American College of Emergency Physicians (ACEP) and EOP

Overview of ACEP Comments on the CY 2019 PFS and QPP Proposed Rule

Monday, October 15, 2018
2:00 PM – 2:30 PM EST
New Executive Office Building, Room 9258

AGENDA

2:00 - 2:05 PM	Welcome and Introductions	All
2:05 - 2:15 PM	Appropriate Use Criteria Program	Laura Wooster, MPH – Associate Executive Director, Public Affairs Jeffrey Davis – Director of Regulatory Affairs
2:15 - 2:25 PM	Qualified Clinical Data Registry (QCDR) Proposals	Laura Wooster and Jeffrey Davis
2:25 - 2:30 PM	Other Issues and Wrap up	All

ACEP Responses to Appropriate Use Criteria (AUC) Program Policies in the CY 2019 PFS and QPP Proposed Rule

- AUC Program for Advanced Imaging Details—created in legislation in 2014, this program will require physicians ordering advanced imaging to first consult appropriate use criteria through approved clinical decision support mechanisms in order for the furnishing provider/radiologist to be able to receive payment.

  ACEP Response:

  - Call on CMS again to correct its misinterpretation of Congress' exemption for emergency medical conditions.
  - If CMS does not make this correction, ask CMS to at least create an additional exemption in cases where clinicians believe that their patients may be experiencing an emergency at the time of ordering.

Detailed Comments on AUC Program

Allow the Consultation of AUC Through a Qualified CDSM to be Performed by Clinical Staff

ACEP supports the proposal to allow the consultation with AUC through a qualified CDSM to be performed by clinical staff working under the direction of the ordering professional, subject to applicable State licensure and scope of practice law. As discussed in detail below, we have significant concerns with emergency physicians consulting with AUC when dealing with potentially emergent situations in EDs. However, in general, and potentially non-emergent situations, allowing clinical staff to consult with the AUC would be beneficial to both the patient and the physician.

Hardship Exemption Comment Solicitation

ACEP remains extremely disappointed and concerned that CMS is not categorially exempting ED encounters from the AUC Program. PAMA exempts emergency services defined as an "applicable imaging service ordered for an individual with an emergency medical condition" (as defined by EMTALA). ACEP appreciated the recognition in the law that the federal EMTALA law imposes a duty to provide a medical screening exam to any individual who comes to the ED. But Congress, through an inadvertent drafting error, referenced the section of EMTALA Sec.1867(e)(1) that defines an emergency medical condition, rather than referencing Sec. 1867(a) which codifies the requirement to provide a medical screening exam. Aside from cases of obvious trauma or severe visible medical symptoms, in most cases a medical screening exam is required before definitively establishing that an emergency medical condition exists.

This is a decision based on the emergency physician's clinical assessment of the patient's presenting symptoms/condition. There are many occasions when the patient appears quite ill or injured and advanced imaging is ordered before the emergency physician can even complete the medical screening exam. In fact, CMS noted in the CY 2017 physician fee schedule proposed rule that:

"While the acuity of some patients in the emergency department might be the same as in a physician's office, in general, more acutely ill patients are more likely to be seen in the emergency department, and that difference is part of the reason there are separate codes describing evaluation and management visits in the Emergency Department setting. Given that the practice of emergency medicine often requires frequent and fast-paced patient reassessments, rapid physician interventions, and sometimes the continuous physician interaction with ancillary staff and consultants, it differs from the pace, intensity, and acuity associated with visits that occur in the office or outpatient setting." [1]

This is in contrast to CMS's explanation of the AUC section in the same rule that stated (emphasis ours) "furthermore, we recognize that **most encounters in an emergency department are not for an emergency medical condition** as defined in section 1867(e)(1) of the Act."[2] It is also runs directly counter to the annual ED survey data collected by the Center for Disease Control (CDC). According to the CDC's most recent National Hospital Ambulatory Medical Care Survey (NHAMCS), only 5.5 percent of ED visits are avoidable (considered non-urgent).[3]

We have pointed these concerns out to CMS staff on several occasions over the past few years to no avail. The House Energy and Commerce Health Subcommittee Chair, Rep. Pitts agreed that this was indeed a drafting error and wrote to CMS's then-Acting Principal Deputy Administration Dr. Patrick Conway on April 15, 2016. Among other requests included in the letter, on page four Chairman Pitts stated:

"When Congress enacted PAMA…we wanted to ensure these provisions did not have an unintended consequence of delaying care for patients who sought medical attention in an ED until after it was determined that they did not have an emergency medical condition (defined in Sec. 1867(e)(1). ***This exception not only covers individuals with an identified emergency medical condition, but also the applicable imaging service ordered to determine whether or not the individual has an emergency medical condition."*** (Emphasis ours).

CMS responded to Chairman Pitts later in 2016 noting that "we will consider this issue as we work on implementing the AUC program." Instead, several months later the Agency in the CY 2017 Physician Fee Schedule Final Rule said (emphasis ours), "We do not have a reason at this time to believe that a categorical exception granted to emergency departments would foster inappropriate use of advanced imaging services. However, we believe such a categorical exception would not be consistent with the statutory requirement under section 1834(q)(4)(C)(i) of the Act, which is framed in terms of individual services." This directly contradicts what Chairman Pitts, who was involved in PAMA's drafting himself, has stated on

[1] CY 2017 Physician Fee Schedule Proposed Rule, 81 Fed. Reg. 46,182 (July 15, 2016).
[2] 81 Fed. Reg. 46,393
[3] The 2015 National Hospital Ambulatory Medical Care Survey (NHAMCS) Report is found at https://www.cdc.gov/nchs/data/nhamcs/web_tables/2015_ed_web_tables.pdf.

Congressional intent.

We therefore again ask CMS to revise the language of 42 CFR. 414.94 to clarify that the AUC exception also applies for the purposes of conducting the required medical screening exam in cases where an emergency medical condition is suspected, not "determined" (a term not found in EMTALA). This needed change will address Congress' request as well as the logic that certain advanced imaging tests may need to be quickly ordered to establish whether an emergency medical condition even exists or not. Requiring an ordering professional in the ED to make a distinction between patients that require AUC and those that have an AUC exemption is an additional burden that will directly impact provision of timely needed care.

As stated above, CMS is seeking comment in the rule on additional hardship exemptions. If CMS does not codify this exception as we have requested, we ask CMS to at least consider creating an additional exemption in cases where clinicians, in their best judgment, believe that their patients may be experiencing an emergency at the time of ordering. Just as CMS lays out in the proposed rule, physicians or clinical staff (if the proposal regarding clinical staff is finalized) would have the opportunity for each patient encounter to request an exemption when they believe their patient is experiencing and emergency. That way, for the safety of these patients, clinicians can move quickly and determine the diagnosis and treatment options. By not addressing this issue and at the very least granting this exemption, CMS may be putting patients' lives at risk.

ACEP Responses to QCDR Policies in the CY 2019 PFS and QPP Proposed Rule

- CMS includes a number of proposals that would affect ACEP's QCDR, the Clinical Emergency Data Registry (CEDR).

  ACEP Response:

  - Strongly oppose CMS' proposal to force QCDR measures approved for MIPS reporting to be generally available for other QCDRs' use without a fee. This proposal would prevent the measure owning-entity from recouping any financial investment it put into developing and maintaining it since they would no longer be allowed to charge a licensing fee.
  - Oppose the proposal to revise the start of the self-nomination period from September 1 to July 1 of the calendar year.
  - Generally support the concept of allowing QCDRs to submit data to CMS that would allow them to create benchmarks for QCDR measures; CMS is seeking comments this issue.
  - Do not support CMS proposal to exclude QCDR measures from the topped out 4-year timeline that is available for other measures.

Detailed Comments on QCDR Proposals

QCDRs Seeking Permission from Another QCDR to Use an Existing Approved Measure

CMS proposes that, beginning with the 2021 MIPS payment year, as a condition of a QCDR measure's approval for purposes of MIPS, the QCDR measure owner would be required to agree to enter into a license agreement with CMS permitting any approved QCDR to submit data on the QCDR measure (without modification) for purposes of MIPS and each applicable MIPS payment year. If a QCDR refuses to enter into such a license agreement, the QCDR measure would be rejected and another QCDR measure of similar clinical concept or topic may be approved in its place.

ACEP strongly opposes this proposal. This proposal would prevent the entity that owns the measure (measure owner) from recouping any of the financial investment put into developing and maintaining the measure, as the measure owner would no longer be allowed to charge a licensing fee. If third parties can routinely use these measures and, in the case of commercial QCDRs, profit off of the societies' time and expense, medical societies may no longer be able to dedicate resources to developing QCDR measures. Without the contribution of medical societies, the measures available to eligible clinicians may be poorly refined and inaccurately capture quality performance. We also have concerns about loss of control, as if other entities can use measures without licensing agreements, the measure owner is not able to control how they are being implemented. Maintenance will be more difficult as well, as the measure owner will not be able to review data collected from the measures. This rule blurs the line between QCDR measures and QPP

measures. If a measure owner was ready to take a measure to the national stage, they would submit it to CMS under the Measures Under Consideration (MUC) process, which is the pathway for becoming a QPP measure. Simply applying to use their own measure in a QCDR does not mean a measure owner is prepared to release their measure to the masses, and this rule would force them to do so. Finally, we note that all measures that are internally developed by ACEP are considered intellectual property and have a copyright. By allowing these measures to be accessed by other QCDRs without a licensing agreement, CMS is effectively violating the copyright of each measure.

Revised Self-Nomination Period for QCDRs

CMS proposes to revise the self-nomination period from September 1 of the year prior to the applicable performance period until November 1 to July 1 of the calendar year prior to the applicable performance period until September 1. ACEP strongly opposes this proposal and requests that CMS does not revise the start of the self-nomination period from September 1 to July 1 of the calendar year. Like many other entities, ACEP follows a lifecycle approach for quality measure development and maintenance, and the revised self-nomination period that is proposed in this rule would interrupt the lifecycle timeline. With the previous year's reporting period ending on March 31, it would be difficult for our team to access the necessary data out of our QCDR and conduct required analysis for measure maintenance in time for the July 1 self-nomination period start. In addition, because CMS requires more data to be submitted with self-nomination applications, the revised reporting period will be more difficult.

QCDR Benchmarks

ACEP generally supports the concept of allowing QCDRs to submit data to CMS that would allow them to create benchmarks for QCDR measures. ACEP's QCDR, CEDR, has access to historical data and would be willing to share it with CMS for the purposes of developing benchmarks for measures. In fact, CEDR analyzes historical data as part of the measure development process to identify measure gaps.

However, we understand the limitations with the data and the fact that CEDR or other registries may not be able to provide CMS everything they may need. In fact, CMS is not entirely clear in the rule what "form or manner" of the data would meet the agency's needs. Some data might be harder to obtain, especially from participants that push data to QCDRs. Furthermore, QCDRs may run into operational issues, especially in terms of only submitting data that includes MIPS eligible clinicians. Thus, we ask that CMS clarify their specific needs in the final rule and work with QCDRs on how to obtain the necessary data.

We also note that developing benchmarks could be a lengthy process, taking more than one year to complete. Another alternative CMS could consider is instituting a more dynamic process for benchmarking QCDR measures. Under such an approach, CMS would accept quarterly data for new measures so that the agency can create preliminary benchmarks that they would share with QCDRs before the final benchmarks are established.

Define the Timeline for Topped Out QCDR Measures

CMS proposes to exclude QCDR measures from the topped out 4-year timeline that was finalized. ACEP does not support this proposal. By not providing QCDRs a grace period to phase out measures, CMS could

limit the number of specialty-specific measures available in the MIPS program. By allowing QCDR measures the same 4-year timeline when topped out, CMS will give measure owners time to appropriately phase out the measure, and determine what subsequent action to take, such as retiring the measure, modifying the measure to make it more robust, or creating a complimentary measure.

Updated Definition of QCDR

CMS proposes to modify the definition of a QCDR to require that an approved entity have clinical expertise in medicine and quality measure development, starting in the 2022 MIPS payment year. There are currently no assurances to practices participating in MIPS, or to the Medicare program, that EHR companies and other commercial organizations are able to interpret, extract and calculate the quality measures accurately. Commercial QCDRs without quality measurement expertise threaten the integrity of quality measure performance data and may inappropriately impact the CMS benchmarks used to calculate MIPS Quality scores. Therefore, ACEP supports CMS' proposal to require that an approved entity have clinical and measure expertise; however, CMS should be careful in how they allow technical entities to partner with an external organization to gain this expertise. If this creates a loophole that allows technical entities to easily bypass this requirement, this policy will be ineffective.

Clinical registries should be designed and managed by entities that understand the intricacies of clinical operations. The requirement of clinical expertise is especially important for quality measurement development, as sound and valid measurement requires clinical expertise and scientific rigor. Measures developed and approved for the MIPS program without this expertise and rigor are not comparable to measures that undergo such process, and it ultimately gives QCDRs without such clinical expertise a greater advantage.

Information Required at the Time of Self-Nomination

ACEP supports CMS' proposal to require QCDRs to include their CMS-assigned QCDR measure ID number when posting their approved QCDR measure specifications, and also when submitting data on the QCDR measures to CMS.

Updated Consideration Criteria for Approval of QCDR Measures

CMS proposes to consolidate their previously finalized standards and criteria used for selecting and approving QCDR measures. Specifically, CMS proposes to apply certain criteria used under the Call for Quality Measures Process when considering QCDR measures for possible inclusion in MIPS beginning with the MIPS 2021 payment year. ACEP does not support this proposal and requests that CMS reconsider these criteria as a requirement, and instead make the criteria high-priority. By requiring these criteria, CMS would limit the number of measures available for QCDR participants. While it is important for measures to be outcomes-based and meaningful, there are existing process measures that are evidence-based and are far from being topped out. These measures are still valuable to improving patient care and should still be considered for inclusion in the QCDR program.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

ACEP Responses to Facility-Based Reporting Option Policies in the CY 2019 PFS and QPP Proposed Rule

- Facility-Based Reporting Option —Starting in 2019, hospital-based physicians can have their quality and cost performance for MIPS be based on that of their facility. For those eligible, CMS will automatically take the higher of the hospital quality/cost score and traditional MIPS score.

ACEP Response:

- Support this option but stress need for individual clinicians and groups to know before the start of performance period whether they meet eligibility criteria for this to ensure time to make decisions about whether to still report quality measures traditionally or simply rely on their facility score.
  - Believe that if CMS does not notify clinicians ahead of time on eligibility, this new option meant to reduce burden will instead add complexity that will make it difficult for them to succeed.

Detailed Comments on Facility-Based Reporting Option

Eligibility for the Facility-based Scoring Option

CMS is proposing that, under the facility-based scoring option, individuals or groups that have 75 percent or more of their covered Part B professional services in an inpatient hospital (POS 21), on-campus outpatient hospital (POS 22), or emergency room (POS 23) setting would automatically receive the performance score for their hospital through the Hospital Value-based Purchasing (HVBP) Program. CMS estimates that most emergency physicians would qualify for this option. CMS is also proposing that that a clinician must have at least a single service billed with the POS code used for the inpatient hospital or emergency room. Furthermore, if CMS is unable to identify a facility with a VBP score to attribute a clinician's performance, that clinician is not eligible for facility-based measurement.

In last year's rule, CMS had not proposed to include POS 22 in the list of eligible settings. While CMS is adding that setting on the list, the agency also believes that a clinician who is to be measured according to the performance of a hospital should at least have a minimal presence in the inpatient or emergency room setting. ACEP had previously supported the inclusion of POS 22 and therefore supports CMS' proposal. We believed that including POS 22 would ensure that this reporting option is more widely available to clinicians who still struggle to identify six relevant MIPS measures and wish to instead be evaluated based on the facility in which they practice. We also thought that it would help to better align CMS's "facility-based" definition with its definition for "hospital-based," which would minimize confusion for clinicians

already struggling to keep up with the complex rules of MIPS.
With respect to the definition of "facility-based," similar to the comments we offer regarding "hospital-based" clinicians (see section on Promoting Interoperability Performance Category), we also recommend that CMS reduce the threshold used to define "facility-based" clinicians from 75 percent of covered professional services to the majority (i.e., 51 percent) to account for the fact that clinicians often work in multiple settings.

Individual and Group Attribution

Under CMS' proposal, individual clinicians who qualify for the facility-based scoring option would automatically receive a MIPS quality and cost payment score derived from the HVBP score for the facility at which the individual clinician provided services to the most Medicare beneficiaries. If there are an equal number of Medicare beneficiaries treated at more than one facility, the value-based purchasing score for the highest scoring facility is used. Groups can quality for the facility-based scoring option if 75 percent or more of clinicians in the group meet the requirements described above for individuals. A facility-based group automatically receives a MIPS quality and cost payment score that is derived from the HVBP score for the facility at which the plurality of clinicians identified as facility-based would have had their score determined if they reported as individuals.

ACEP understands that under the facility-reporting option, groups (no matter what size) would receive one HVBP score from one hospital, which is determined based on where the plurality of their individual clinicians saw the most Medicare beneficiaries. ACEP is concerned that it would be almost impossible for large groups to try to predict what hospital they would be attributed to. If one Tax Identification Number (TIN) includes individual clinicians practicing in multiple settings, that TIN would have to first figure out which of their clinicians were eligible for the facility-based reporting option and then determine where these clinicians saw the majority of their patients. Once the TIN was able to ascertain this information, it would have to notify individual clinicians about their reporting options. As described below, while we appreciate CMS' attempt to reduce burden by creating this option, clinicians must have a good understanding of how they would fare under this option in order to make important decisions about how to participate in MIPS. One possible solution would be to give large TINs the option of voluntarily opting-in and notifying CMS which individual National Provider Identifiers (NPIs) that fall under the TIN should have their quality and cost performance category scores determined based on a facility's performance. By incorporating this opt-in policy, CMS would create a pathway for TINs to coordinate with individual physicians on meaningful quality measures or seek the input of physicians of how they would like to participate in MIPS. This would also make it easier for groups to be notified about their performance prior to the start of the MIPS performance period, which would in turn help them decide whether or not to report through traditional MIPS.

Timeline for Determining Eligibility

In order to determine whether an individual is eligible for the facility-based reporting option, CMS proposes to use data from the initial 12-month segment beginning on October 1 of the calendar year 2 years prior to the applicable performance period and ending on September 30 of the calendar year preceding the applicable performance period with a 30-day claims run out. Therefore, theoretically, clinicians could know their eligibility status before the start of the performance period. However, it is unclear from the proposed

rule when exactly clinicians and groups will be notified that they qualify for the facility-based option and what hospital they will be aligned to. **ACEP asks that CMS clarify in the final rule 1) when both individual clinicians and groups will be notified that they qualify for the facility-based option; and 2) when both individual and groups will be notified about what hospital they are aligned to.**

ACEP has heard from CMS that the agency hopes to notify individual clinicians that they would qualify for the facility-based scoring option around the same time that they tell clinicians whether they are eligible for MIPS. Again, this notification should take place before the start of the performance period. However, we note that CMS has not yet met this deadline for the first two years of the Program.

CMS is also proposing individuals and groups can still report quality measures through another submission mechanism (such as a QCDR) and receive a "traditional" MIPS score for quality. If they do so, CMS would automatically take the highest of the HVBP score and the traditional MIPS score. While ACEP supports CMS' proposal to allow clinicians to continue reporting traditionally and automatically applying the higher score, we nevertheless want to make sure that clinicians understand all of their options before the start of the performance period.

Since CMS is proposing that the quality performance period will be 12-months, clinicians need to know up front, before the start of the performance period, whether they meet the eligibility criteria for the facility-based reporting option. If they do, they will need to have time to make decisions about whether to report individually or as a group and whether to still report quality measures traditionally or simply rely on their hospital's HVBP score. We believe that if CMS does not notify clinicians ahead of time about their eligibility status, this new option, which is meant to reduce burden, will instead add a layer of complexity to the program that will make it difficult for clinicians to be successful.

Measures in Facility-Based Scoring

CMS is proposing to adopt all the measures for the Hospital VBP Program into MIPS for purposes of facility-based scoring. CMS also proposes to adopt for facility-based measurement the measure set that CMS finalizes for the fiscal year Hospital VBP program for which payment begins during the applicable MIPS performance period For example, for the 2019 MIPS performance period, which runs on the 2019 calendar year, CMS proposes to adopt the FY 2020 Hospital VBP Program measure set, for which payment begins on October 1, 2019. CMS will also apply the same timeline to the total performance score methodology. Given this timeline, it is unclear when individuals and groups will actually find out what their hospitals' VBP scores are. **ACEP asks that CMS clarify in the final rule when both individual clinicians and groups will be told what their hospital's VBP score is for a given year. ACEP recommends that CMS inform individual clinicians and groups about their hospitals VBP score as soon as practically feasible, preferably before clinicians are required to report data for the performance period.**

Furthermore, CMS is proposing that the quality and cost performance category scores would be established by determining the percentile performance of the facility in the Hospital VBP Program for the specified year, then awarding a score associated with that same percentile performance in the MIPS quality and cost performance categories for those MIPS eligible clinicians who are not eligible to be scored under facility-based measurement for the MIPS payment year. ACEP agrees with this methodology and believes that is an appropriate way of translating the hospital's VBP score to a MIPS score. However, ACEP encourages

CMS to be extremely transparent with individual clinicians and groups when describing how their hospital's VBP score translates to their MIPS score.

Expansion of Facility-Based Measurement to Use in Other Settings

CMS notes that the agency may consider opportunities to expand the concept of facility-based measurement into other facilities and programs and future years. CMS is particularly interested in the opportunity to expand facility-based measurement into post-acute care (PAC) and the end-stage renal disease (ESRD) settings and seeks comment on how CMS may do so. ACEP supports the idea of expanding the policy beyond the inpatient setting. While MACRA specifically prohibits the use of measures for hospital outpatient departments under this policy, there is an explicit exception in the case of items and services furnished by emergency physicians, radiologists, and anesthesiologists. Therefore, when implementing this policy in future years, we strongly urge CMS to recognize the variety of other emergency-focused, facility-level measures now in use, such as those developed by ACEP's CEDR and those used under the Hospital Outpatient Quality Reporting Program. ACEP would appreciate the opportunity to work with CMS in the coming year to identify alternative facility-based measures that would better capture the quality of emergency care.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

FACT SHEET

ACEP Responses to Major Medicare Payment Rule for CY 2019

Each year, CMS releases several proposed regulations that, once finalized, directly impact how emergency physicians are paid under Medicare. This year, CMS combined the Physician Fee Schedule and the Quality Payment Program (MACRA) proposals into a single rule.

Key provisions of the rule and ACEP's responses to them are below—note that these are all only *proposed* by CMS. We expect final regulations setting CY 2019 payment policy to be released by CMS in early November.

To see ACEP's full response to this rule, please click here.

Medicare Physician Fee Schedule Proposals

- Restructuring Evaluation and Management (E/M) Codes and Streamlining Documentation Requirements —in an effort to reduce physician administrative burden, CMS is proposing to streamline documentation requirements, but at the same time create a blended payment rate for office/outpatient E/M level 2 through 5 visits. **The proposals do NOT initially impact the emergency medicine E/M code set**, but CMS does seek comment on potential such changes to these codes in the future.

  ACEP Response:

  - Disagree that CMS' proposal related to streamlining documentation requirements would reduce burden overall, since clinicians would still need to document for other purposes such as clinical, legal, operational, and quality reporting.
  - Strongly oppose CMS' proposal to reduce payment by 50 percent for the least expensive procedure or visit that the same physician (or physician within the same group) furnishes on the same day as a separately identifiable E/M visit (as coded with Modifier-25)
  - Agree with CMS' decision to initially exempt the ED visit code set. It is currently at review at the AMA RUC, which needs to provide recommended values to CMS first. We also urge CMS to consider the unique and unpredictable environment of EDs and the complexity of patients seen as it begins to think about proposing any changes to the ED E/M code set in the future.
    - If CMS were to ever apply this blended payment policy to the ED E/M code set, we support additional add-on codes for complexity.
  - Do not support CMS' implementation date of January 1, 2019 and we urge CMS to delay the start date to January 1, 2020 or even later.

- Teaching Physician Documentation Requirements for E/M Services—in line with the E/M burden reduction proposal, CMS is proposing to remove current requirement that teaching physicians document extent of their participation in the review and direction of the services furnished to each beneficiary, and instead just require documentation that the teaching physician was present at time of service.

  ACEP Response:

  - Concerned that proposal did not mention requirements around medical students. Including medical student documentation in the revised policy would extend the intended relief from the regulatory burden of duplicate documentation on the same patient.

- AUC program for advanced imaging details—created in legislation in 2014, this program will require physicians ordering advanced imaging to first consult appropriate use criteria through approved clinical decision support mechanisms in order for the furnishing provider/radiologist to be able to receive payment.

  ACEP Response:

  - Call on CMS again to correct its misinterpretation of Congress' exemption for emergency medical conditions.
  - If CMS does not make this correction, ask CMS to at least create an additional exemption in cases where clinicians believe that their patients may be experiencing an emergency at the time of ordering.

- Modernizing Medicare Physician Payment by Recognizing Communication Technology-Based Services—CMS proposes to pay separately for two newly defined physicians' services furnished remotely using communication technology (virtual check-ins and evaluating patient-submitted images and videos).

  ACEP Response:

  - Urge CMS to consider allowing emergency physicians practicing in the ED to bill for these new remote physician services. ACEP could work with CMS on ensuring appropriate reimbursement, that all EMTALA obligations are fulfilled, and that patients are still able and encouraged to come to the ED with full coverage without any hesitation when there is a chance they might need immediate emergency care.

- Bundled Episode Payment for Substance Use Disorder (SUD) Treatment—as part of CMS' effort to combat the opioid epidemic, CMS is seeking comment on creating a bundled payment for components of Medication Assisted Treatment (MAT) such as management and counseling services to help expand access to treatment for SUDs. This new payment would be part of the Medicare physician fee schedule.

  ACEP Response:

  - Strongly encourage CMS to ensure that a bundled payment adequately funds ED-initiated MAT along with the other necessary wrap-around features of it such as treatment management and counseling.
  - Given importance of MAT as a tool to address the opioid crisis, we urge CMS to go beyond scope of their proposal and make a significant investment in MAT, either through a broader model or grant funded by the Center for Medicare & Medicaid Innovation (CMMI).

Quality Payment Program Proposals

- More flexibility for participation—CMS is allowing clinicians to opt-in to MIPS if they exceed one or two, but not all three, of the low-volume threshold criteria (less than $90,000 Medicare Part B charges; fewer than 200 beneficiaries; or less than 200 covered professional services).

  ACEP Response:

  - Support this additional flexibility, but note that the more clinicians exempted from MIPS, the lower the bonus range, given the program's budget neutrality construct.
    - Ask CMS to be mindful of how low positive adjustments could affect participation going forward.

- Use your facility's score—Starting in 2019, hospital-based physicians can have their quality and cost performance for MIPS be based on that of their facility. For those eligible, CMS will automatically take the higher of the hospital quality/cost score and traditional MIPS score.

  ACEP Response:

  - Support this option but stress need for individual clinicians and groups to know before the start of performance period whether they meet eligibility criteria for this to ensure time to make decisions about whether to still report quality measures traditionally or simply rely on their facility score.
    - Believe that if CMS does not notify clinicians ahead of time on eligibility, this new option meant to reduce burden will instead add complexity that will make it difficult for them to succeed.

- Increasing Performance Threshold—CMS is proposing to increase the performance threshold needed for a MIPS bonus payment from 15 to 30 points, and the threshold to get an exceptional performance bonus from 70 to 80 points.

  ACEP Response:

  - Do not support these increases. The proposed performance threshold increase of 50 percent is a large jump for CMS to make in one year. Encourage CMS to establish a more reasonable performance threshold of 25 points.
    - Urge CMS to keep the exceptional performance threshold at 70 points, since raising it to 80 points will adversely affect those specialties that do not have many reportable measures.

- Qualified Clinical Data Registries—CMS includes a number of proposals that would affect ACEP's QCDR, the Clinical Emergency Data Registry (CEDR).

  ACEP Response:

  - Vehemently oppose CMS' proposal to force QCDR measures approved for MIPS reporting to be generally available for other QCDRs' use without a fee. This proposal would prevent the measure owning-entity from recouping any financial investment it put into developing and maintaining it since they would no longer be allowed to charge a licensing fee.
  - Strongly oppose the proposal to revise the start of the self-nomination period from September 1 to July 1 of the calendar year.
  - Generally support the concept of allowing QCDRs to submit data to CMS that would allow them to create benchmarks for QCDR measures; CMS is seeking comments this issue.
  - Do not support CMS proposal to exclude QCDR measures from the topped out 4-year timeline that is available for other measures.

Requests for Information

- Price Transparency—CMS is including requests for information (RFIs) on price transparency in multiple proposed rules. This RFI seeks comment on what role providers should play in making prices available to their patients.

  ACEP Response:

  - Discuss the unique nature of emergency care, our obligations under EMTALA, and the importance of enforcing the Prudent Layperson Standard (PLP). We believe that it is the responsibility of insurers to clearly provide information to consumers prior to the emergency about the potential costs of seeking emergency care under their particular coverage.