lack of any guidance or further detail explaining how CMS will determine which measures would be considered to be health equity-related. We encourage CMS to provide additional information on what characteristics or other features of a quality measure would enable it to be classified with this label.

***Data Completeness***

CMS is proposing to maintain the current data completeness threshold (the percentage of applicable patients on which providers must report on for a particular measure) at 70 percent for the 2023 performance period, but is proposing to increase the data completeness threshold to at least 75 percent for the 2024 and 2025 performance period.

**ACEP opposes the proposed increase in the threshold for the 2024 and 2025 performance periods.** We believe that physicians and group practices are being held to an unreasonably high bar – higher than other quality programs like the Medicare Part C and D Star ratings and certain hospital reporting programs that only require a sample of patients for each quality measure. In addition, some emergency physicians practice across multiple settings with

different EHR and documentation systems, yet their specific NPI/TIN remains the same. Since these different settings do not integrate data seamlessly, it is challenging for some emergency physicians to even reach the current 70 percent data completeness threshold. Until enough data and care can be integrated across settings, it is premature to continue to increase the data completeness threshold.

Increasing the threshold would also increase administrative burden and overall cost of complying with MIPS requirements. Many of the MIPS requirements are increasing and with the introduction of MVPs and the continued shift to digital quality measures, adding additional reporting burdens may overwhelm physicians and their group practices. Physicians need stability in the program to focus on improvement and reduced burden to successfully transition to MVPs and digital quality measures.

***Modify the MIPS Quality Measure Set***

CMS is proposing to reduce the inventory of quality measures from 200 to 194 through the removal of 15 and addition of nine MIPS quality measures (a net decrease of six quality measures). With respect to the emergency medicine specialty set, CMS is proposing to add the following five quality measures.

- Appropriate Treatment for Upper Respiratory Infection (URI): Percentage of episodes for patients 3 months of age and older with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event.

  ACEP supports the inclusion of this measure in the emergency medicine specialty set. This measure is extremely meaningful to the practice of emergency medicine and is already a popular measure for emergency physicians to report.

- Preventive Care and Screening: Screening for Depression and Follow-Up Plan: Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the eligible encounter.

  ACEP does not support the inclusion of this measure in the emergency medicine specialty set. This measure is not clinically relevant to the practice of emergency medicine, as emergency clinicians do not typically conduct this comprehensive screening in the ED. We also believe that the administrative burden associated with reporting this measure outweighs its benefit.

  Another issue with this measure is the inability for emergency physicians to have access to all the data necessary to calculate and report on it. The EHR systems that emergency physicians use in EDs do not always receive data from other parts of the hospital, so it is possible that another physician completed this screening for the patient without the emergency physician knowing or being able to locate that information. ACEP also notes that in order to calculate this measure electronically, it would be difficult to only rely on data from the ED encounter. In many cases, emergency physicians do not have access to a patient's longitudinal medical record during episodes of emergency care.

  Further, it is important to note that some EDs may not have the resources and staffing required to conduct these surveys for every patient. With limited time and staffing constraints, emergency physicians and other

clinicians working in the ED should be focused on dealing with the acute emergency case. Additional screenings could delay necessary care for that particular patient or other patients who still need to be treated.

In all, while ACEP does appreciate that CMS is trying to add new measures to the emergency medicine specialty set, this particular measure (as well as the two below) do not add clinical value and overall are not meaningful to emergency physicians.

- Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention: Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within the measurement period AND who received tobacco cessation intervention on the date of the encounter or within the previous 12 months if identified as a tobacco user. Three rates are reported: a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within the measurement period. b. Percentage of patients aged 18 years and older who were identified as a tobacco user who received tobacco cessation intervention on the date of the encounter or within the previous 12 months. c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times during the measurement period AND who received tobacco cessation intervention if identified as a tobacco user on the date of the encounter or within the previous 12 months.

  ACEP does not support this measure for the same reasons cited above with respect to the depression measure. We believe this measure is not clinically relevant to emergency care and will add to administrative burden. Cessation counseling would be particularly difficult and time-consuming to document for each patient. It would also not be clinically relevant to screen every patient that comes to the ED for smoking cessation or counseling. Further, if the patient is admitted to the hospital, the counseling becomes part of the discharge process which never gets translated to an ED chart. In other words, in this situation, the emergency physician would have no documentation that the counseling actually occurred.

  ACEP wants to make it clear that emergency physicians are committed to addressing smoking cessation, but more appropriate measures for the ED setting exist to help accomplish this goal. We note that we have developed an ED-specific measure in ACEP's QCDR, CEDR, called "Tobacco Use: Screening and Cessation Intervention for Patients with Asthma and COPD." This measure captures the percentage of patients aged 18 years and older with a diagnosis of asthma or chronic obstructive pulmonary disease (COPD) seen in the ED and discharged who were screened for tobacco use during any ED encounter AND who received tobacco cessation intervention if identified as a tobacco user.

- Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling: Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 12 months AND who received brief counseling if identified as an unhealthy alcohol user.

  ACEP does not support this measure for the same reasons cited above with respect to the depression and tobacco use measures. We believe this measure is not clinically relevant and will add to administrative burden. Again, emergency physicians are committed to treating patients with alcohol use disorder, but this particular measure is not meaningful in the ED setting.

- Screening for Social Drivers of Health: Percent of beneficiaries 18 years and older screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.

ACEP supports the overall intent of this measure but has concerns with its inclusion in the emergency medicine specialty set. As stated earlier in our response to the RFI on the Screening for Social Determinates of Health (SDOH) and Screen Positive Rate for SDOH, we overall believe that that quality measures should account for risk factors such as lack of access to food, housing, and/or transportation that affect patients' ability to adhere to treatment plans. We are however concerned about the ability of emergency physicians to report this measure since ED systems do not always have access to records from other parts of the hospital. Without access to this data, this quality measure cannot be fully calculated and scored. We also note that this screening is done at the facility level, and it may be difficult for individual physicians to report the measure at the individual reporting level.

In addition, as stated above, many institutions have limited resources to conduct these types of screening on every patient. It may be more feasible to limit the screening to certain patients where it would yield the most benefit—for instance patients who are homeless or lack health insurance.

CMS requests comment on whether this measure should be mandatory for MVPs going forward as part of the foundational layer. We believe this measure should first be tested in the MIPS program before making it a required MVP measure. Furthermore, we have specific concerns about applying it to the emergency medicine-specific MVP, the Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP. The measures within the MVP target patients with high-acuity conditions who are often admitted to the hospital. When patients are admitted, this screening would usually be performed when they are discharged, and therefore the screening would not be conducted in the ED or captured in the ED record.

Beyond the emergency medicine specialty set, ACEP would also like to comment on the proposed modification to the "Initiation and Engagement of Alcohol and Other Drug Dependence Treatment measure." CMS is proposing to update the measure logic and logic definitions to remove emergency department visits and medically managed withdrawals from the negative lookback rules to align with the measure intent in part since CMS believes that "***the emergency department may not represent the best setting for the initiation of SUD treatment***…" (emphasis added).[39] ACEP notes that there is a plethora of evidence around the benefits of initiating medication assisted treatment (MAT) for the treatment of opioid use disorder (OUD) and other substance abuse disorders (including alcohol abuse disorder) in the ED. Many people rely on the ED for this life saving treatment, and we highlight some of evidence around the effectiveness of MAT previously in our previous response to the "Modifications Related to Medicare Coverage for OUD Treatment Services Furnished by OTPs" section of the rule. Thus, we question the rationale behind why CMS would include such a statement in the proposed rule.

**Cost Performance Category**

***ACEP encourages CMS to continue to develop episodes that capture the clinical screening, diagnostic testing, and stabilization work done by emergency physicians before a patient is admitted into the hospital.*** CMS' contractor, Acumen, convened a workgroup that developed an emergency medicine episode-based cost measure. ACEP nominated a few individuals to serve on that workgroup, and we are pleased that three ACEP

[39] Medicare and Medicaid Programs; CY 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicare and Medicaid Provider Enrollment Policies, Including for Skilled Nursing Facilities; Conditions of Payment for Suppliers of Durable Medicaid Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); and Implementing Requirements for Manufacturers of Certain Single-Dose Container or Single-Use Package Drugs To Provide Refunds With Respect to Discarded Amounts Proposed Rule. 87 Fed. Reg. 46764. (July 29, 2022).

members are participating in it—including as the chair of the workgroup. We are hopeful that this measure will be proposed in next year's rule for implementation starting in CY 2024.

ACEP is also concerned about CMS' decision to change the designation of the Medicare Spending Per Beneficiary (MSPB) clinician cost measure to a care episode group. We are concerned that this technical change could reduce urgency to develop new episode-based cost measures as classifying MSPB as a care episode group would help CMS achieve its statutory mandate to capture half of expenditures under Medicare Parts A and B via episode-based cost measures.

**Improvement Activities Performance Category**

CMS is proposing to add four new improvement activities, modify five existing improvement activities, and remove six existing improvement activities.

ACEP has comments on the following proposed changes:

***Removals***

- **PSPA 6: Consultation of the Prescription Drug Monitoring Program:** ACEP believes that it is imperative that this improvement activity continue to be utilized in light of our nation's opioid epidemic, as it allows emergency physicians to identify and protect patients at risk of opioid addition and/or overdose based on their past prescription history when issuing new controlled substance schedule II opioid prescriptions. However, we do note that some emergency physicians have trouble meeting the 90 percent threshold for this improvement activity, as it may be difficult and overly burdensome to review the history of controlled substance prescriptions using state Prescription Drug Monitoring Programs (PDMPs) for that high a percentage of patients.

  This measure is also integral to ACEP's opioid initiative under our Emergency Quality Network (E-QUAL). E-QUAL is a collaborative-driven, practice change network tailored to the unique environment of emergency medicine. Founded in 2015 as part of the CMS Transforming Clinical Practice Initiative, ACEP has rapidly grown E-QUAL to include over 1,000 EDs and 30,000 emergency clinicians in national learning networks focused on national health priorities that demonstrate the value of emergency care. It is designed to achieve higher quality patient outcomes at lower cost by creating and accumulating meaningful tools targeted at emergency clinicians and quality improvement leaders to advance local quality improvement efforts focused on high-impact areas that demonstrate the value of emergency care like reducing harm from opioids. E-QUAL is designed to study methods of quality improvement implementation and discover "what is working" to improve patient care.

- **PSPA 20: Leadership engagement in regular guidance and demonstrated commitment for implementing practice improvement change:** ACEP also opposes the removal of this measure. This improvement activity institutionalizes quality improvement within organizations by making it an explicit component of the leadership's role and responsibility. It also strengthens the commitment to care quality across the field of emergency medicine. E-QUAL celebrates the successes of institutions embarking on improving quality in their respective sites of which many are rural and critical access site. It is noteworthy that greater than 290 participating sites within E-QUAL (representing 18,000 clinicians who served over 15 million patients) claimed this valuable improvement activity credit in 2020 and 2021.

***Additions***

- **IA_PCMH: Electronic submission of Patient Centered Medical Home accreditation:** ACEP supports the addition of this measure. Achieving Patient-Centered Medical Home certification can lead to significant and sustainable practice improvements, including greater efficiency in the delivery of care and improved patient satisfaction, which are all directly related to improved health outcomes. Improved patient satisfaction across the house of medicine including emergency medicine directly correlates to establishing trust for our patient population.

- **Create and implement a plan to improve care for lesbian, gay, bisexual, transgender, and queer patients:** ACEP strongly believes that discrimination in any form should be prohibited in health care. Both by law and by oath, emergency physicians must care for all patients seeking emergency medical treatment. Denial of emergency care or delay in providing emergency services on the basis of race, religion, sexual orientation, gender identity, ethnic background, social status, type of illness, or ability to pay is unethical under the Code of Ethics as emergency physicians.

  We recognize that marginalized populations are more likely to experience social inequalities and health care disparities, which places vulnerable populations at a higher risk of mismanaged disease process and/or death. Lesbian, gay, bisexual, and transgender (LGBTQ) patients are not exempt from such disparities. We therefore believe that it is important to create plans to improve care for this population.

- **Create and implement a language access plan:** ACEP supports the addition of this measure. The likelihood for patients with communication barriers to suffer unnecessary pain, experience potential errors in medication administration, and have delays in emergency centered care is amplified when communication impediment is noted. While many large institutions have access to services such as translators or language lines, some hospitals may not have contingencies in place to address such barriers.

**<u>Promoting Interoperability</u>**

Although most emergency physicians are deemed hospital-based clinicians and are therefore exempt from the Promoting Interoperability performance category of MIPS, there are a few proposals on which ACEP would like to comment.

***Reporting Period***

ACEP supports CMS' proposal to maintain the 90-day performance period for the Promoting Interoperability category for CY 2023. Allowing physicians to choose any continuous 90-day period provides physicians the ability to select the performance period that best meets their needs—giving them flexibility to focus on patient care while still meeting CMS reporting requirements. We urge CMS to consider the long-term impact of the COVID-19 pandemic on physician medical practices, particularly those in small and rural settings, and to maintain the 90-day performance period going forward.

***Changes to the Query of Prescription Drug Monitoring Program Measure under the Electronic Prescribing Objective***

CMS is proposing to require MIPS eligible clinicians to report the Query of PDMP measure for the Promoting Interoperability performance category beginning in CY 2023. CMS is also proposing to expand the Query of PDMP

measure to include Schedule III and IV drugs in addition to Schedule II opioids.

ACEP is concerned with CMS' proposal to mandate and expand this measure simultaneously. We have historically supported CMS' proposals to keep the reporting of this measure optional. While ACEP believes that PDMPs have the potential to play an important role in addressing the opioid crisis as well as deaths related to other prescriptions drugs, they are still in the development stage. We are still learning about how to best implement PDMPs and their effectiveness. While some states have seen changes in prescribing behaviors, use of multiple providers by patients, and decreased substance abuse treatment admissions, the data are mixed. A systematic review of the effectiveness of PDMPs by Rhodes et al. concluded that there is limited evidence to support overall associations between PDMPs and reductions in opioid-related consequences.[40] It is unclear why opioid prescribing rates have been shown to decrease in some states after implementation of PDMPs, but no significant changes have been found in others. Studies on the effects of PDMPs on opioid overdoses have similarly been mixed with some studies finding no change in overdose following PDMP implementation and others finding an increase in overdose.[41] Part of the challenge is that there is a wide variation in how PDMPs are implemented in each state, including how they are integrated into EHRs and the time frame for updating new prescriptions. We think that CMS should move slowly to allow sufficient time for PDMPs to evolve and our understanding of best practices for their use to grow. An important step for PDMPs to reach their potential is to become fully integrated into clinicians' EHRs and their workflow. We support effective and interoperable PDMPs that push prescription data to emergency physicians, rather than requiring them to separately sign into and pull the data from the PDMP. Although all states host PDMPs, some states have not made commitments to make their PDMPs state-of-the-art, and as a result, they are cumbersome, may not contain real-time data, and contain potentially unreliable information. In addition, patients may cross state lines for care, and not all states are part of InterConnect, which shares interstate information about dispensed prescriptions. Finally, PDMPs may be an important tool for minimizing potential harm from prescription drugs but should work in tandem with other opioid prevention programs to maximize their impact.

***Promoting Interoperability Scoring***

CMS is making various proposals that would affect the scoring of the objectives and measures for the performance period in CY 2023. ACEP supports these changes, with the notable exception of the requirement to report the Query of PDMP measure—as noted above.

***Patient Access to Health Information Measure – Request for Information (RFI)***

CMS is seeking comments on how to further promote equitable patient access and use of their health information without adding unnecessary burden on clinicians. ACEP strongly supports patients' access to their health information. We also believe that all physicians have an ethical and legal duty to guard and respect the confidential nature of the personal information conveyed during the patient-physician encounter. We recognize that we are entering into a whole new world in terms of data sharing and consumer access to their health care information and that it is even more essential now to protect that information after the initial encounter.

[40] Rhodes, E., Wilson, M., Robinson, A. *et al.* The effectiveness of prescription drug monitoring programs at reducing opioid-related harms and consequences: a systematic review. *BMC Health Serv Res* 19, 784 (2019). https://doi.org/10.1186/s12913-019-4642-8.

[41] Dickson-Gomez J, Christenson E, Weeks M, et al. Effects of Implementation and Enforcement Differences in Prescription Drug Monitoring Programs in 3 States: Connecticut, Kentucky, and Wisconsin. Substance Abuse: Research and Treatment. January 2021. doi:10.1177/1178221821992349.

In addition, we are extremely cognizant of how access to information about patient encounters affects the physician-patient relationship The 21st Century Cures Act's information blocking and data sharing, implemented by the Office the National Coordinator (ONC) for Health Information Technology within the U.S. Department of Health and Human Services (HHS), require that patient notes, lab results, and other information be shared with patients—with some limited exceptions.

In May 2021, ACEP polled our members to gather emergency physicians' overall input on the data sharing requirements. The biggest issue flagged repeatedly in the poll was around the timing of the data sharing. Specifically, respondents reported significant unintended consequences associated with sharing notes and lab results immediately—before emergency physicians are able to discuss the results with their patients. Over two-thirds of respondents in the poll stated that lab results are shared immediately with patients once they are available (also interestingly, over 20 percent did not know when the results are shared with patients). According to these respondents, this policy of sharing notes immediately has caused patient confusion, anger, and sadness—with some extremely compelling examples, including patients who have found out they had cancer or a miscarriage without first being able to discuss their diagnosis with a physician. Further, there are numerous examples of patients misreading or misinterpreting clinical notes and lab results, causing physicians to have to spend significant time correcting those misconceptions and consoling patients. Patients also sometimes ask about trivial, incidental findings when it is probably best to spend time discussing their presenting complaint and key results.

Over three-quarters of respondents to ACEP's poll were concerned about liability (i.e., getting sued) when they share notes with patients. Added to that is a fear of the consequences of not sharing data and being penalized. Other related concerns are 1) accidentally causing patient harm (real, physical harm) by failing to block something (like injuries caused by partner violence) that could qualify for blocking; 2) causing non-physical harm by sharing something alarming or worrisome; and 3) being penalized or cited for blocking when it may well have been out of the physician's control. Overall, we expected more clarity and guidance by now about liability for information blocking – and how much individual providers might be on the hook for infractions versus institutional-level penalties.

Further, over 60 percent of respondents believed that these requirements caused them to spend more time on documentation. Roughly the same percentage of respondents also said that they have changed their documentation habits—including avoiding language that could potentially upset or confuse patients. Some respondents said that their notes are shorter, but it takes longer to write them.

ACEP is also concerned with the ability for patients to see personal information from physicians and other members of the clinical team including personal cell phone numbers that may be included in the medical record. This personally-identifiable clinician information should not be shared with patients—particularly in light of the growing number of cases of reported violent episodes in the ED and other health care settings.

Although these regulations have been implemented by ONC, we believe that CMS also plays an important role in ensuring that information is shared with patients in a safe and productive way. For example, one specific question that CMS poses is whether there are potential unintended consequences in allowing patients to add information to their records. We strongly believe that physicians should be notified when patients access their health records and request that changes be made to their medical records. If patients do not like or agree with certain language in their medical record, then they should be able to speak to their physician without being first allowed to make changes or additions. There could be specific clinical reasons why a medical record is worded the way it is and allowing patients to make changes could in some cases result in unintended alterations that could impact their care in the future.

**MIPS Final Scoring Methodology**

***Scoring Administrative Claims Measures in the Quality Performance Category Using Performance Period Benchmarks***

Beginning with the CY 2023 performance period/2025 MIPS payment year, CMS is proposing to score administrative claims measures using performance period benchmarks. CMS believes that using a performance period benchmark to score these measures would allow for scores that are more reflective of current performance, while adding no additional burden to clinicians. ACEP is concerned that using performance year benchmarks would make it impossible for clinicians to know ahead of time what each measure's performance benchmark is and may therefore make it more difficult to improve performance on the measure year after year.

***Assigning Measure Achievement Points for Topped Out Measures***

ACEP appreciates CMS' clarification that when a measure is suppressed or had its performance period truncated because of a substantive change or a change in clinical guidelines, the topped-out measure resets entirely the year following the change. We agree that it is appropriate to reset the topped-out measure, since there is no longer a historical benchmark with which to compare the measure for the purpose of determining whether it is topped out.

***Cost Performance Score***

CMS is proposing to establish a maximum cost improvement score of one percentage point for the cost performance category beginning with the CY 2022 performance period/2024 MIPS payment year. ACEP does not support this proposal and believes that CMS should increase the maximum cost improvement score to at least five percent. The Cost Category is currently 30 percent of the total MIPS score, and therefore performance on the attribute cost measure(s) has a significant impact on a clinician's MIPS score. Currently, the main cost measure that some emergency physicians are accountable for in MIPS is the Medicare spending per beneficiary (MSPB) clinician measure. The MSPB measure captures the "cost of services performed by hospitals and other healthcare providers during the period immediately prior to, during, and following a beneficiary's hospital stay." It attributes all Medicare Part A and B costs occurring in the episode window to the clinician(s) responsible for care—which could end up indirectly being an emergency physician. In the past, ACEP has argued that this measure does not appropriately reflect costs of services that are controlled by emergency physicians, as emergency physicians are not the physicians who are driving the cost of care during a hospital stay. Many emergency physicians do not know how they are attributed to the measure and feel helpless to improve their performance. They also do not receive timely feedback on the measure. As described above, we are excited about the potential of an emergency medicine-specific cost measure that could be implemented as soon as CY 2024. However, in the meantime, CMS must increase transparency in terms of how the measure is calculated and physicians' performance on the measure. Further, CMS must increase incentives, including the improvement bonus, for performing well on cost measures.

***Calculating the Final Score***

*Complex Bonus*

**ACEP strongly supports the proposal that a facility-based MIPS eligible clinician would be eligible to receive the complex patient bonus, even if they do not submit data for at least one MIPS performance category. We urge CMS to finalize the proposal.**

*Facility-based Scoring Option*

In the Fiscal Year (FY) Inpatient Prospective Payment System (IPPS) final rule, CMS stated that it will suppress measures under the Hospital Value-Based Purchasing Program (HVBP) in FY 2023. CMS instituted a similar policy last year, and hospitals again will not receive a HVBP score and will not be eligible for any positive or negative payment adjustments based on their performance in the program.

ACEP is disappointed that CMS again has decided to eliminate the facility-based scoring option under MIPS in 2022. In order to protect hospital-based clinicians that depend on this option, ACEP strongly believes that CMS should reverse that decision and provide hospital-based clinicians a viable opportunity to utilize this option. CMS could consider using an HVBP score from a prior year in order to determine a MIPS eligible clinician's facility score. If CMS is not able to use other data to determine a facility score, then CMS should create a hold harmless provision to ensure that hospital-based clinicians are not penalized and do not receive a downward adjustment simply because a facility score is not able to be calculated.

In this rule, CMS does include some proposals to strengthen the facility-based scoring option including making facility-based MIPS eligible clinicians eligible for the complex bonus (discussed above) and expanding eligibility to include virtual groups. ACEP supports this effort but believes that more action needs to be taken. While many hospital-based clinicians do report traditionally through MIPS and do not solely rely on the facility-based scoring option, some clinicians, especially those in small practices and those located in rural areas, may count on the facility-based scoring option in order to receive the best possible MIPS performance score. In some cases, these clinicians do not have the resources or technological capability to report quality measures through an EHR, registry, or QCDR. In addition, there are other circumstances where hospitals are simply not sharing EHR data elements with QCDRs that are necessary for MIPS reporting. In fact, a substantial number of emergency physicians that use ACEP's QCDR, CEDR, to report quality measures are unable to receive any data from their hospitals. Without these data elements, the quality measures cannot be fully calculated and scored. Hospitals may claim that they cannot share the data for privacy and security purposes, but there are no regulations that impede hospitals from doing so. Thus, these hospital-based clinicians may also need to rely on the facility-based scoring option unless CMS takes more concrete going forward to help improve data exchange between hospital EHRs and registries.

*Performance Threshold*

CMS is proposing to set the performance threshold in 2023 at 75 points, the same as the 2022 performance threshold. ACEP notes that there is no exceptional bonus threshold starting in the 2023 performance period. The 2022 performance period (which impacts payments in 2024) was the last year the additional funding for exceptional performance was available.

In the Impact Analysis of the rule,[42] CMS believes that approximately a third of MIPS eligible clinicians would receive a negative payment adjustment for the CY 2023 performance period/2025 MIPS payment year if the proposal is finalized and the performance threshold is equal to 75 points.

ACEP supports this proposal, as we do not believe that CMS should increase the performance threshold above the 2022 threshold. The COVID-19 pandemic has affected MIPS participation for the last two years, and it is unclear how COVID-19 will impact MIPS reporting in 2022 or even in 2023. There is already an Extreme and Uncontrollable

[42] 87 Fed. Reg. 46415. (July 29, 2022).

Circumstances Exception application in 2022, and if there is no such exception process in place in performance year 2023, that year may be the first time since performance year 2018 that some clinicians would report in MIPS. Therefore, we feel that it is appropriate to slowly ramp up the performance threshold over time.

**Qualified Clinical Data Registries (QCDRs)**

QCDRs are third-party intermediaries that help clinicians report under MIPS. As stated previously, ACEP has its own QCDR called CEDR. CMS has separate policies governing QCDRs and the approval of QCDR measures. In general, ACEP believes that CMS should do more to promote the use of clinical data registries. One major ongoing issue for specialists is not being able to report on measures that are meaningful to them. Emergency physicians have experienced this problem in the past, and that is specifically why ACEP developed CEDR. Through CEDR, ACEP reduces the burden for our members and makes MIPS reporting a meaningful experience for them. We strive to make reporting as integrated with our members' clinical workflow as possible and constantly work on improving their experiences and refining and updating our measures so that they find value in reporting them. We have found that if our members can report on measures that are truly clinically relevant, they become more engaged in the process of quality improvement. For each measure we develop, a Technical Expert Panel comprised of clinical, measurement, and informatics experts in the field of emergency medicine is assembled, and several criteria are considered when designing a measure, including each measure's impact on emergency medicine, as well as whether the measures are scientifically acceptable, actionable at the specified level of measurement, feasible, reliable, and valid. Through our work and partnership with CMS, ***we are proud to be a certified QCDR and have helped tens of thousands of emergency physicians participate successfully in MIPS.***

QCDRs have proven to be an excellent way to collect data and report quality measures. QCDR measure owners invest significant resources into measure development, data collection, and validation. Additionally, QCDR measure owners develop these measures for use beyond MIPS reporting (e.g., research, guideline development, quality improvement, etc.). Section 1848(q)(5)(B)(ii)(l) of the Social Security Act, as added by Section 101 of the Medicare Access and CHIP Reauthorization Act (MACRA), requires HHS to encourage the use of QCDRs to report quality measures under MIPS. This is why we strongly believe, in line with this statutory requirement, that ***CMS should continue to refine the QCDR option under MIPS to streamline the self-nomination process and provide better incentives for organizations, including medical associations such as ours, to continue to invest in their QCDRs and develop new, meaningful measures for specialists to use for MIPS reporting and other clinical and research purposes. Conversely, CMS should refrain from finalizing proposals that would impose significant and unreasonable burdens on QCDRs.***

In this year's rule, CMS includes the following proposals:

***QCDR Measure Self-Nomination Requirements***

CMS is proposing to clarify the requirements for publicly posting the approved measure specifications. Specifically, CMS is proposing to revise the language such that entities must publicly post measure specifications no later than 15 calendar days following CMS's posting of approved QCDR measure specifications on a CMS website and that QCDRs need to confirm that the measure specifications they post align with the measure specifications posted by CMS. ACEP appreciates the clarification and supports the proposal.

***QCDR Measure Approval Criteria***

CMS proposes to revise its QCDR measure approval requirements by delaying the requirement for a QCDR measure to be fully developed and tested with complete testing results at the clinician level until the CY 2024 performance year. Under this proposal, a QCDR measure approved for the CY 2023 performance year or earlier would not need to be fully developed and tested until the CY 2024 performance year. A new QCDR measure proposed for the CY 2024 performance year would be required to meet face validity.

ACEP supports this proposal. While testing measures and ensuring their validity is critical, we believe that the QCDR testing requirements are stringent, place a significant burden on QCDRs, and make it difficult for some smaller QCDRs to continue participating in the MIPS program. We also believe that, because the COVID-19 Extreme and Uncontrollable Circumstances Exception policy decreased the number of groups reporting to MIPS via QCDRs, CMS should only require face validity for the first two MIPS payment years for which the measures are approved or until two years after the end of the COVID-19 PHE, whichever is later. We also think that QCDR statisticians familiar with sample sizes and populations should decide the level of testing (clinician, facility, or group) required.

In addition, we request that CMS also delay the testing requirements for measures in MVPs. The development and testing process for measures is a lengthy and costly process and will inhibit the ability of new measures to be incorporated into MVPs.

***Remedial Action and Termination of Third-Party Intermediaries***

In the rule, CMS proposes one revised and one new requirement for Corrective Action Plans (CAPs) and proposed termination of certain approved QCDRs and Qualified Registries that continue to fail to submit performance data. ACEP does not support these proposals and believes it is premature to institute such a policy given the impact COVID-19 has had on MIPS participation and QCDR stewards. Many QCDRs halted reporting at various times over the last few years due to the stop in elective surgeries and surge in COVID cases, which has greatly impacted reporting. We urge CMS to revisit this policy.

***Request for Information on Third-Party Intermediary Support of MVPs***

Given public comments on the challenges of the current requirement to support all quality measures within an MVP, CMS is requesting input on the following:

> ***Should third-party intermediaries have the flexibility to choose which measures they will support within an MVP?***

ACEP believes that QCDRs play a crucial role in helping clinicians meet the MIPS reporting requirements and will therefore be instrumental in the overall success of MVPs. In order to maximize participation in MVPs, QCDRs should have the capability of supporting all the QPP measures within the MVP and all the QCDR measures that they own or for which they have a licensed agreement with the measure owner. We do note that QCDRs are not required to support QCDR measures owned by another QCDR if they have not obtained permission to use such measure. In other words, QCDRs do not need to support all QCDR measures in an MVP if they did not steward the QCDR measure. If a QCDR intends on supporting all QCDR measures, it must first obtain permission to use any QCDR measure owned by another QCDR. Further, a QCDR is not required to grant permission to other QCDRs to use their measures.

***What are the barriers/burdens that third party intermediaries face to supporting all measures within an MVP?***

Maintaining and operating a QCDR is expensive, and smaller QCDRs may find it cost-prohibitive to support all measures within an MVP.

***What type of technical educational resources would be helpful for QCDRs, qualified registries, and Health IT vendors to support all measures within an MVP?***

ACEP appreciates the technical support and educational resources that CMS provides to QCDRs. However, as discussed above, we urge CMS going forward to streamline the self-nomination process and refrain from placing significant and unreasonable burdens on QCDRs.

***Request for Information on National Continuing Medical Education (CME) Accreditation Organizations Submitting Improvement Activities***

Currently, the only entities that are permitted to submit attestations on behalf of clinicians are third-party intermediaries which includes QCDRs, qualified registries, health IT vendors, and CMS-approved survey vendors. CMS is considering approaches to including CME accreditation organizations as third-party intermediaries; however, the current third-party intermediary policies do not allow third-party intermediaries to submit data solely for the Improvement Activities performance category.

ACEP supports this option, as it provides another avenue for clinicians to receive support complying with MIPS requirements. We do however believe that if this option is added, clinicians should be made aware that CME Accreditation Organizations can only help them meet one performance category, and they will need to find a different method of reporting or third-party entity to meet the Quality (and, in some cases, Promoting Interoperability) Categories.

**Public Reporting**

ACEP continues to be concerned that all quality measures reported by clinicians are included in the Compare rating. Under MIPS, clinicians have an incentive to report more than the six required measures since CMS will count the six with the highest scores. While CMS does not penalize clinicians who want to report on more than six measures, the Compare website provides the inverse incentive by counting and publicly reporting on every measure a clinician reports in their rating. Therefore, if clinicians report more than six measures and do poorly on one measure, their MIPS score will not be impacted, but their Compare rating will be. Clinicians should not be penalized for submitting to CMS more data than what is required. Besides the impact on clinicians, we believe CMS should strive to get as complete data as possible to improve quality and patient safety and therefore should want to incentivize clinicians to report on as many measures as possible.

We are also concerned that clinicians will only report on measures they perform well on due to the disincentive to report more than six measures. Due to this disincentive, CMS is only seeing a small subset of performance for any measure, and a subset that will be skewed to high performance. This may cause CMS to judge these measures to be "topped out" when in fact the majority of clinicians are not reporting on those measures due to the continuing need for improvement. It is in CMS' interest for the health of patients to encourage physicians to continue to improve in those areas, rather than drop the measure for reporting. Dropping measures unnecessarily also increases physician

burden (having to retool reporting systems) and increases costs to CMS (having to both develop and review new measures) as well as to measure stewards.

In this year's rule, CMS proposes to identify clinicians who perform telehealth services using Place of Service Code 02 (indicating telehealth) on paid physician and ancillary service (that is, carrier) claims or modifier 95 appended on paid claims. While ACEP supports this concept, we believe that the indicator seems more applicable to primary care and specialist in the ambulatory clinics than to emergency physicians. While emergency physicians do provide telehealth services, patients looking for emergency physicians would likely be seeking in-person care. However, as telehealth opportunities expand in emergency medicine, this indicator may come more helpful to patients as there may be more emergency physician practices that offer a telehealth version of an ED visit.

**Advanced APMs**

As stated above, while many emergency physicians are ready to participate in APMs, they do not have many opportunities to do so. In order to fill this gap in available emergency medicine APMs, ACEP developed the emergency medicine-specific APM, the Acute Unscheduled Care Model (AUCM). ACEP is still waiting for CMS to incorporate elements of the model into existing APMs—and in the meantime, most emergency physicians participate in MIPS rather than Advanced APMs.

With that context, we would like to offer the following comments.

***RFI on QPP Incentives Beginning in PY 2023***

After performance year 2022, which correlates with payment year 2024, there is no further statutory authority for a five percent APM Incentive Payment for eligible clinicians who become Qualifying APM Participants (QPs) for a year. In performance year 2023, which correlates with payment year 2025, the statute does not provide for any type of incentive for eligible clinicians who become QPs. Beginning in CY 2026, there is a separate conversion factor update for clinicians who participate in MIPS and those that are QPs. The conversion factor update for clinicians who are QPs is 0.75 percent, and the update for clinicians who are not QPs (and therefore must participate in MIPS) is 0.25 percent.

CMS believes that after CY 2026, clinicians who participate in MIPS and receive a positive MIPS adjustment (in addition to the general 0.25 percent conversion factor adjustment they will receive) may actually receive a higher overall payment under the PFS than those who participate in Advanced APMs and only receive a 0.75 percent conversation factor increase. CMS is therefore concerned that there may be more of an incentive to participate in MIPS than Advanced APMs.

While ACEP shares CMS' concerns about the relative incentive between participating in MIPS and being in Advanced APMs, we believe it is important to reiterate that many specialists do not even have an opportunity to participate in Advanced APMs in the first place. It is therefore unfair to specialists that they had no reasonable chance to ever qualify for the now-expired five percent APM incentive payment. CMS should make it a priority to work with Congress on extending the five percent bonus.

We also note that extending the five percent bonus would create a better incentive for large health care systems that are already participating in Advanced APMs to continue to do so and not decide to revert back to the MIPS program. Since these organizations have more staff and technological resources to manage and report metrics to CMS, they

tend to score much better than small and independent practices in MIPS. If all these organizations believe that they can fare better financially by participating in MIPS than in an Advanced APM and therefore stop participating in APMs, then MIPS scores will become heavily skewed and only these organizations will receive positive payment adjustments. In other words, these organizations will benefit at the expense of small and independent practices. This trend will not necessarily result in an increase in quality or a decrease in costs—which is the goal of MIPS—but may actually exacerbate health outcomes since smaller practices that care for underserved populations may wind up receiving downward payment adjustments.

***Request for Information: Potential Transition to Individual QP Determinations Only***

CMS is requesting public comment on the idea of transitioning away from an APM Entity level QP determination and instead calculating Threshold Scores and making QP determinations at the individual eligible clinician level for all eligible clinicians in Advanced APMs and Other Payer Advanced APMs. CMS believes making QP determinations at the individual eligible clinician level may have several benefits over the current policy.

ACEP understands the rationale CMS articulates for possibly transitioning away from APM Entity level QP determination and instead calculating Threshold Scores and making QP determinations at the individual eligible clinician level. We are however concerned about the impact of such a methodology change on the ability for specialists to become QPs. Although not many specialists currently participate in APMs, it is difficult for specialists who do to meet the QP threshold. This methodology change could make it even more challenging since specialists on their own may not be able to treat enough patients or have enough of their services covered under the APM to meet the high QP patient count or payment thresholds. If the goal is to eventually create more opportunities for specialists to participate in APMs, any QP methodology that CMS implements must ensure that it does not disadvantage specialists and thereby discourage them from participating in APMs.

We appreciate the opportunity to share our comments. If you have any questions, please contact Jeffrey Davis, ACEP's Director of Regulatory and External Affairs at jdavis@acep.org.

Sincerely,

Gillian Schmitz, MD, FACEP

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ACEP President