American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

September 9, 2024 **CMS-1807-P**

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Medicare and Medicaid Programs; CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayment

Dear Administrator Brooks-LaSure:

On behalf of our nearly 40,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to comment on 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 9.

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Executive Summary of Comments

The Physician Fee Schedule

- ***Unsustainable payment rates and inadequate short-term fixes:*** In this proposed rule, the Centers for Medicare & Medicaid Services (CMS) proposes a physician fee schedule (PFS) conversion factor of $32.3562, a decrease of $0.93 or -2.8% percent from the calendar year (CY) 2024 PFS conversion factor of $33.2875. If such a reduction is finalized, emergency physicians would experience the full impact of that reduction, due to the expiration of the 2.93 percent patch implemented by Congress in the Consolidated Appropriations Act of 2023 (CAA, 2023) and the CAA, 2024. This would be layered over the pending sequestration cuts, compounding the decrease in payment even further. Year after year, physicians are subject to payment cuts that are simply unsustainable and, without intervention, will cause access to Medicare-participating physicians to become a significant issue in the long term. We request that CMS do everything within its authority to mitigate the reduction and recognize that the complete resolution of this issue will require action by Congress; we therefore urge the agency to work with Congress on a permanent fix to the broken Medicare payment system.

- ***Determination of Practice Expense (PE) Relative Value Scale Units (RVUs)***
  - *Adjusting RVUs To Match the PE Share of the Medicare Economic Index (MEI):* The MEI reflects the weighted-average annual price change for various inputs involved in delivering physicians' services. In this proposed rule, CMS is proposing to continue delay of implementation of the finalized 2017-based MEI cost share weights for the RVUs to be consistent with their efforts to balance payment stability and predictability with incorporating new data through more routine updates. ACEP continues to support CMS' ongoing delay in the implementation of the MEI cost-share weights, as the PFS conversion factor and physician payment rates must first be stabilized.

  - *Development of Strategies for Updates to Practice Expense Data Collection and Methodology:* CMS seeks comment currently on the approaches that utilize independent data from third-party sources who are not market stakeholders to prevent bias in the information collected in the American Medical Association (AMA) physician practice information survey (PPIS), to calculate practice expense costs. Overall, ACEP supports the current AMA PPIS and Relative Value Scale Update Committee (RUC) process, as we believe it is fair and balanced, and we are opposed to making changes that could distort the value of codes under the PFS.

- ***Telehealth Services***
  - *Changes to the Medicare Telehealth Services List:* CMS does not propose any changes to the approved telehealth list through December 31, 2024, wherein all five emergency department (ED) evaluation and management (E/M) code levels 1-5 (CPT codes 99281-99285), the critical care codes, and the observation codes are set to expire. ACEP supports keeping these emergency medicine codes on the Medicare Telehealth Services List through at least the end of CY 2025, and we encourage CMS to consider keeping these codes permanently on the Medicare Telehealth Services List going forward.

  - *Other Non-Face-to-Face Services Involving Communications Technology under the PFS:* CMS is proposing further telehealth flexibilities concerning the definition of direct supervision and allowing physicians to use audio/video communications technology when a resident furnishes Medicare telehealth services in all residency training locations through the end of CY 2025. ACEP continues to support CMS's flexibility regarding supervision requirements as it allows for the extended reach of board-eligible or board-certified emergency physicians to rural and underserved populations in areas of the country where there may not be any such physicians available.

- ***Valuation of Specific Codes***
  - *Telemedicine E/M Services:* CMS is proposing NOT to adopt the new Current Procedural Terminology (CPT) codes for reporting telemedicine E/M services, as CMS believes that such services already have a more specific code that should be used for purposes of Medicare. ACEP appreciates CMS' recognition of the work that the AMA RUC put into drafting the telemedicine E/M services codes, as we were one of the specialty societies involved in this process, and we support the future valuation of these services.

  - *Request for Information for Services Addressing Health-Related Social Needs:* CMS is soliciting broad comments on last year's finalized G-codes for coding and payment services for services addressing health-related social needs and for administration of a social determinants of health (SDOH) risk assessment. ACEP encourages the agency to consider broadening the scope of the codes and to work with other payers to adopt them for their patient populations. Further, we note that despite the disproportionate representation of social vulnerability

in so many ED patients, most EDs do not currently have the necessary resources to initiate interventions on SDOH for their patients, making them unable to bill the new codes, even though these services would positively impact their patients.

- ***E/M Visits: Office/Outpatient (O/O) E/M Visit Complexity Add-on:*** In last year's rule, CMS finalized HCPCS code G2211, or the "add-on code for complexity." CMS is now proposing an expansion in the use of the code when the office and outpatient (O/O) E/M base code is reported by the same practitioner on the same day as other types of visits furnished in the office or outpatient setting. ACEP cautions CMS against expanding the usage of this code. We have numerous concerns about the lack of need for the code, the lack of clarity of when to bill for the code, and CMS' failure to go through the normal CPT process to create the code.

- ***Enhanced Care Management:*** CMS is proposing to establish coding and make payment under the PFS for a new set of advanced primary care management (APCM) services described by three new HCPCS G-codes. ACEP supports CMS' effort to incentivize the delivery of advanced primary care services to Medicare beneficiaries. However, we do believe that CMS, at the same time, should recognize that promoting primary care alone will not resolve all the issues facing our health care system. In addition to supporting primary care, CMS should also be supporting the safety net, and that includes establishing the necessary resources and incentives to ensure safe transitions from the ED.

- ***Advancing Access to Behavioral Health Services***
  - *Safety Planning Interventions (SPI) and Post-Discharge Telephonic Follow-up Contacts*
    - SPI: CMS is proposing to establish an add-on G-code (GSPI1) for interventions initiated or furnished in the ED or other crisis settings for patients with suicidality or at risk of suicide. ACEP appreciates CMS' efforts to address the issue of increased deaths by suicide amongst the Medicare population through SPI. While we agree that SPI requires training and expertise, ACEP urges CMS to allow the code to be performed by trained clinical staff under the supervision of a licensed physician/mental health practitioner.

    - Post-Discharge Telephonic Follow-Up Contacts Intervention (FCI): CMS is proposing to create a monthly billing code (GFCI1) to describe the specific protocols involved in furnishing post-discharge follow-up contacts that are performed in conjunction with a discharge from the ED for a crisis encounter. ACEP supports the inclusion of an add-on code; however, the availability of resources varies widely from ED to ED and community to community. Thus, while this code could improve patient outcomes, it is imperative that less-resourced EDs are not penalized because they do not have the same monetary resources or staffing availability as other facilities.

  - *Comment Solicitation on Payment for Services Furnished in Additional Settings, including Freestanding Substance Use Disorder (SUD) Treatment Facilities, Crisis Stabilization Units, Urgent Care Centers, and Certified Community Behavioral Health Clinics (CCBHCs)*
    - Freestanding SUD Treatment Facilities: CMS seeks comment to determine whether potential coding and payment for IOP services under the PFS would facilitate these services being billed in additional settings. ACEP believes that freestanding SUD facilities and other entities that furnish IOP services serve an important function in their communities and thus should have a sustainable structure for reimbursement because of their vital role in treatment engagement.

- Crisis Stabilization Units: CMS is interested in feedback on the operations and services provided at crisis stabilization units. Innovative approaches such as crisis stabilization units have helped communities improve coordination of emergency psychiatric care, and they can serve as models for other communities to implement and build upon to help alleviate the overall load on the mental health care system and emergency psychiatric boarding.

- Urgent Care Centers: CMS is interested in feedback on the types of services alternatives to EDs should offer to meet beneficiaries' non-emergent, urgent care needs as well as system capacity and workforce issues broadly. ACEP appreciates the important role that non-emergency facilities, such as urgent care centers, can play treating patients. However, it is essential to preserve the fundamental right for patients to seek emergency care when they think they are experiencing a medical emergency. As CMS contemplates the role of urgent care centers, we would encourage CMS to consider how best to educate beneficiaries about when they should seek emergency treatment, their right to do so, and when another setting such as an urgent care center may be appropriate to address their health care needs. ACEP continues to believe that physician-led care teams offer the highest quality of care, and every urgent care should seek to have an emergency physician on staff. In the setting of physician-led teams, urgent care should be capable of caring for the full range of non-life-threatening conditions.

- ***Medicare Payments for Dental Services:*** CMS proposes to add to the list of clinical scenarios under which fee-for-service Medicare payment may be made for dental services inextricably linked to covered services. 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. However, we express caution to CMS about how it decides to finance any additional services under Medicare Parts A and B in the future.

- ***Modifications Related to Medicare Coverage for Opioid Use Disorder (OUD) Treatment Services Furnished by Opioid Treatment Programs (OTPs)***
  - *Telecommunications Flexibilities*
    - Audio-Only Periodic Assessments: CMS is proposing to extend telemedicine flexibilities to allow periodic assessments to be furnished using audio-only communication technology for the initiation of treatment with buprenorphine on a permanent basis. ACEP is supportive of proposals that expand access to services and reduce regulatory access barriers to OUD treatment and we encourage CMS to continue working with the Substance Abuse and Mental Health Administration (SAMHSA) and the Drug Enforcement Agency (DEA) to permanently extend telehealth flexibilities for non-OTP practitioners. However, as CMS expands flexibilities for audio-only services, the agency should be mindful of the implications of this expansion on budget neutrality.

    - Proposal to Allow OTPs to Use Audio-Visual Telecommunications for Initiation of Treatment with Methadone: CMS is proposing to allow the OTP intake add-on code (HCPCS code G2076) to be furnished via two-way audio-video communications technology when billed for the initiation of treatment with methadone. Given the proven success of providing medications for opioid use disorder (MOUD) for the treatment of OUD, ACEP supports the additional flexibility allowing for the conduction of initiation via telehealth.

- *Proposals Related to Reforms to 42 CFR Part 8:* CMS proposes to update payment for intake activities furnished by OTPs to include payment for SDOH assessments. ACEP supports this proposal and urges CMS to finalize it as proposed, as OTPs can more easily capture data from populations who experience health inequities more acutely, and there should be reimbursement mechanisms in place to screen for and coordinate care for unmet social needs.

- ***Medicare Shared Savings Program (MSSP):*** CMS proposes a number of new MSSP policies, including establishing a new prepaid shared savings option, modifying the financial methodology to encourage participation, aligning quality measure reporting with the Universal Foundation of quality measures, and accounting for the impact of certain improper payments in performance year and benchmark expenditures. ACEP overall supports these proposals, as we believe that they will help increase participation in accountable care organizations (ACOs) and enable ACOs to focus more on underserved populations. However, we note that not many emergency physicians directly participate in the MSSP, and we urge CMS to create additional incentives for specialists, like emergency physicians, to get engaged in the MSSP and other ACO initiatives.

- ***Medicare Payment for Preventive Services:*** CMS is proposing to revise and expand coverage of these preventive vaccines through various policies. Vaccinations may ultimately reduce unnecessary ED utilization and lead to improved health outcomes. Offer and administration of preventive services within the ED however entails thoughtful consideration of ED capacity and community needs, including consideration of evidence-based strategies; consideration of local disease and risk factor epidemiology; and attention to capacity.

- ***Request for Information: Building upon the MIPS Value Pathways (MVPs) Framework to Improve Ambulatory Specialty Care:*** CMS is considering a model design that would increase specialty participation in APMs by leveraging the MVP framework. CMS is soliciting comments on several parameters of the model, including considering mandatory participation of relevant specialty care providers to overcome challenges such as selection bias and participant attrition. ACEP supports the general concept of creating a specialty care model but strongly opposes the idea that such a model require participation by certain physicians. We also offer more general comments on MVPs and APM frameworks.

- ***Low Titer O+ Whole Blood Transfusion Therapy During Ground Ambulance Transport:*** Under the Ambulance Fee Schedule (AFS), Medicare Part B covers seven levels of service for ground (including water) ambulance transports, including advanced life support, level 2 (ALS2). CMS proposes to modify the definition of ALS2 by adding the administration of low titer O+ whole blood transfusion (WBT) to the current list of ALS2 procedures. ACEP appreciates CMS' proposal and requests that universal whole blood products – including O- as well as O+ - be added under ALS2 as well as blood component therapies that are used as alternatives when whole blood products are unavailable.

The Quality Payment Program

- ***Transforming the Quality Payment Program:*** CMS is considering several approaches that would assist in making MIPS Value Pathways (MVPs) available to all Merit-based Incentive Payment System (MIPS) eligible clinicians. However, all approaches to be more inclusive of clinicians are hindered by the existing gaps in quality and cost measures. ACEP believes it may be premature to consider the transition to MVP, as there has been limited uptake of the MVP based upon the reporting trends from last year. We believe that the primary reason

why so few emergency physicians have reported the emergency medicine MVP is because there are not sufficient incentives in place that would encourage them to do so. Further, whilst we see the value of MVPs as a reporting option and acknowledge that broader participation in MVPs supports CMS' long-term goal to transition clinicians to participate in APMs, we have concerns about the ambiguous and dubious pathways that will transition clinicians from MVP participation to APM participation.

- *Barriers to Submitting MVPs:* There are several barriers for clinicians to participate in MVPs that are both perceived and actual, and both operational and financial. For many clinicians, these obstacles to MVP participation simply outweigh the benefits from reporting. We offer several suggestions in our response for additional incentives that CMS could offer to encourage clinicians to participate in MVPs.

- *Meaningful MVP Participation:* CMS asks if the agency should consider developing a more global MVP with broadly applicable measures as an interim bridge for those clinicians with too few specialty-specific quality measures. ACEP supports a generic MVP approach with certain parameters. Further, we appreciate the flexibility that a more global MVP would provide so more clinicians can participate in the MVP reporting process.

- *Subgroup Reporting:* CMS seeks comment on the technological and operational barriers that impact the ability to successfully submit subgroup level data. ACEP believes that subgroup reporting should be optional for the foreseeable future. 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.

- ***MVP Development, Maintenance, and Scoring***
  - *Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP:* ACEP developed an emergency medicine-focused MVP called the "Adopting Best Practices and Promoting Patient Safety within Emergency Medicine" MVP. We are pleased that in the CY 2022 PFS final rule, CMS finalized this MVP—and that CMS continues to refine the MVP as needed.

  - *MVP Requirements and Scoring:* CMS is proposing to update the registration process and scoring policies for population health measures in the quality performance category, clarify the alignment between scoring cost measures in MVPs and traditional MIPS, update requirements and scoring policies in the improvement activities performance category, and update the requirements for subgroup reporting in the promoting interoperability performance category. While ACEP has concerns about the use of population measures in MVPs, we support CMS' proposal to use the highest score attributable to clinicians.
    - Data Submission in the Quality Performance Category – Multiple Data Submission in the Quality and Improvement Activities Performance Categories: CMS proposes to codify that if the agency receives multiple submissions for an individual clinician, group, subgroup, or virtual group for the quality or improvement activities performance from submitters from separate organizations, the agency scores each and assigns the highest of the scores for the performance category. If multiple submissions are received from the same organization, then CMS will use the most recent submission. ACEP does not support CMS' proposal to codify existing policy on the treatment of multiple data submissions for the quality and improvement activities category when multiple submissions are received from the same organization, and CMS should maintain its existing policy to assign the highest score.

- ***MIPS Performance Category Measures and Scoring***
  - *Quality Performance Category*
    - Data Completeness Criteria: CMS proposes to maintain the current data completeness threshold at 75 percent through the 2028 performance period to create stability in quality reporting requirements. ACEP supports this proposal, as we believe that physicians and group practices are already being held to a high bar, and it is challenging for some emergency physicians to even reach the current 75 percent data completeness threshold due to current market factors.

    - Modifying the MIPS Quality Measure Set: CMS is proposing to reduce the inventory of quality measures from 196 to 194 through the removal of 11, addition of nine, and editing of 66 MIPS quality measures (a net decrease of two quality measures). For the emergency medicine specialty set, CMS is proposing the removal of two measures and the addition of one measure.

  - *Cost Performance Category:* CMS proposes a significant potential change to the cost scoring methodology starting in the 2024 performance period/2026 MIPS payment year wherein the agency would use a new distribution for cost scoring in which the median cost for a measure would be set at a score derived from the performance threshold established for that MIPS payment year. They also propose an established process for removing MIPS cost measures. Overall, ACEP appreciates CMS' efforts towards improving the scoring process, as by design, only half of clinicians who submit MIPS scores receive a positive adjustment. However, these reforms do not resolve the core deficiencies of the category.

  - *Improvement Activities Performance Category:* CMS is proposing to add two new improvement activities, modify two existing improvement activities, and remove eight previously adopted improvement activities for the CY 2025 performance period/2027 MIPS payment year (a net decrease of six). CMS is also proposing two scoring and reporting policy modifications. ACEP supports these proposals, as we believe that the current designation of weights for improvement activities is artificial and does not actually correlate with the value of the activity to both clinicians and their patients.

  - *Promoting Interoperability Performance Category:* Though most emergency physicians are deemed hospital-based clinicians and therefore exempt from the promoting interoperability performance category, there are a few questions in the request for information (RFI) in which ACEP offers comments in this section.
    - RFI Regarding Public Health Reporting and Data Exchange: CMS is exploring how the Promoting Interoperability performance category could advance public health infrastructure through more advanced use of health IT and data exchange standards. They set forth a series of goals and principles for the performance category's Public Health and Clinical Data Exchange objective, provide information about recommended updates to health IT certification criteria and seek public comment on potential updates that could help achieve these goals. ACEP offers comments around numerator/denominator reporting requirements, improvement of public health readiness via enhanced interoperability, and reducing reporting burden for clinicians.

- ***MIPS Final Scoring Methodology***
  - *Topped Out Measures:* CMS proposes to, beginning with the CY 2025 performance period/2027 MIPS payment year, remove the current 7-point cap for certain topped out measures, making the 97th percentile performance rate correspond to 7.5 measure achievement points. ACEP comments that removal of topped out measures

specifically for specialty measure sets removes the incentive for specialties to develop measures for their clinicians.

- ***MIPS Payment Adjustments***
  - *Establishing the Performance Threshold:* CMS proposes to maintain the 2025 MIPS performance threshold of 75 points to avoid a negative adjustment. ACEP strongly supports this proposal because for some clinicians, this may be the first or second year they have reported since the hiatus in reporting caused by the COVID-19 public health emergency (PHE), so it is most appropriate to slowly increase the performance threshold over time.

  - *Proposal to Adopt Reweighting Performance Category(ies) Policy When a Third Party Intermediary Did Not Submit Data Due to Reasons Outside the MIPS Eligible Clinician's Control:* CMS is proposing to allow clinicians to request reweighting for quality, improvement activities, and/or Promoting Interoperability performance category(ies) where data are inaccessible and unable to be submitted because the clinician delegated submission of the data to their third-party intermediary and the third-party intermediary failed to submit the data on the clinician's behalf in accordance with applicable deadlines. ACEP supports this proposal and believes that clinicians should not be penalized for unpredictable elements outside of their control.

- ***Third-Party Intermediary Requirements:*** Overall, ACEP believes that CMS should do more to promote the use of qualified clinical data registries (QCDRs). We urge CMS to consider requiring hospitals to share data with hospital-based clinician groups. With respect to QCDR measure approval requirements, 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.

- ***Qualifying APM Participant (QP) Determinations and the APM Incentive:*** ACEP remains extremely concerned about the trajectory of the Advanced APM track of the QPP. It is imperative that CMS 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. We also encourage CMS to work with Congress to ensure that there are better incentives for participating in an Advanced APM by prioritizing extending the five percent bonus for participation in Advanced APMs.

The Physician Fee Schedule

Physician Fee Schedule (PFS) Conversion Factor

In this proposed rule, the Centers for Medicare & Medicaid Services (CMS) proposes a physician fee schedule (PFS) conversion factor of $32.3562, decrease of $0.93 or -2.8% percent from the calendar year (CY) 2024 PFS conversion factor of $33.2875. If such a reduction is finalized, emergency physicians would experience the full impact of that reduction, due to the expiration of the 2.93 percent patch implemented by Congress in the Consolidated Appropriations Act of 2023 (CAA, 2023) and the CAA, 2024.

As background, over the last several years there have been a series of Congressional fixes to help offset a significant negative budget neutrality adjustment. The budget neutrality requirement under the Medicare PFS forces CMS to make an overarching adjustment to physician payments to counterbalance any increases in code values that CMS implements. CMS usually does this by adjusting the Medicare "conversion factor" (CF) which converts the building blocks of PFS codes (relative value units or RVUs) into a dollar amount. Congress has been able to offset the majority of the budget neutrality cut that was expected go into place in 2021, 2022, 2023, and 2024. With respect to 2024, Congress provided a total of 2.93 percent in relief through the CAA, 2023 and the CAA, 2024. Since the relief that was provided in 2024 only lasts for one year and CMS must operate within its current statutory limitations, the agency had to cut that amount from the 2025 CF. In addition to that 2.93 percent cut, CMS made other adjustments to code values and added new codes. All these modifications lead to a .05 percent positive budget neutrality adjustment.

The proposed CY 2025 PFS conversion factor reflects the statutory 2.93% cut and the 0.05 percent budget neutrality adjustment, yielding a -2.8 percent reduction.

Conversion factors	CY 2024 CF	CY 2025 CF	Difference	Percent Cut
Proposed 2024 CF	33.2875	32.3562	-0.9313	-2.797

Medicare Payment Inadequacy

Medicare payment to physicians is simply inadequate. An analysis conducted by ACEP found that ***Medicare payments have decreased by 29 percent when comparing Medicare payments to inflation*** between the 2001 and 2024.[1] In fact, the CY 2025 proposed CF is 12% less than the CF was in 1998 (the first year that CMS established a single CF) despite the fact that costs have increased by 92% over the same time period.[2] Even the 2024 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

[1] https://www.ama-assn.org/system/files/2024-medicare-updates-inflation-chart.pdf

[2] From July 1998 to July 2024, the CPI-U has increased from 163.2 to 314.540 (Sources: Bureau of Labor Statistics (https://www.bls.gov/cpi/tables/historical-cpi-u-201710.pdf, https://www.bls.gov/news.release/pdf/cpi.pdf)). The CPI-U for Medical Care grew at an even higher percentage, 149.7%, from 244.7 to 611.137 during the same timeframe (Consumer Price Index 1998 and CPI-U by Expenditure Category, 2024).

the long term.[3] Given the fact that annual updates to physician payments are already not 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 medicine clinicians will experience this across-the-board reduction to their reimbursement in 2025. This cut to emergency medicine, if finalized, would jeopardize the nation's critically needed safety net, and we request that CMS do everything within its authority to mitigate the reduction. We also recognize that the complete resolution of this issue will require action by Congress, and we therefore urge the agency to work with Congress on a permanent fix to the broken Medicare payment system.

We would also like to note that a 2.9 percent reduction to Medicare reimbursement for emergency physicians and other emergency medicine health care professionals would be *layered on top of the pending sequestration cuts*. Combined with these additional cuts, the total reduction would have rippling effects across the health care system and have a detrimental impact on access to care. Looking forward, many emergency physicians are already very concerned about the viability of their groups—even without this looming payment reduction. For the safety and wellbeing of the American public, ***EVERY emergency physician and emergency physician group must be supported and protected in order to preserve the safety net on which millions of Americans rely.***

Determination of Practice Expense (PE) Relative Value Units (RVUs)

Adjusting RVUs To Match the PE Share of the Medicare Economic Index (MEI)

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 CF, 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 the CY 2023 PFS final rule, CMS finalized to rebase and revise the MEI to reflect more current market conditions faced by physicians in furnishing physicians' services (referred to as the "2017-based MEI"), delaying the implementation of the finalized CY 2023 rebased and revised MEI, which many commenters, including ACEP, supported. In this proposed rule, CMS is proposing to continue delay of implementation of the finalized 2017-based MEI cost share weights for the RVUs to be consistent with their efforts to balance payment stability and predictability with incorporating new data through more routine updates. Thus, CMS is not proposing to incorporate the 2017-based MEI for rate-setting for CY 2025.

ACEP continues to support CMS' ongoing delay in the implementation of the MEI cost share weights for purposes of balancing payment stability and predictability. 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 CF, including the proposed reduction to the CY 2025 CF, are unacceptable. As discussed in the CY 2023 proposed and final rules, there would be a large negative impact on numerous specialties, including emergency medicine (-8.0 percent), if CMS were to go forward with this policy. 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.

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[3] The 2024 Medicare Trustees Report is available at: https://www.cms.gov/files/document/2024-medicare-trustees-report.pdf.

Development of Strategies for Updates to Practice Expense Data Collection and Methodology

CMS currently utilizes data from the American Medical Association (AMA) physician practice information survey (PPIS), to calculate practice expense costs, such as non-physician clinical staff, medical supplies, equipment, and other overhead expenses. The agency affirms its commitment to refining this methodology and requests public comment on the approaches that utilize independent data from third-party sources who are not market stakeholders to prevent bias in the information collected in the PPIS.

Overall, ACEP supports the current AMA PPIS and Relative Value Scale Update Committee (RUC) process and is opposed to making changes that could distort the value of codes under the PFS. The RUC process for valuing services is fair and balanced, as experts across all specialties engage in deeply informed discussions and must come to a consensus (a two-thirds vote) to approve any recommendations. Having all major specialties at the table, within the budget neutrality confines of the PFS, ensures that any changes are evidence-based and justifiable.

Telehealth Services

Changes to the Medicare Telehealth Services List

In the CY 2024 PFS final rule, CMS created a new "provisional" category when considering whether to add, remove, or change the status of a service on the Medicare Telehealth Services List, along with a permanent category and established criteria for codes to be added to each category. If added to the provisional category, CMS did not specify how long a code could remain there before being removed.

During that rulemaking cycle, CMS added all five emergency department (ED) evaluation and management (E/M) code levels 1-5 (CPT codes 99281-99285), the critical care codes, and the observation codes on the approved telehealth list through at least December 31, 2024. In this year's rule, CMS does not propose any changes to current provisional codes.

ACEP supports keeping these emergency medicine codes on the Medicare Telehealth Services List through at least the end of CY 2025. We have made great strides in the delivery of emergency telehealth services, enabling patients to get timely, personalized, high-quality care. Being able to provide these services remotely has also helped the nation's hospitals maintain the capacity they need to provide emergency care at all times. Further, the results from current innovative emergency telehealth initiatives suggest that having the ability to provide emergency and observation services remotely to Medicare beneficiaries improves care and lowers costs across the country, in both urban and rural areas. In general, studies have shown that physicians and patients are extremely satisfied with the care being provided through these models, and costs have decreased due to avoided ED visits and inpatient admissions. We encourage CMS to consider keeping these codes permanently on the Medicare Telehealth Services List going forward.

Other Non-Face-to-Face Services Involving Communications Technology under the PFS

CMS is proposing other telehealth flexibilities, including:

- Continuation of the definition of "direct supervision" to permit the presence and "immediate availability" of the supervising practitioner through real-time audio and visual interactive telecommunications through December 31, 2025;

- Permanently defining "direct supervision" to include audio-video communications technology for a subset of services ((1) services furnished incident to a physician or other practitioner's service when provided by auxiliary personnel employed by the billing practitioner and working under their direct supervision, and for which the underlying HCPCS code has been assigned a PC/TC indicator of '5'; and (2) services described by CPT code 99211 (Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional); and
- Allowing teaching physicians to use audio/video real-time communications technology when the resident furnishes Medicare telehealth services in all residency training locations through the end of CY 2025.

ACEP continues to support CMS' flexibility regarding supervision requirements as it allows for the extended reach of board-eligible or board-certified emergency physicians to rural and underserved populations in areas of the country where there may not be any such physicians available. 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. We believe that it is essential to have board-certified or board-eligible emergency physicians directly supervise all care delivered in EDs, and telehealth represents a viable tool to accomplish this goal. ACEP therefore supports these proposals and urges CMS to finalize them as proposed.

Valuation of Specific Codes

Telemedicine E/M Services

In February 2023, the CPT Editorial Panel added a new E/M subsection to the draft CPT codebook for Telemedicine Services. The Panel added 17 codes for reporting telemedicine E/M services (9X075, 9X076, 9X077, 9X078, 9X079, 9X080, 9X081, 9X082, 9X083, 9X084, 9X085, 9X086, 9X087, 9X088, 9X089, 9X090, and 9X091). However, CMS is proposing NOT to adopt CPT codes 9X075-9X090, because they believe that such services already have a more specific code that should be used for purposes of Medicare, "which in this case would be the existing office/outpatient E/M codes currently on the Medicare telehealth services list when billed with the appropriate POS code to identify the location of the beneficiary and, when applicable, the appropriate modifier to identify the service as being furnished via audio-only communication technology." CPT code 9X091 (*Brief communication technology-based service (eg, virtual check-in) by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related evaluation and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment, 5-10 minutes of medical discussion)*, which is intended to replace HCPCS code G2012, is being adopted by CMS as a substitute for HCPCS code G2012. CMS states that the Social Security Act specifications regarding Medicare payment for services furnished via telecommunications technology apply only to an explicit set of physician services, and the introduction of new CPT codes alone does not grant CMS the authority to pay for visits furnished through interactive communications technology.

ACEP appreciates CMS' recognition of the work that the AMA RUC put into drafting the telemedicine E/M services codes, as we were one of the specialty societies involved in this process, and we support the future valuation of these services. We look forward to engaging with CMS and other stakeholders as we continually evaluate the important role telehealth services can play providing timely, quality care to Medicare patients.

Request for Information for Services Addressing Health-Related Social Needs

In the CY 2024 PFS final rule, CMS finalized G-codes to reflect new coding and payment practices for services addressing health-related social needs and for administration of a social determinants of health (SDOH) risk assessment. In this year's proposed rule, CMS is soliciting broad comments on these newly implemented codes to better address the social needs of beneficiaries and to fully encompass what interested parties and commenters believe should be included in the recently established coding and payment. More specifically, the agency is interested in feedback regarding any barriers to furnishing the services addressing health-related social needs, and if the service described by the codes are allowing practitioners to better address unmet social needs that interfere with the practitioners' ability to diagnose and treat the patient. Finally, CMS seeks comment on barriers in the continuum of care for patients who screen positive for social needs.

ACEP continues to support paying for patient navigation services and believes that these services should also be used in other contexts and by other payers. As CMS evaluates the usage of these codes over time, we encourage the agency to consider broadening the scope of the codes and to work with other payers to adopt them for their patient populations.

EDs serve a unique purpose in the health care system as we are bound by the Emergency Medical Treatment and Labor Act (EMTALA), which requires us to provide a medical screening examination to every individual who "comes to the emergency department" seeking examination or treatment and to stabilize those patients with emergency medical conditions. We treat all patients who come through our doors, regardless of their insurance status or ability to pay. Vulnerable patients, including those who are uninsured or under-insured, are more likely to avoid seeking more routine care or visiting a primary care physician or specialist for minor conditions or symptoms. Such deferral or delay will often result in exacerbation of their condition or symptoms, and eventually, may result in a trip to the ED. At this point, due to the progression of their condition, their care in the ED will be costlier and more complex, increasing the strain on the health care system at large.

However, despite the disproportionate representation of social vulnerability in so many ED patients, most EDs do not currently have the necessary resources to initiate interventions on SDOH for their patients. Even though HCPCS Code G0136 allows clinicians to bill for SDOH risk assessment, CMS expects clinicians to then initiate interventions and transitional care for their patients as a condition of billing the code: as stated in the CY 2024 PFS final rule, "*An SDOH risk assessment without appropriate follow-up for identified needs would serve little purpose.*"[4] However, critical resources, such as social workers, case managers, and community health workers, are not properly integrated and allocated into the emergency care model, hampering the ability to address health inequities directly from the ED setting, and preventing clinicians to bill for G0136 in the ED. Additional funding to ensure feasibility of assessment and accessible follow-up care could pave the way for a more streamlined continuum of care, potentially transforming the post-ED outcomes and long-term health trajectories of some the country's most vulnerable populations, as well as reduce costs for low-acuity ED care use for visits in which patients delayed care because they did not have access to a primary care physician or specialist.

[4] 88 FR 78818 (November 16, 2023).

E/M Visits: Office/Outpatient (O/O) E/M Visit Complexity Add-on

In last year's rule, CMS finalized HCPCS code G2211, or the "add-on code for complexity," which "reflects the time, intensity, and PE resources involved when practitioners furnish the kinds of O/O E/M visit services that enable them to build longitudinal relationships with all patients (that is, not only those patients who have a chronic condition or single high-risk disease) and to address the majority of a patient's health care needs with consistency and continuity over longer periods of time." The relationship between the patient and the practitioner is the determining factor for when the add-on code should be billed.

Based on feedback that CMS received that the current policy is not well aligned with their policy objective for establishing the add-on payment, CMS is proposing an expansion in the use of the code when the office and outpatient O/O E/M base code is reported by the same practitioner on the same day as an annual wellness visit (AWV), vaccine administration, or any Medicare Part B preventive service furnished in the office or outpatient setting.

ACEP cautions CMS against expanding the usage of this code before clinicians have had ample experience using it appropriately. When CMS proposed the code last year, ACEP expressed numerous concerns about the need for the code (as there are CPT codes already in existence that measure the time and resources it takes to provide care to complex patients), the lack of clarity of when to bill for the code, and CMS's failure to go through the normal CPT process to create the code.[5] We still have these same concerns, and though CMS recently released guidance, clinicians need time and experience to truly understand when it is appropriate to bill the code. Thus, the agency should not expand the circumstances in which the code can be billed.

Enhanced Care Management

In conjunction with their policy priorities to strengthen primary care, CMS is proposing to establish coding and make payment under the PFS for a new set of advanced primary care management (APCM) services described by three new HCPCS G-codes. The proposed APCM services would incorporate elements of several existing care management and communication technology-based services into a bundle of services that reflects the essential elements of the delivery of advanced primary care, including Principal Care Management, Transitional Care Management, and Chronic Care Management, stratified into three levels based on the number of chronic conditions and enrollment as a Qualified Medicare Beneficiary. This new proposed coding and payment makes use of lessons learned from the CMS Innovation Center's testing of a series of advanced primary care models for the goals of better recognition and describing of advanced primary care services, encouraging primary care practice transformation, ensuring that patients have access to high quality primary care services, and simplifying billing and documentation requirements. The proposed codes also represent a step towards paying for primary care services with hybrid payments (a mix of encounter and population-based payments) to support longitudinal relationships between primary care providers and beneficiaries by paying for care in larger units of service, and, according to CMS, will also help drive accountable care.

ACEP supports CMS's effort to incentivize the delivery of advanced primary care services to Medicare beneficiaries. However, we do believe that CMS should, at the same time, recognize that promoting primary care alone will not resolve all the issues facing our health care system. For example, while one goal of enhancing primary care services is to help avoid ED visits, there are over 130 million ED visits a year; *it would be impossible to avoid them all.* Further, due

[5] ACEP's response to the CY 2024 proposed rule is available here: https://www.regulations.gov/comment/CMS-2023-0121-21210.

to the nature of acute, unscheduled care, it is impossible to determine until after the fact if much of these visits are "avoidable," even with expanded access to primary care.

Therefore, in addition to supporting primary care, CMS should also be ***supporting the safety net***, and that includes establishing the necessary resources and incentives to ensure safe transitions from the ED. As stated above, the integration of screening for social needs and investment in follow-up care after these screenings could facilitate the allocation of critical resources into the emergency medicine care model, address health inequities by paving the way for a more streamlined continuum of care, and transform the long-term health trajectories of the country's most vulnerable populations.

Advancing Access to Behavioral Health Services

Safety Planning Interventions and Post-Discharge Telephonic Follow-up Contacts

Safety Planning Interventions (SPI)

In the CY 2024 PFS proposed rule, CMS sought comment on whether there is a need for potential separate coding and payment for interventions initiated or furnished in the emergency department (ED) or other crisis settings for patients with suicidality or at risk of suicide, such as safety planning interventions and/or telephonic post-discharge follow-up contacts after an ED visit or crisis encounter, or whether existing payment mechanisms are sufficient to support furnishing such interventions when indicated. We had previously commented that a designated code for SPI would make it significantly easier to document that SPI was furnished, including in quality reporting and value-based payment programs, especially since elevated suicide risk is particularly prevalent among ED patients.[6]

In light of our previous comments, CMS is proposing to establish an add-on G-code *(HCPCS code GSPI1: Safety planning interventions, including assisting the patient in the identification of the following personalized elements of a safety plan: recognizing warning signs of an impending suicidal crisis; employing internal coping strategies; utilizing social contacts and social settings as a means of distraction from suicidal thoughts; utilizing family members, significant others, caregivers, and/or friends to help resolve the crisis; contacting mental health professionals or agencies; and making the environment safe; (List separately in addition to an E/M visit or psychotherapy that would be billed along with an E/M visit when SPIs are performed)).*

CMS seeks public feedback regarding the setting in which a safety planning intervention encounter might occur and if GSPI1 might be appropriate to be billed as a stand-alone code in certain contexts. The agency also requests input on the clinician types that might be the safety planning intervention as a stand-alone procedure.

ACEP appreciates CMS' efforts to address the issue of increased deaths by suicide amongst the Medicare population through safety planning intervention. EDs throughout the country have witnessed a sharp increase in mental health-related visits, with one study finding that adults aged 65 or older demonstrated the largest increase in suicide attempts.[7] Additionally, research has suggested that universal suicide risk screening of adult ED patients approximately doubles

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[6] Goldman-Mellor S, Olfson M, Lidon-Moyano C, Schoenbaum M. Association of Suicide and Other Mortality With Emergency Department Presentation. JAMA Netw Open. 2019 Dec 2;2(12):e1917571. doi: 10.1001/jamanetworkopen.2019.17571. PMID: 31834399; PMCID: PMC6991205.

[7] Tanner J. Bommersbach, M.D., M.P.H., et al. *American Journal of Psychiatry,* Volume 181, Number 8. https://psychiatryonline.org/doi/10.1176/appi.ajp.20230397.

the number (from 3 percent to 6 percent) of patients identified as needing care for acute/emergent suicide risk,[8] thus demonstrating that the ED is a clinically appropriate setting for safety planning interventions to be performed.

Currently, CMS is proposing that GSPI1 must be performed by the billing practitioner. While we agree that SPI requires training and expertise, requiring the billing practitioner (the emergency physician) to perform the intervention would be an inappropriate use of ED resources when other clinicians such as nurses, licensed clinical social workers, and other mental health professionals could appropriately perform it. Thus, ACEP urges CMS to allow GSPI1 to be performed by trained clinical staff under the supervision of a licensed physician/mental health practitioner.

Post-Discharge Telephonic Follow-Up Contacts Intervention (FCI)

In the rule, CMS cites studies suggesting that patients seen in the ED with deliberate self-harm, intentional overdose, and/or suicidal ideation have been associated with substantially increased risk of suicide and other mortality during the year following their visit to the ED. However, according to a study conducted by The Joint Commission referenced by CMS, fewer than half of responding hospitals reported furnishing any post-discharge follow-up contacts. Of these, only 33 percent (16 percent of responding hospitals overall) reported reaching discharged patients "most of the time." Further, among hospitals that furnish follow-up contacts, fewer than half reported covering any of the main aims of FCI. Thus, to align with evidence suggesting that FCI reduces suicidal behavior in discharged ED patients with elevated suicide risk, CMS is proposing to create a monthly billing code to describe the specific protocols involved in furnishing post-discharge follow-up contacts that are performed in conjunction with a discharge from the ED for a crisis encounter, as a bundled service describing four calls in a month, each lasting between 10-20 minutes. The proposed G-code is HCPCS code GFCI1: *Post discharge telephonic follow-up contacts performed in conjunction with a discharge from the emergency department for behavioral health or other crisis encounter, per calendar month.*

ACEP supports the inclusion of an add-on code for post-discharge follow-up contacts performed in conjunction with a discharge from the ED for a crisis encounter. Innovative approaches to psychiatric emergency care follow-up have helped communities improve coordination of emergency psychiatric care, and providing follow-up care to patients after psychiatric hospitalization can improve patient outcomes, decrease the likelihood of re-hospitalization, and decrease the overall cost of outpatient care.[9,10,11] However, the availability of resources, whether monetary, staffing, or access to follow-up services and patient access to long-term mental and behavioral health care varies widely from ED to ED and community to community. Thus, while this add-on code could improve patient outcomes, it is imperative that less-resourced EDs are not penalized because they do not have the same monetary resources or staffing availability as other facilities.

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[8] Miller IW, Camargo CA Jr, Arias SA, et al. Suicide Prevention in an Emergency Department Population: The ED-SAFE Study. JAMA Psychiatry. 2017;74(6):563-570. doi:10.1001/jamapsychiatry.2017.0678

[9] Barekatain M, Maracy MR, Rajabi F, Baratian H. (2014). Aftercare services for patients with severe mental disorder: A randomized controlled trial. J Res Med Sci. 19(3):240-5.

[10] Luxton DD, June JD, Comtois KA. (2013). Can post-discharge follow-up contacts prevent suicide and suicidal behavior? A review of the evidence. Crisis. 34(1):32-41. doi: 10.1027/0227-5910/a000158.

[11] Glazer, W. (2010). Tackling adherence in the real world. Behavioral Healthcare, 30(3), 28-30.

Comment Solicitation on Payment for Services Furnished in Additional Settings, including Freestanding Substance Use Disorder (SUD) Treatment Facilities, Crisis Stabilization Units, Urgent Care Centers, and Certified Community Behavioral Health Clinics (CCBHCs)

In the rule, CMS seeks comment on how to appropriately pay for services delivered in a number of different settings. ACEP understands that some of these payment changes would help ensure that patients receive care in the most appropriate health care setting. While we support this goal, we urge CMS to not enact any policies that would in any way inhibit the ability for patients to seek care in the ED when they believe they are experiencing medical emergencies. With that context in mind, our specific comments are below.

SUD Treatment Facilities

In the CY 2024 Outpatient Prospective Payment System (OPPS) final rule, CMS finalized payment for intense outpatient programs (IOP) services furnished in hospital outpatient departments (HOPDs), Community Mental Health Centers (CMHCs), Federally Qualified Health Centers (FQHCs), and Rural Health Clinics (RHCs), and Opioid Treatment Programs (OTPs). CMS has heard from other treatment settings that furnish IOP services that do not fall into the categories of HOPDs, CMHCs, FQHCs, RHCs, or OTPs, such as freestanding SUD facilities, that have an interest in billing Medicare for these services. In light of this input, CMS seeks comment on whether IOP services are furnished in other settings in order to determine whether potential coding and payment for IOP services under the PFS would facilitate these services being billed in additional settings.

ACEP believes that freestanding SUD facilities and other entities that furnish IOP services serve an important function in their communities. Access to these services is critical in the management and treatment of SUD and may prevent overdoses or other acute conditions that result in an ED visit. Because of their vital role in treatment engagement and the life-saving services they provide, freestanding SUD facilities should have a sustainable structure for reimbursement.

Crisis Stabilization Units

CMS is seeking comment on entities that offer community-based crisis stabilization, including 24/7 receiving and short-term stabilization centers that provide immediate access to voluntary and/or involuntary care, without the need for a referral. Regarding such crisis stabilization units, CMS is interested in feedback on the types of services they provide and bill, the impact of crisis stabilization units on underserved areas, types of employment models, and any other relevant feedback.

The ED serves as the critical health care safety net not only for acute injuries, but for psychiatric emergencies as well. However, most EDs are not ideal facilities to provide longer-term care for patients experiencing a mental health crisis – they are often hectic, noisy, and particularly disruptive for behavioral health patients. But due to the fragmented nature of mental health care infrastructure in the U.S., persistent lack of sufficient resources, and longstanding shortages of mental and behavioral health professionals, far too many Americans have limited options for the longer-term follow-up treatment they need and deserve. Therefore, even though the ED is not the best option for these patients, it is often their *only* option. These health care resource challenges contribute to long ED wait times and aggravate "boarding" issues, a scenario where patients are kept in the ED for extended periods of time due to a lack of available inpatient beds or space in other facilities to which they could be transferred. Overcrowding and boarding

are not failures of the ED or the emergency physicians who care for patients; rather, they are symptoms of larger systemic issues that must be addressed to eliminate bottlenecks in health care delivery and reduce the burden on the already-strained health care safety net.

Reducing boarding and mitigating its effects on all patients is critical in improving patient outcomes and patients' overall health, especially for those with mental or behavioral health needs. ED boarding challenges disproportionately affect patients with behavioral health needs who wait on average **three times longer** than medical patients because of these significant gaps in our health care system. Some research has shown that 75 percent of psychiatric emergency patients, if promptly evaluated and treated in an appropriate location – away from the active and disruptive ED setting – have their symptoms resolve to the point they can be discharged in less than 24 hours, further highlighting the need to provide timely, efficient, and appropriate mental health care.

Across the country, communities have adopted innovative alternative models to improve emergency psychiatric care and reduce psychiatric patient boarding, the goals of which can also be met by community-based crisis stabilization units. Some examples include:

- Behavioral Health Emergency Rooms (BHERs). BHERs are separate areas of the ED that specialize in proactive rapid-assessment, stabilization, and treatment of patients in experiencing a behavioral health crisis. Care is delivered via a multidisciplinary team of emergency physicians, psychiatrists, psychiatric nurses, and social workers. This service is operational 24 hours a day, 7 days a week, 365 days a year. These dedicated spaces provide patients with a safer, private, and more peaceful setting in which to de-escalate and receive specialized care.

  By initiating proactive assessments in a BHER, 40-50 percent of patients can be safely discharged home, reducing ED boarding time. Additionally, optimizing transition of care through Integrated Outpatient Care clinics ensures ongoing high-quality medical and behavioral health care follow-up with convenient and comprehensive treatment options for patients.

- EmPath (Emergency Psychiatric Assessment Treatment and Healing) Units. The EmPath Unit is a separate, hospital-based setting solely for psychiatric emergencies with the safe, calming, homelike environment of a community mental health crisis clinic combined with the ED's ability to take care of any patient who presents for treatment. This unit accepts all suitable patients regardless of the severity of their illness, legal status, dangerousness, substance use intoxication or withdrawal, or co-morbid medical problems – all factors that typically exclude such patients from community programs and thus who would likely experience boarding in an ED in the traditional medical system.

  EmPath units provide immediate access to individualized care from a comprehensive mental health care team of psychiatrists, psychologists, mental health nurses, social workers, and other licensed mental health care professionals. This team partners directly with patients and their families to address the immediate mental crisis and to develop a longer-term care plan through appropriate follow-up services. In some instances, EmPath units have reduced regional ED boarding by 80 percent and have also reduced the need for—and incidence of—coercive measures (such as physical restraints), episodes of agitation, and psychiatric hospitalization.

These innovative approaches have helped communities improve coordination of emergency psychiatric care, and they can serve as models for other communities to implement and build upon – through crisis stabilization units or otherwise – to help alleviate the overall load on the mental health care system.

Urgent Care Centers

CMS states that it is has received concerns from interest parties that hospital EDs are often used by beneficiaries to address non-emergent urgent care needs that could be appropriately served in less acute settings, but where other settings, such as physician offices, urgent care centers or other clinics, are not available or readily accessible. According to CMS, patients enter EDs to treat common conditions like allergic reactions, lacerations, sprains and fractures, common respiratory illnesses (for example, flu or RSV), and bacterial infections (for example, strep throat, urinary tract infections or foodborne illness), which "often can be treated in less acute settings." CMS is thus interested in system capacity and workforce issues broadly and are interested in hearing more on those issues, including how entities such as urgent care centers can play a role in addressing some of the capacity issues in EDs. In particular, CMS is interested in feedback on the types of services that alternatives to EDs should offer to meet beneficiaries' non-emergent, urgent care needs; the adequacy of the "Urgent Care Facility" Place of Service code (POS 20) and its distinctiveness from the "Walk-in Retail Health Clinic (POS 17) and "Office" (POS 11) codes; and the accuracy of the current code set.

ACEP appreciates the important role that non-emergency facilities, such as urgent care centers, can play treating patients. However, it is essential to preserve the fundamental right for patients to seek emergency care when they think they are experiencing a medical emergency. This right is embedded in our health care system through a series of legal protections, including the Prudent Layperson Standard (PLP). The PLP requires patients to be covered for emergency care based on their symptoms, not on the final diagnosis. Specifically, under the PLP, an emergency medical condition, is defined as one "manifesting itself by acute symptoms of sufficient severity (including severe pain) 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 the following:

- Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part."

For example, if a patient presented to the ED with chest pain, but it turned out to be gastric reflux or non-cardiac related, that service must be fully covered—since patients, under the PLP, were experiencing what they thought was an emergency medical condition. Emergency and non-emergency symptoms frequently overlap and in many cases emergency physicians do not know if a patient's symptoms require emergency treatment without first performing a medical examination and testing. People who believe they are having a medical emergency should not hesitate in seeking care in the ED, and fears that their health coverage (including Medicare) will refuse to cover such a visit should not be a contributing factor in their decision. ACEP has put out a resource, called "know when to go" that lists out some of the common symptoms that could be signs of a medical emergency and should trigger individuals to call 911 or seek immediate medical care. As CMS contemplates the role of urgent care centers, we would encourage CMS to consider how best to educate beneficiaries about when they should seek emergency treatment, their right to do so, and when another setting such as an urgent care center may be appropriate to address their health care needs.

Similarly, we urge CMS to take much greater care in the terminology it uses to distinguish between an appropriate and inappropriate ED visit, specifically the phrase "unnecessary" ED visits. In fact, the Centers for Disease Control and Prevention (CDC) has historically estimated that there are less than 5 percent "non-urgent" ED visits a year.[12] Generically categorizing ED visits as unnecessary fails to account for the fundamental fact that the appropriateness of a visit is based on a patient's presenting symptoms, not the ultimate diagnosis. Thus, as clearly required by the PLP (defined above), one could only claim that a particular ED visit was unnecessary *after* a comprehensive review of the patient's presenting systems, medical history, and what drove them to seek care at the ED—and even then it could still be a judgment call. **CMS should therefore only make a distinction between an "emergent" and "non-emergent" encounter based on a full evaluation of an individual patient's case as the PLP requires.**

ACEP does believe that urgent care centers could play a role in providing care for patients who have urgent, but non-emergent conditions. Patients who know that they have a non-emergency medical condition, but do not know where to seek treatment, should go to an urgent care setting to receive care. Many times, patients with minor conditions have no viable alternative to seeking care, especially at nights and on weekends, then going to the ED. Many urgent care centers are closed after 8 pm and entirely on Sundays; if urgent care centers are available 24 hours a day, 7-days a week, they may be able to present a viable option for these patients rather than the ED.

If individuals have questions about where to go to seek treatment, emergency clinicians, especially emergency physicians, are the best suited to help patients understand whether their symptoms could be signs of a medical emergency. Emergency physicians are highly trained in evaluating and analyzing patients with acute, undifferentiated conditions and making quick determinations about the general severity of a patient's condition. As a result of this unique skill set, ACEP has also discussed opportunities for emergency physicians to work outside the four walls of the ED, including doing more telehealth and triage services and helping to staff urgent care centers and other facilities. In fact, extrapolated Medicare claims data from 2022 show that, among claims for physician services billed with the Place of Service 20 modifier for urgent care centers, 14 percent were billed by specialists in emergency medicine.[13]

ACEP continues to believe that physician-led care teams offer the highest quality of care, and every urgent care should seek to have an emergency physician on staff. In the setting of physician-led teams, urgent care should be capable of caring for the full range of non-life-threatening conditions. CMS should work with other stakeholders to ensure that appropriate incentives are in place to encourage physician staffing of all urgent care settings.

Boarding and Overcrowding

In response to CMS's question regarding how the expanded use of urgent care centers would help alleviate overcrowding, ACEP does not think that this is a simple answer. ED "boarding," a scenario where patients are kept in the ED for extended periods of time due to a lack of available inpatient beds or space in other facilities to where they can be transferred, is a longstanding challenge for EDs but is now at crisis levels across the country, with many hospitals near or at their breaking point. As stated above, overcrowding and boarding are not failures of the ED or the emergency physicians caring for patients; rather, they are symptoms of larger systemic issues. etc. While the causes of ED boarding are multifactorial, growing staffing shortages throughout the health care system have recently brought

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[12] National Hospital Ambulatory Medical Care Survey: 2021 Emergency Department Summary Tables. Available at: https://www.cdc.gov/nchs/data/nhamcs/web_tables/2021-nhamcs-ed-web-tables-508.pdf.
[13] This percentage is based on an internal analysis of 2022 Medicare claims data.

this issue to a critical point, and the resulting added stress and burnout are leading to an exodus of physicians and nurses – further exacerbating the crisis and spiraling the system towards a very real risk of collapse.

While reducing patient volume of low acuity cases could alleviate some of the overcrowding issues, much of the issue driving boarding is actually on the back end—trying to move patients from the ED to the most appropriate post-acute healthcare setting. Therefore, we do not believe that the expanded use of urgent care issues would resolve the crisis we are facing.

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 when dental services are furnished in either the inpatient or outpatient setting when the dental services are inextricably linked to, and substantially related and integral to the clinical success of, other covered services.

In last year's rule, CMS finalized expanded payment for dental services. In this year's rule, CMS is proposing to add to the list of clinical scenarios under which FFS Medicare payment may be made for dental services inextricably linked to covered services to include: (1) dental or oral examination in the inpatient or outpatient setting prior to Medicare-covered dialysis services for beneficiaries with end-stage renal disease; and (2) medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to, or contemporaneously with, Medicare-covered dialysis services for beneficiaries with end-stage renal disease.

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, serious complications like sepsis, endocarditis, mediastinitis, or brain abscess. Additionally, periodontal disease has been linked to chronic diseases including diabetes, heart disease, and stroke, which can present in urgent, high-acuity events. 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 these visits.[14] The visits, borne from untreated dental issues due to insufficient dental care, cause undue pressure on EDs as emergency physicians treat every patient that comes to the ED. Had patients had access to preventive dental care, these patients would not have conditions progress to requiring emergency care. Therefore, ACEP continues to support 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 continue to urge CMS to be mindful about how it decides to finance any additional services under Medicare Parts A and B in the future. Although CMS does not anticipate any significant increase in utilization or payment impact for these additional dental services given the historically low utilization of these therapies, that

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[14] Kim PC, Zhou W, McCoy SJ, et al. Factors Associated with Preventable Emergency Department Visits for Nontraumatic Dental Conditions in the U.S. Int J Environ Res Public Health. 2019;16(19):3671. Published 2019 Sep 30. doi:10.3390/ijerph16193671

assumption could change going forward. 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 if additional dental-related services begin to significantly increase spending in the PFS without any change in how they are financed.

Modifications Related to Medicare Coverage for Opioid Use Disorder (OUD) Treatment Services Furnished by Opioid Treatment Programs (OTPs)

Telecommunication Flexibilities

Audio-Only Periodic Assessments

CMS currently authorizes telecommunication flexibilities for the initiation of treatment with buprenorphine, including a temporary provision to allow periodic assessments to be furnished using audio-only communication technology, set to end at the end of CY 2024. CMS is proposing to extend that flexibility on a permanent basis beginning January 1, 2025.

ACEP is supportive of proposals that expand access to services and reduce regulatory access barriers to OUD treatment. We strongly urge CMS to continue working with the Substance Abuse and Mental Health Administration (SAMHSA) and the Drug Enforcement Agency (DEA) to permanently extend telehealth flexibilities for non-OTP practitioners, including emergency physicians practicing in the ED, as well. ACEP acknowledges that many patients who need these services may not have access to reliable broadband technology necessary to have an audio/visual telehealth appointment. Thus, we appreciate the flexibility so those patients can access the services they need.

However, as CMS expands flexibilities for audio-only services, the agency should be mindful of the implications of this expansion on budget neutrality, particularly for those clinicians who do not typically provide and bill for those services.

Proposal to Allow OTPs to Use Audio-Visual Telecommunications for Initiation of Treatment with Methadone

Prior to the COVID-19 public health emergency (PHE), the Ryan Haight Online Pharmacy Consumer Protection Act of 2008 (Pub. L. 110-425) amended the Controlled Substances Act and instructed the DEA to promulgate regulations that required health care providers to conduct an in-person examination in the presence of a practitioner prior to prescribing controlled substances (for example, methadone, buprenorphine, etc.) to patients, with certain exceptions to prevent the distribution and dispensing of controlled substances by means of the internet without at least one in-person medical evaluation before writing a prescription. Similarly, SAMHSA regulations under 42 CFR 8.12(f)(2) have historically required a complete physical evaluation before a patient begins treatment at an OTP.

However, after the declaration of the PHE for COVID-19, the DEA and SAMHSA jointly issued flexibilities for prescribing of controlled substances via telehealth to ensure patient therapies would remain accessible. Consequently, OTPs were exempted from the requirement to perform an in-person physical evaluation for any patient who would be treated by the OTP with buprenorphine if a program physician, primary care physician, or an authorized healthcare professional under the supervision of a program physician determines that an adequate evaluation of the patient can

be accomplished via telehealth through an audio-video or audio-only evaluation. At the time, this exemption applied exclusively to patients with an OUD being treated at an OTP with buprenorphine, and it did not apply to new patients initiating treatment with methadone. This meant that new OTP patients starting treatment with methadone would need to still receive an in-person physical evaluation prior to the OTP prescribing methadone.

However, in this proposed rule, CMS is now proposing to allow the OTP intake add-on code (HCPCS code G2076) to be furnished via two-way audio-video communications technology when billed for the initiation of treatment with methadone, to the extent that the use of audio-video telecommunications technology to initiate treatment with methadone is authorized by DEA and SAMHSA at the time the service is furnished. They are however not proposing to extend the aforementioned audio-only option to initiation of methadone.

Given the proven success of providing medications for opioid use disorder (MOUD) for the treatment of OUD, ACEP supports the additional flexibility allowing for the conduction of initiation via telehealth. However, we note that this proposed rule only governs OTPs, and most of the services provided by emergency physicians fall outside of OTPs, in EDs. We understand that the DEA has authority over the prescribing of buprenorphine by non-OTP providers. At the beginning of the COVID-19 PHE, the DEA issued waivers to allow DEA-registered practitioners to prescribe controlled substances to their patients without having to interact in-person with their patients. Under the DEA's policy (which became effective on March 31, 2020), authorized practitioners can prescribe buprenorphine over the telephone to new or existing patients with OUD without having to first conduct an examination of the patient in person or via telehealth.

Like buprenorphine, methadone is a life-saving medication that can be initiated in the ED to treat patients with OUD. While buprenorphine is more commonly initiated in the ED, methadone is a life-saving alternative treatment option that may be preferred by patients who have not been successful with buprenorphine in managing their OUD.[15] Methadone is associated with high retention rates when flexibly delivered at low fixed doses and has been shown as equally suppressive of illicit opioid use.[16] 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. Thus, while ACEP supports telemedicine prescribing flexibilities, we ask that CMS extend the audio-only option to prescribing methadone as well as buprenorphine, while still being mindful of the implications of this expansion on budget neutrality.

Proposals Related to Reforms to 42 CFR Part 8

CMS is proposing payment increases in response to recent regulatory reforms for OUD treatment finalized by SAMHSA at 42 CFR part 8. Specifically, CMS is proposing to update payment for intake activities furnished by OTPs to include payment for SDOH assessments to adequately reflect additional effort for OTPs to identify a patient's unmet health-related social needs or the need and interest for harm reduction interventions and recovery support services that are critical to the treatment of an OUD, to help OTPs address key issues during initial assessments that may increase the risk of a patient leaving OUD treatment prematurely or that pose barriers to treatment engagement. CMS is also requesting information to understand how OTPs currently coordinate care and make referrals to

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[15] ASAM. The American Society of Addiction Medicine National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 focused update. *J Addict Med.* 2020;14(2S):1–91.

[16] Mattick RP, Breen C, Kimber J, et al. Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. *Cochrane database of systematic reviews.* 2014;(2):CD002207.

community-based organizations that address unmet health-related social needs, provide harm reduction services, and/or offer recovery support services.

ACEP supports this proposal and urges CMS to finalize it as proposed. As a general trend, people with OUD are more likely to have limited financial resources, difficulty in accessing medical care, underemployment, and under-insurance. Therefore, OTPs have the ability to more easily capture data from populations who experience health inequities more acutely, and there should be reimbursement mechanisms in place to screen for and coordinate care for unmet social needs.

Medicare Shared Savings Program (MSSP)

CMS proposes to a number of new MSSP policies, including establishing a new prepaid shared savings option, modifying the financial methodology to encourage participation, aligning quality measure reporting with the Universal Foundation of quality measures, and accounting for the impact of certain improper payments in performance year and benchmark expenditures.

ACEP overall supports these proposals, as we believe that they will help increase participation in accountable care organizations (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, we note that not many emergency physicians directly participate in the MSSP. Going forward, we urge CMS to create additional incentives for specialists, like emergency physicians, 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) latest strategic plan,[17] CMMI states that specialists must be engaged in ACO initiatives to help achieve an overarching goal for all Medicare beneficiaries and the vast majority of Medicaid beneficiaries to be 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 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. As described here and in other sections throughout our letter, ACEP created an emergency medicine APM called the Acute Unscheduled Care Model (AUCM) in 2017. 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.

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[17] The CMS Innovation Center Strategy Refresh is available here: https://www.cms.gov/priorities/innovation/strategic-direction-whitepaper.

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 concepts into the MSSP and other ACO initiatives.

Medicare Payment for Preventive Services

Under section 1861(s)(10) of the Social Security Act, Medicare Part B covers both the vaccine and vaccine administration for the specified preventive vaccines including pneumococcal, influenza, hepatitis B and COVID-19 vaccines. For CY 2025, CMS is proposing to revise and expand coverage of these preventive vaccines through various policies.

The ED is a common, and often essential, access point to the health care system. In some cases, particularly among underserved communities with limited access to routine outpatient services, ED visits represent a potential opportunity to provide preventive services. Vaccinations may ultimately reduce unnecessary ED utilization and lead to improved health outcomes. At the same time, preventive services are not the primary function of the ED. Offer and administration of preventive services within the ED entails thoughtful consideration of ED capacity and community needs, including consideration of evidence-based strategies drawn from the United States Preventive Services Task Force (USPSTF), the CDC, peer-reviewed emergency medicine literature, and other trusted sources; consideration of local disease and risk factor epidemiology; and attention to capacity, such that primary ED functions (treating emergency conditions) are not delayed. Vaccine administration processes should be developed to work within ED workflow and minimize impact on patients and ED staff and performed in a manner that is financially sustainable to patients and the health system. Further, efforts should be made to ensure that patients are not unintentionally vaccinated multiple times. Interoperable electronic health records (EHRs) should be utilized to track vaccine administration and vaccination records.

Request for Information: Building upon the MIPS Value Pathways (MVPs) Framework to Improve Ambulatory Specialty Care

In the proposed rule, CMS seeks comment regarding the design of a future ambulatory specialty model. Specifically, CMS is considering a model design that would increase specialty participation in APMs by leveraging the MVP framework. Participants under this model would not receive a MIPS payment adjustment, but instead would receive a payment adjustment based on (1) a set of clinically relevant MVP measures that they are required to report and (2) comparing the participant's final score against a limited pool of clinicians (other model participants of their same specialty type and clinical profile).

CMS is soliciting comments on several parameters of the model, including considering mandatory participation of relevant specialty care providers to overcome challenges such as selection bias and participant attrition. CMS expects this ambulatory specialty model would be implemented no earlier than 2026, ensuring participants have sufficient time to prepare for the model.

ACEP supports the general concept of creating a specialty care model, but **strongly opposes the idea that such a model require participation by certain physicians**. Our concerns for mandatory participation do not stem from our lack of desire for emergency physicians to participate in APMs, but rather from the reality of where most emergency physician practices now are in their value-based care journey. ACEP has not sat on the sidelines during this movement towards promoting value over volume. We helped develop an emergency medicine-focused MVP, Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP, that CMS included in the *first batch* of MVPs, starting in 2023. When ACEP initially submitted the MVP for consideration in 2021, we based it in part on an emergency medicine APM that we had previously developed – the Acute Unscheduled Care Model (AUCM). Like AUCM, the goal of the MVP was to focus on undifferentiated high-risk conditions. Some of the quality category measures within the MVP address chest pain, abdominal pain, headache, and back pain – all common conditions that are seen on a daily basis. Importantly, ED disposition decisions for these conditions have considerable influence on health care quality and cost, as there is significant variation in admission rates for all the conditions and variation in opioid prescribing and imaging utilization rates with respect to atraumatic back pain and headache. All in all, we had hoped that because of the linkage between the emergency medicine MVP and AUCM, CMS over time would see enough value in targeting these conditions that the agency would eventually transition the MVP to an APM like the AUCM.

While that was our aspirational goal in proposing the MVP, unfortunately the uptake in MVP has been too low for any transition to APMs to be viable at this time. Emergency physicians also have to gain more experience with the new emergency medicine cost measure that was just adopted in 2024. Due to the delay in receiving performance feedback on cost measures, it would be premature to use that cost measure in any APM. Thus, CMS should delay the implementation of the model past 2026 and not implement it until: 1) the uptick of MVP reporting increases, and 2) the performance feedback on cost measures significantly improves.

In addition, although many emergency physicians are ready to participate in an APM, not many have experience in down-side risk financial arrangements. Requiring clinicians to participate in any APM before they have had enough time to fully understand how to be successful in a model would not only be unfair to those clinicians but would also hinder—not advance—the movement towards value-based care. Thus, it is essential that any APM be voluntary and not mandatory.

With respect to the structure of the specialty care APM for emergency medicine, we strongly recommend that CMS use the AUCM as the basis for constructing any future model. The AUCM is an episode-based, bundled-payment model like the Bundled Payments for Care Improvement Advanced Model (BPCI Advanced). As initially designed, for the first two to three years, the model would focus on episodes related to four high-volume ED conditions – abdominal pain, altered mental status, chest pain and syncope. The model would then expand to include additional diagnoses (excluding those that result in greater than a 90 percent admission rates per condition) as well as qualifying visits by dual-eligible beneficiaries. To maximize participation from both large and small physician groups, the model would include three options for risk-sharing that enable emergency physicians to either take on downside risk immediately or ease into risk over time. ACEP believes that the model has the opportunity to significantly reduce Medicare spending, while improving the quality of care that patients receive in the ED.

From the patient perspective, patients would receive better quality and more coordinated care if such a model were implemented. Under the model, a patient who arrived at the ED would be assessed by a clinician to determine if their presenting symptoms are associated with one of the targeted diagnostic categories. Concurrent to clinical care, the

patient would undergo a safe discharge assessment (SDA) to identify socioeconomic factors and potential barriers to safe discharge, needs related to care coordination, and additional assistance that may be necessary. This interaction is designed to support patient and family engagement and to lay the groundwork for shared decision-making at the time of discharge. The physician would then participate in shared decision-making at the time of discharge and provide discharge instructions to the patient and family. If the emergency physician, in collaboration with the primary care physician or designated specialist, determines that the patient is a candidate for discharge, the information captured during the SDA would be used to generate unique patient discharge instructions including identifying symptoms that would require rapid reassessment and return to the ED.

After the initial ED visit, the patient would expect to receive excellent follow-up care from the ED physician, their primary care physician, and other specialists as needed. In fact, the whole model is centered on care coordination from the time the decision is made to discharge the patient to the end of each episode. Major care coordination activities include:

- Using care coordinators to facilitate appropriate discharge which has proven effective in the inpatient to outpatient arena;
- Employing shared decision making to ensure that patients understand their treatment options;
- Enabling emergency physicians to partner with primary care and to manage unscheduled care episodes by protocol;
- Enabling emergency physicians to arrange for a post-discharge home visit when appropriate;
- Enabling use of telehealth to follow up with discharged beneficiaries; and
- Incorporating payment for one post discharge follow up visit at home or an ED visit for selected conditions when post discharge follow up is not available within 48 hours.

ACEP would be happy to work with CMS on how to incorporate features of the AUCM into a specialty care model geared towards emergency physicians.

Low Titer O+ Whole Blood Transfusion Therapy During Ground Ambulance Transport

Under the Ambulance Fee Schedule (AFS), Medicare Part B covers seven levels of service for ground (including water) ambulance transports and two levels of service for air ambulance transports. The levels of service for ground ambulance transports include basic life support (emergency); basic life support (non-emergency); advanced life support, level 1 (ALS1) (emergency); ALS1 (nonemergency); advanced life support, level 2 (ALS2); paramedic intercept; and specialty care transport (§410.40(c)).

While there may be variance between jurisdictions, the protocols for many emergency medical services (EMS) systems currently providing whole blood transfusion (WBT) are designed for patients who require complex management at the advanced life support level, demonstrating suspicion of blood loss along with evidence of physiologic shock as indicated by parameters such as low blood pressure, an elevated pulse rate, or slow capillary refill. Based on the usage of WBT, as most patients requiring such transfusions are generally critically injured or ill and often suffering from cardio-respiratory failure and/or shock, and therefore are likely to receive one or more procedures currently listed as ALS procedures in the definition of ALS2, CMS proposes to modify the definition of ALS2 at §414.605 by adding the administration of low titer O+ WBT to the current list of ALS2 procedures. Under this proposal, a ground ambulance transport that provides WBT would itself constitute an ALS2-level transport.

CMS recognizes that some established EMS systems may already provide WBT to treat patients in hemorrhagic shock, while other jurisdictions, including those in rural areas, do not, and often will instead rely on alternative blood product treatments such as packed red blood cells (PRBCs) and plasma, which has the same training, administration, and monitoring as for WBT. While CMS does not include alternative blood product treatments in the proposal, the agency seeks comment on whether alternative blood product treatments should be added to the list of ALS2 procedures.

ACEP appreciates CMS' proposal to modify the definition of ALS2 to include ground ambulance transport that provides WBT, thereby providing coverage for low titer O+ blood transfusion therapy under Medicare. We agree with CMS' assertion that the clinical acuity of a patient receiving whole blood in pre-hospital care would be equivalent to that of a patient receiving blood component therapy, thereby making it appropriate to fall under the ALS2 definition. However, availability of whole blood products varies across EMS systems. When whole blood is not available, EMS systems utilize blood component therapy as an alternative. Thus, we request that universal whole blood products – including O- as well as O+ - be added under ALS2, as well as blood component therapies that are used as alternatives when whole blood products are unavailable.

It is important to note that WBT can be clinically appropriate – and necessary – in both ground ambulance and air ambulance settings. Thus, ACEP supports coverage of WBT therapy for both ground ambulance transports and air ambulance transports and asks for clarity on the omission of air ambulance coverage from the proposal.

The Quality Payment Program

Under the Quality Payment Program (QPP), eligible clinicians can be subject to payment adjustments based upon performance under the Merit-based Incentive Payment System (MIPS), or they can participate in the Advanced Alternative Payment Model (APM) track. Eligible clinicians in MIPS will have payments increased, maintained, or decreased based on relative performance in four categories: quality, cost, promoting interoperability and improvement activities. CMS has also implemented a new alternative to traditional MIPS, called the MIPS Value Pathways (MVPs), as a voluntary option but in the rule, the agency signals efforts to move exclusively towards this reporting pathway by 2029.

Transforming the Quality Payment Program – Request for Information

General Comments

Medicare plays a lead role in CMS' goal of transitioning the health care system away from fee-for-service payment, which incentivizes the quantity of care, toward value-based payment, which incentivizes higher-quality care and smarter spending. One of the CMS National Quality Strategy goals is to improve quality and health outcomes across the health care journey through the implementation of a "Universal Foundation" of impactful measures across all quality and value-based programs, with the intent to focus clinician attention on specific quality measures, reduce burden, help identify disparities in care, prioritize development of interoperable digital quality measures, allow for cross-comparisons across programs, and help identify measurement gaps.

In this request for information (RFI), CMS addresses how to achieve full MVP adoption and subgroup participation as the agency moves toward the sunsetting of traditional MIPS. CMS seeks comment on, but does not propose, a target sunset date of performance year 2029/payment year 2031. CMS intends to obtain more meaningful comparable

performance data and to drive higher value care through MVPs and to provide as much transparency as possible about the timing for sunsetting traditional MIPS. Specifically, CMS seeks feedback on clinician readiness to report MVPs, how to ensure there are applicable MVPs for all clinicians, including the option of creation of broadly applicable MVP(s), and what guidance/parameters are needed for multispecialty groups to place clinicians into subgroups for reporting an MVP relevant to the scope of care provided.

CMS is considering several approaches that would assist in making MVPs available to all MIPS eligible clinicians. However, as we detail below, all approaches to being more inclusive of clinicians are hindered by the existing gaps in quality and cost measures. These approaches include expanding previously finalized MVPs to include different specialties included in care delivery for patient population; expanding previously finalized MVPs to include subspecialties; developing MVPs based on multiple specialty Measure Sets; developing MVPs based on cross-cutting and broadly applicable measures; and, developing MVPs for non-patient facing MIPS eligible clinicians.

ACEP believes it may be premature to consider the transition to MVPs. We do appreciate the implementation of the "Adopting Best Practices and Promoting Patient Safety within Emergency Medicine" MVP. However, as described in our response to the ambulatory specialty care model RFI above, we are generally concerned that there has been limited uptake of the MVP based upon the reporting trends from last year. We believe that the primary reason why so few emergency physicians have reported the emergency medicine MVP is because there are not sufficient incentives in place that would encourage them to do so. Further, whilst we see the value of MVPs as a reporting option and acknowledge that broader participation in MVPs supports CMS' long-term goal to transition clinicians to participate in APMs, we have concerns about the ambiguous and dubious pathways that will transition clinicians from MVP participation to APM participation. As previously mentioned in the ambulatory specialty care model RFI response, the emergency medicine MVP was constructed based off the Acute Unscheduled Care Model (AUCM), which ACEP developed to fill the gap in available emergency medicine APMs. As there is significant synergy between this MVP and the AUCM, the overlap of measures will allow the MVP to serve as the vehicle needed to incrementally phase emergency clinicians into APMs. However, because of the delayed implementation by CMMI of the AUCM despite the "Deserves Priority Designation" given to the model by the Physician-Focused Payment Model Technical Advisory Committee (PTAC), emergency clinicians continue to be left out of the process of transitioning to APMs and thus fail to see the practicality and advantage of reporting under the MVP.

Barriers to Submitting MVPs

There are several barriers for clinicians to participate in MVPs that are both perceived and actual and both operational and financial. For many clinicians, these obstacles to MVP participation simply outweigh the benefits from reporting. We offer several suggestions for additional incentives that CMS could offer to encourage clinicians to participate in MVPs.

ACEP believes there should be additional incentives for initially participating in an MVP over traditional MIPS. Although we had hoped that participating in the emergency medicine MVP would 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, many emergency physicians have been hesitant to make any changes to their reporting patterns. To encourage clinicians to go through the effort of making necessary reporting changes, ACEP 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 in these critical initial stages.

In addition to establishing a participation incentive bonus, clinicians who participate in MVPs should also be held harmless from 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 overall and are not able to choose from as broad a range of quality measures and improvement activities. Under traditional MIPS, clinicians report on as many quality measures as possible, 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 the Emergency Medicine MVP, they would only be able to report up to 12 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.

CMS should also eliminate the foundational layer of population-based measures included in each MVP. Overall, ACEP believes 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 that are actually under the control of the physician. As hospital-based clinicians, we are concerned about the measure reliability and applicability, case size, attribution, and 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 sufficiently granular information for physicians to make improvements in practice. Physicians do not treat a defined population, but rather treat patients as individuals tailored to their specific needs.

Finally, should CMS decide to sunset traditional MIPS, the agency must consider the implications on quality measures that have been developed and maintained by medical societies. The development of quality measures has required significant effort, time, and resources, and we do not want those to simply go away as needed changes are brought to the program. **Qualified clinical data registry (QCDR) measures have been developed for the sole purpose of improving care for patients seen by such specialists, and such a valuable tool must be maintained.**

Meaningful MVP Participation

Though emergency medicine is included as one of the newest MVPs, many specialties do not currently have reportable MVPs. CMS asks if the agency should consider developing a more global MVP with broadly applicable measures as an interim bridge for those clinicians with too few specialty-specific quality measures.

ACEP supports a generic MVP approach. It should embody the same special circumstances as other MVPs and traditional MIPS. This generic MVP would rely on CMS-calculated quality measures and only include participant input for promoting interoperability and improvement activities performance categories. In addition, although some emergency physicians can report the emergency medicine MVP, given different practice arrangements amongst emergency physicians, not all of them may find that this MVP is appropriate for their practice. Therefore, we appreciate the flexibility that a more global MVP would provide so more clinicians can participate in the MVP reporting process.

Subgroup Reporting

CMS established a voluntary subgroup participation option for clinicians choosing to report an MVP beginning in the CY 2023 performance period/2025 MIPS payment year and finalized a mandatory subgroup reporting requirement for multispecialty groups choosing to report as an MVP Participant beginning in the CY 2026 performance period/2028 MIPS payment year. Beginning with the CY 2026 performance period/2028 MIPS payment year, a single specialty group may continue to submit data for an MVP at the group level, and a multispecialty group must form subgroups to report an MVP.

CMS seeks comment on the technological barriers, if any, that impact the ability to successfully submit subgroup level data. The agency asks how to balance the increase in burden for multispecialty groups while allowing comprehensive reporting on the diverse range of services provided by the clinicians in a group and consider establishing a process during MVP registration for groups to self-identity if the group is considered a single specialty or multispecialty group. Lastly, CMS asks for additional approaches to consider for providing guidance to groups on appropriately placing clinicians into subgroups based on the scope of care provided.

ACEP believes that subgroup reporting should be optional for the foreseeable future. We are concerned with 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, which can span multiple specialties. 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, the 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.

Subgroup reporting will also highly discourage MIPS participation in the future as multispecialty tax identification numbers (TINs) will find the cost of reporting MIPS exceeding the penalties. A group with three to four specialties will need as many as four different solutions (third party intermediaries, web reporting, etc.). In many cases, these subgroups may only have one or two eligible physicians. Simply put, the cost of reporting will likely outweigh any bonuses received. The likely reaction will be that groups will choose to report nothing and take the penalty as that will cost less than reporting. Thus, subgroup reporting should be optional and small groups should be exempt from subgroup reporting as the burden placed on the group is much too large.

Finally, 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.

MVP Development, Maintenance, and Scoring

Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP

As stated previously, ACEP developed an emergency medicine-focused MVP called the "Adopting Best Practices and Promoting Patient Safety within Emergency Medicine" MVP. We are pleased that in the CY 2022 PFS final rule, CMS finalized seven MVPs available for reporting beginning with the CY 2023 performance period/2025 MIPS payment year, including Adopting Best Practices and Promoting Patient Safety within Emergency Medicine—and that CMS continues to refine this MVP as needed.

MVP Requirements and Scoring

In this proposed rule, CMS is proposing to update the registration process and scoring policies for population health measures in the quality performance category, clarify the alignment between scoring cost measures in MVPs and traditional MIPS, update requirements and scoring policies for improvement activities in the improvement activities performance category, and update the requirements for subgroup reporting in the Promoting Interoperability performance category. Specifically, for the Quality performance category, CMS is proposing to use the highest score of all available population measures, rather than having participants select their own population measure, to avoid inadvertent selection of measures that may not meet the case minimum requirement.

While ACEP has concerns about the use of population measures in MVPs, we support CMS' proposal to use the highest score attributable to clinicians and urge the agency to finalize this proposal if it were to continue using population measures in MVPs.

Data Submission in the Quality Performance Category – Multiple Data Submission in the Quality and Improvement Activities Performance Categories

CMS proposes to codify that if the agency receives multiple submissions for an individual clinician, group, subgroup, or virtual group for the quality or improvement activities performance from submitters from separate organizations, the agency scores each and assigns the highest of the scores for the performance category. If multiple submissions are received from the same organization, then CMS will use the most recent submission. ACEP does not support CMS' proposal to codify existing policy on the treatment of multiple data submissions for the quality and improvement activities category when multiple submissions are received from the same organization. CMS should maintain its existing policy to assign the highest score.

MIPS Performance Category Measures and Activities

Quality Performance Category

Data Completeness Criteria

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 75 percent through the 2028 performance period to create stability in quality reporting requirements.

ACEP supports this proposal, as we believe that physicians and group practices are already being held to a 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 75 percent data completeness threshold. Until enough data and care can be integrated across settings, it would be unfair 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. Therefore, again, we urge CMS to maintain the current data completeness threshold, as proposed.

Modifying the MIPS Quality Measure Set

CMS is proposing to reduce the inventory of quality measures from 196 to 194 through the removal of 11, addition of nine and editing of 66 (a net decrease of two quality measures). For the emergency medicine specialty set, CMS is proposing the removal of the following measures:

- 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 or up to 2 days after the date of the qualifying encounter.

  In the PFS CY 2023 proposed rule comments, ACEP commented that we did 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 commented 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.

  Thus, based on our past comments, ACEP supports the removal of this measure from the emergency medicine specialty set.

- Ultrasound Determination of Pregnancy Location for Pregnant Patients with Abdominal Pain: Percentage of pregnant female patients aged 14 to 50 who present to the emergency department (ED) with a chief complaint of abdominal pain or vaginal bleeding who receive a trans-abdominal or transvaginal ultrasound to determine pregnancy location.

CMS is proposing removal of this measure because it has been "topped out." ACEP agrees with the removal of this measure.

For the emergency medicine specialty set, CMS is proposing the addition of the following measure:

- Elder Maltreatment Screen and Follow up Plan: Percentage of patients aged 60 years and older with a documented elder maltreatment screen using an Elder Maltreatment screening tool AND documented follow-up plan on the date of the positive screen.

  ACEP supports the inclusion of this measure in the emergency medicine specialty set. Hospitals are increasingly faced with older patients who have complex medical, physiological, and psychosocial needs that are often inadequately addressed by the current health care infrastructure. In response to this gap in care, we need to develop measures that identify clinical frameworks based on evidence-based best practices to provide goal-centered, clinically effective care for older patients. To accomplish this objective, ACEP created and operates the Geriatric Emergency Department Accreditation program, or GEDA. Geriatric emergency departments (GEDs) incorporate specially trained staff, assess older patients in a more comprehensive way, and take steps to make sure the patient experience is more comfortable and less intimidating for older adults. All of this allows for a better care experience for older adults while in the ED and safer transitions to a community setting for those who do not need medical admission. One of the hallmarks of GEDs is their enhanced screening processes, in which patients receive additional screenings that can quickly uncover physical or mental health risks that are more common in older adults, including screening for elder mistreatment.

  We are encouraged that CMS recognizes the benefits of having EDs that focus on the care and needs of the geriatric population, and we look forward to working with CMS to continue advancing geriatric emergency care.

Cost Performance Category

CMS proposes a significant potential change to the cost scoring methodology starting in the 2024 performance period/2026 MIPS payment year. If finalized, these changes would take effect when 2024 final scores are released in summer 2025. Under this proposal, CMS would use a new distribution for cost scoring in which the median cost for a measure would be set at a score derived from the performance threshold established for that MIPS payment year. This differs from the current scoring methodology, where the benchmark is based on average performance of all MIPS eligible clinicians during that same performance period, which has meant that participants have not known how they will potentially be scored. For example, for the CY 2024 performance period, the median would be set at 7.5 and benchmark point ranges would then be calculated based on standard deviations from the median. CMS's analysis shows that this change for MIPS eligible clinicians assessed on at least one cost measure and receiving a cost performance category score would increase by 3.89 points and would not negatively impact MIPS eligible clinicians whose average costs for a specific cost measure are around the median.

Currently, CMS does not have an established process for removing the MIPS cost measures. The rule outlines factors the agency may consider to remove cost measures, including the following:

- It is not feasible to implement the measure specifications.
- The measure steward is no longer able to maintain the cost measure.
- The implementation costs or negative unintended consequences associated with a cost measure outweigh the benefit of its continued use in the MIPS cost performance category.
- The measure specifications do not reflect current clinical practice or guidelines.
- A more applicable measure is available, including a measure that applies across settings, applies across populations or is more proximal in time to desired patient outcomes for the particular topic.

CMS may retain a cost measure that meets one or more of these criteria if the agency determines the benefit of retaining the measure outweighs the benefit of removing it.

Overall, ACEP supports these changes to the cost category. We appreciate CMS' efforts towards improving the scoring process, as by design, only half of clinicians who submit MIPS scores receive a positive adjustment. **However, while CMS has tried to identify and address some of the issues with the cost category, these reforms do not resolve the core deficiencies of the category: the lack of transparency around attribution; the lack of clinical relevancy to so many clinicians; the lack of timely feedback that is essential for improving performance; and, the lengthy process for developing new measures.**

Many of our members have expressed concern and frustration about not understanding what measures they are attributed to and about not receiving timely feedback in order to make actionable improvements to their scores year over year. We urge the agency to improve their processes around performance reports and accountability around attribution for the cost performance category.

Every entity involved in MIPS reporting—including QCDRs—is required to give periodic updates on performance during the year. However, to establish the same level of transparency, we urge CMS to follow the same reporting requirements on the cost category as all other MIPS entities and report metrics on the cost category measures on at least a quarterly basis. This routine update and assessment would mitigate confusion and frustration with the ambiguity around the cost category.

Improvement Activities Performance Category

CMS is proposing to add two new improvement activities, modify two existing improvement activities, and remove eight previously adopted improvement activities for the CY 2025 performance period/2027 MIPS payment year and future years. This is an initial step in efforts to streamline the Inventory over the coming rulemaking cycles to include only the most robust and clinically meaningful improvement activities, as over the last several performance years, CMS has observed that some activities "have not remained aligned with the latest updates to clinical practice standards, have not incorporated the latest national priorities, and/or have activity requirements that are no longer substantive enough to promote a sufficient level of clinical practice improvement in today's health care environment."

In line with its goal to streamline the improvement activities performance category, CMS is also proposing two scoring and reporting policy modifications: eliminating the weights of improvement activities and reducing the number of activities to which clinicians are required to attest to achieve a full score in the improvement activities performance category.

ACEP supports these proposals, as we believe that the current designation of weights for improvement activities is artificial and does not actually correlate with the value of the activity to both clinicians and their patients.

Promoting Interoperability Performance Category

Though most emergency physicians are deemed hospital-based clinicians and therefore exempt from the promoting interoperability performance category, ACEP offers comments to the relevant questions in the RFI in this section.

Request for Information (RFI) Regarding Public Health Reporting and Data Exchange

CMS is working in partnership with the Centers for Disease Control and Prevention (CDC) and the Office of the Assistant Secretary for Technology Policy and Office of the National Coordinator for Health Information Technology (ASTP/ONC) to explore how the promoting interoperability performance category could advance public health infrastructure through more advanced use of health IT and data exchange standards. They set forth a series of goals and principles for the performance category's Public Health and Clinical Data Exchange objective, provide information about recommended updates to health IT certification criteria under consideration that may impact MIPS eligible clinicians and seek public comment on potential updates that could help achieve these goals.

Goal #1: Quality, Timeliness, and Completeness of Public Health Reporting

The promoting interoperability performance category's requirement that MIPS eligible clinicians report the level of "active engagement" between the MIPS eligible clinician and a public health agency (PHA) has provided a basis to broadly incentivize the exchange of electronic health record (EHR) data. However, because active engagement reporting only requires an attestation of whether a MIPS eligible clinician is reporting production data or still in the process of validation, CMS states that this approach does not allow the agency to assess MIPS eligible clinicians on the comprehensiveness, quality, or timeliness of the data they provide to PHAs. CMS is considering whether alternatives to the "active engagement" approach for the measures under the Public Health and Clinical Data Exchange objective could better allow assessment of MIPS eligible clinician's performance, meet the data needs of PHAs, and ultimately allow incentivization for increased performance in these areas.

- *Should CMS shift to numerator/denominator reporting requirements for current and future measures in the Public Health and Clinical Data Exchange objective? If so, should CMS prioritize only certain measures for numerator/denominator reporting?*

ACEP believes that a further shift to numerator/denominator reporting requirements for current and future measures in the Public Health and Clinical Data Exchange objective presents significant challenges. Numerator/denominator measures inherently add to the complexity of reporting within the promoting interoperability category and MIPS. This complexity could be particularly burdensome for specialty physician groups, who often lack direct access to hospital systems and sophisticated reporting tools. Overburdened and understaffed hospital IT departments are often unable or unwilling to customize reports to specific patient types, which could further complicate reporting processes.

This increased reporting burden could de-incentivize participation in the program, especially among smaller practices and specialty groups. A decline in participation would not only affect the completeness of the data collected but also potentially undermine the program's overall goals of improving public health outcomes through data exchange.

- *Should CMS continue to add measures under the Public Health and Clinical Data Exchange objective to include additional system-specific requirements (for example, vital records)? If so, which ones and why? Should CMS create a new measure for each new type of data or use case added to the Public Health and Clinical Data Exchange objective? What are the risks of including too many measures under the objective? Alternatively, should CMS explore ways to group data types and use cases under a more limited set of Public Health and Clinical Data Exchange objective measure? If so, are there specific scenarios where doing so would make sense?*

ACEP believes that because EHR systems are chosen and managed by hospital systems by which many clinicians are contracted, individual clinicians are far removed from the data exchange and interoperability performance of their EHR. Thus, qualitative data on the entire facility should be captured, but not attributed to the individual clinician or specialty group/TIN, in lieu of continuing to add measures under the Public Health and Clinical Data Exchange objective and further complicating reporting processes.

Anecdotal reports suggest that some healthcare providers are attesting to active engagement with public health for the eCR measure if they report cases for at least one notifiable condition (for example, COVID-19).

- *What potential benefit versus burden trade-offs CMS should consider? How should CMS account for varying levels of public health readiness and capacity for expanding conditions reported electronically, such as in rural areas? What additional levers besides the Promoting Interoperability performance category should CMS explore to improve the completeness of reporting to public health? How should CMS work with other partners to incentivize or require reporting?*

ACEP agrees with CMS that public health readiness and capacity for expanding public health outcomes could be strengthened by improved interoperability and data reporting completeness. 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. However, the biggest challenge that QCDRs face 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. Thus, the bureaucratic ownership and red tape impeding data flow from and between hospitals, clinicians, and public health institutions hinders public health readiness.

Goal #2: Flexibility and Adaptability of the Public Health Reporting Enterprise

During the COVID-19 and Mpox public health emergencies (PHEs), health care providers and PHAs often had to quickly update their systems to report case, laboratory, and vaccination data related to these novel pathogens and interventions devised in response to them. In this section, CMS is seeking information about how the promoting interoperability performance category could improve the ability for public health infrastructure to quickly adapt to new threats.

- *How can CMS and ONC work with EHR vendors to ensure that provider systems are being continually updated to meet new data needs, such as those in rural areas?*

ACEP believes that institutions that have outdated and/or cost-effective, lower-end EHR that is less maneuverable are typically those in rural and underserved areas that do not have the resources to continually update and improve their EHR systems. Instead of targeting individual institutions with limited resources, CMS and ONC should work with larger EHR vendors to make their products more interoperable with older systems, instead of the other way around. Doing so would enable more rural systems to migrate into more interoperability without taking on an untenable cost.

Goal #3: Increasing Bi-Directional Exchange with Public Health Agencies

The transition to, and use of, more modern, flexible approaches and networks that support data exchange between and across public health and healthcare is a key goal of HHS efforts to modernize the public health information infrastructure. CMS seeks comment on ways that the Promoting Interoperability performance category can support this transition.

ACEP strongly believes that hospital cooperation to share data at all or at a reasonable cost is a major barrier to these vital activities. CMS must create appropriate incentives for hospitals to both cooperate and provide data to data aggregators such as ACEP's Emergency Medicine Data Institute. EMDI puts data and technology to work to elevate the impact and visibility of emergency medicine. EMDI data metrics will inform future benchmarking and predictive modeling of major health events, helping to shape national health policy and population health management.

Encouraging entities to submit data to data aggregators would help advance the goal of the Trusted Exchange Framework and Common Agreement (TEFCA). One option for incentives might be for CMS to designate, certify, or somehow sanction data aggregators like EMDI as essential public health data arbiters. Hospitals should be required to share data within scope to meet public health objectives.

Goal #4: Significantly Reduce Reporting Burden for Healthcare Providers

- *How can the Promoting Interoperability performance category balance robust Public Health and Clinical Data Exchange objective requirements with our desire to reduce burden on MIPS eligible clinicians?*

ACEP believes that the measures which require a numerator and denominator should not be TIN specific. Because these measures are based on the hospital systems such as e-Prescribing and Provider to Patient Exchange, the calculated scores would remain consistent between the various specialty groups and TINs. Filtering these reports for specific types of patients is burdensome for the specialty groups as they do not have direct access to hospital systems and reporting tools. Additionally, facility IT departments may be unable to allocate the appropriate resources to filter out specific patients. Each TIN should be permitted to report the scores for the entire facility.

- *How can new technical approaches to data exchange with PHAs, such as the use of FHIR APIs, reduce burden for MIPS eligible clinicians? What are potential barriers to achieving burden reduction as these new approaches are implemented?*

ACEP knows that many burdens exist 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 EMDI 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 Final Scoring Methodology

Topped Out Measures

Topped out measures are measures for which measure performance is considered so high and unvarying that meaningful distinctions and improvements in performance can no longer be made. Per CMS, topped out measures do not provide an opportunity for continued improvement nor, more broadly, do payment adjustments based on topped out measures incentivize clinicians to improve their care, and as a result, CMS previously finalized policies to identify and cap the scoring potential of such measures.

However, clinicians reporting specialty sets in which there is high presence of topped out measures receiving the 7-point cap are often facing both limited measure choice and limited scoring opportunities. To address this, CMS proposes to, beginning with the CY 2025 performance period/2027 MIPS payment year, remove the 7-point cap for certain topped out measures. The 97th percentile performance rate would then correspond to 7.5 measure achievement points. CMS would conduct an analysis annually to determine which specialty measure sets are impacted by limited measure choice and which measures should be subject to the scoring cap exemption.

ACEP recognizes that some specialties have limited opportunities to report measures meaningful to them, and those measures that they can choose can soon become topped out. ***These specialties should not be penalized because of their limited options of measures from which to choose.*** Development of MIPS measures involves significant investments of time, money, and administrative burden. Removal of topped out measures specifically for specialty measure sets removes the incentive for specialties to develop measures for their clinicians.

MIPS Payment Adjustments

Establishing the Performance Threshold

To avoid a negative adjustment and be eligible for a positive payment adjustment, a clinician's MIPS total score must reach a performance threshold. CMS proposes to maintain the 2025 MIPS performance threshold of 75 points. Historically, CMS had increased the MIPS performance threshold, but during the COVID-19 PHE, the agency maintained a 75-point threshold for consecutive years, allowing MIPS participants to avoid additional quality reporting challenges. The agency could still change the threshold in the final rule and in future years as the program continues to develop.

ACEP strongly supports this proposal. For some clinicians, this may be the first or second year they have reported since the hiatus in reporting caused by the COVID-19 PHE. In order to reintegrate back into MIPS reporting, ACEP believes it is most appropriate to slowly increase the performance threshold over time. Raising the performance

threshold too quickly would penalize clinicians for not meeting a threshold that does not accurately represent the actual performance of the majority of MIPS eligible clinicians. It would also have a more detrimental impact on smaller physician practices and those located in rural areas, as these practices may not have the resources necessary to perform as well in MIPS. CMS must keep the threshold at 75 points in performance year 2025, as it has proposed.

Proposal to Adopt Reweighting Performance Category(ies) Policy When a Third-Party Intermediary Did Not Submit Data Due to Reasons Outside the MIPS Eligible Clinician's Control

CMS is proposing to allow clinicians to request reweighting for quality, improvement activities, and/or promoting interoperability performance category(ies) where data are inaccessible and unable to be submitted due to reasons outside of the control of the clinician because the clinician delegated submission of the data to their third party intermediary (evidenced by a written agreement) and the third party intermediary didn't submit the data on the clinician's behalf in accordance with applicable deadlines.

ACEP supports this proposal. Clinicians should not be penalized for unpredictable elements outside of a clinician's control. Recently, CMS granted extensions for reporting hardships caused by cyberattacks on medical claims processors. We appreciate CMS' continued efforts to make MIPS performance scoring as fair as possible by taking adverse uncontrollable events into account and allowing for corrective action when clinicians' scores may be negatively impacted.

Third-Party Intermediary Requirements

Overall, ACEP believes that CMS should do more to promote the use of QCDRs. A number of challenges and burdens limiting the uptake of QCDRs persist. For ACEP's QCDR, the Clinical Emergency Data Registry (CEDR), the biggest challenge has been garnering the cooperation of hospitals on behalf of our clinician client base. As previously noted, hospitals have no incentive to build or maintain data feeds to serve their contacted clinicians. In fact, a substantial number of emergency physicians that use CEDR to report quality measures are unable to receive any data at all 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 MIPS facility-based scoring option unless CMS takes more concrete actions going forward to help improve data exchange between hospital EHRs and registries. In addition, hospitals often charge clinicians groups exorbitant fees to build these data feeds. We urge CMS to consider requiring hospitals to share data with hospital-based clinician groups.

Further, as emergency physicians strive to provide high-quality, objective, and evidence-based medicine, we should ensure clinician-led registries have access to Medicare claims data. These data are critical in tracking patient outcomes over time, expanding the ability to assess the safety and effectiveness of care, and providing information necessary to assess the cost of delivered care.

Another 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 that has helped tens of thousands of emergency physicians participate successfully in MIPS.

With respect to QCDR measure approval requirements, while testing measures and ensuring their validity is critical, we believe that the QCDR testing requirements are overly stringent, place a significant burden on QCDRs, and make it difficult for some smaller QCDRs to continue participating in the MIPS program. We also suggest that QCDR statisticians familiar with sample sizes and populations should be the ones to decide the level of testing (clinician, facility, or group) required. We therefore reiterate our request that CMS 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.

CMS must create an exemption for hospital-based clinicians when the hospital changes their EHR vendor. These conversions create chaos in data acquisition and registry participation as patient care is the focus of the hospital when converting. Complicating matters, the prior EHR vendor often becomes completely unresponsive for issues long before the conversion takes place, preventing effective participation for a full year of data. The new vendor is focused on patient care; thus, registry data becomes a low priority, hampering the integration to the registry. Physician groups are in no position to elevate the MIPS data need over patient care.

Qualifying APM Participant (QP) Determinations and the APM Incentive

ACEP remains extremely concerned about the trajectory of the Advanced APM track of the QPP. As previously discussed in multiple sections throughout our letter, ACEP created the emergency medicine APM called the Acute Unscheduled Care Model (AUCM) in 2017. We believe that emergency physicians are eager and ready to be in an APM and that their participation in APMs is vital to our collective goal of improving quality and reducing costs. Every day, emergency physicians act as gatekeepers to hospitals, making critical decisions about whether the patient should be kept for observation, admitted to the hospital, or discharged. The AUCM model is designed to reflect and reward this important role that emergency physicians play in the health care system. However, despite the promise of AUCM and the benefit that engaging emergency physicians in APMs can bring, to date, most health care delivery reforms, have focused on primary care and chronic disease management for the purpose of decreasing the need for acute care and reducing ED utilization and spending. These are undoubtedly critical aspects of our health care system – but neglecting to incorporate acute care delivery in large-scale health system redesign is a lost opportunity. It also perpetuates an incorrect and harmful notion of the ED as a "failure" of the health care system, rather than recognizing the unique role of emergency physicians as the safety net who care for patients at their greatest time of need. Even the best managed patients may have acute needs that cannot be adequately addressed in another setting or occur after regular hours. Thus, it is imperative that CMS 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.

We also encourage CMS to work with Congress to ensure that there are better incentives for participating in an Advanced APM. Under the Medicare Access and CHIP Reauthorization Act (MACRA), eligible clinicians who become Qualifying APM Participants (QPs) were eligible for a 5 percent APM Incentive Payment. However, after performance year 2022 (with a corresponding payment year of 2024), there was no further statutory authority for this bonus in MACRA. Congress extended the bonus for performance year 2023 (payment year 2025) in the CAA, 2023 at a lower rate of 3.5 percent. ACEP believes these bonuses should be extended further. Beginning in 2026, there is a separate conversion factor update for clinicians who participate in MIPS and those who are QPs. The conversion factor update for QPs is 0.75 percent, and the update for non-QP MIPS clinicians is 0.25 percent. After 2026, CMS believes that 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 conversion factor increase. We share CMS' concern that this financial structure may incentivize more clinicians to participate in MIPS than Advanced APMs but reiterate that many specialists like emergency physicians simply have no opportunity to participate in Advanced APMs. It is simply unfair that most specialists had no reasonable chance to qualify for the now expired five percent APM incentive payment. Thus, CMS should work with Congress to prioritize extending the five percent bonus for participation in Advanced APMs.

We appreciate the opportunity to provide comments. If you have any questions, please contact Erin Grossmann, ACEP's Manager of Regulatory and External Affairs, at egrossmann@acep.org.

Sincerely,

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