Emergency Department EDPMA Practice Management Association

September 11, 2017

Submitted Electronically

Seema Verma, MPH
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
Room 445–G
200 Independence Avenue SW
Washington, DC 20201

Re. CMS-1676-P: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program

Dear Administrator Verma:

The Emergency Department Practice Management Association (EDPMA) is one of the nation's largest professional physician trade associations focused on the delivery of high-quality, cost-effective care in the emergency department. EDPMA's membership includes emergency medicine physician groups, as well as billing, coding, and other professional support organizations that assist healthcare providers in our nation's emergency departments. Together, EDPMA's members deliver (or directly support) health care for about half of the 136 million patients that visit U.S. emergency departments each year. We work collectively and collaboratively to deliver essential healthcare services, often unmet elsewhere, to an underserved patient population who often has nowhere else to turn.

EDPMA appreciates the opportunity to provide input as you finalize payment and other policies under the Medicare Physician Fee Schedule (MPFS) for CY 2018.

Determination of Malpractice Relative Value Units (RVUs)

CMS proposes to use the most recent premium data for malpractice (MP) RVUs for 2018 and to align the update of MP premium data and MP Geographic Price Cost Indices (GPCIs) to once every 3 years. While EDPMA would generally support the alignment of incorporating the MP premium data, we have serious concerns about the wide swing in MP RVU updates this premium data caused and question the level of transparency with which the data and methodology for the update occurred. In addition, CMS relies on a methodology that is wholly independent of how medical liability insurance rates are set. Much of data, methodology, and assumptions used for

the update appear, not in the proposed rule, but in the interim report[1] written by CMS' contractor that led to the proposals. ***We are concerned that the methodology and assumptions have not been properly vetted and included in the proposed rule for comment***. Therefore, ***EDPMA recommends that CMS delay incorporation of the updated premium data and corresponding MP RVU updates.***

Calculating a national average MP premium for each specialty: The contractor's report addresses the calculation the national average MP premium for each specialty. The report notes that it examined the differences in national average premiums across specialties under four different calculations:

- Using population estimates as weights for price-adjusted premiums (the CYs 2016 and 2017 methodology)
- Using only work and PE RVUs as weights for price-adjusted premiums
- Using total RVUs as weights for price-adjusted premiums
- Using total and MP RVUs as weights (the CY 2015 methodology)

CMS adopts the recommendation that the specialty-specific national averages continue to be weighted by population. EDPMA is very concerned that using population as the weighting proxy is an inappropriate mechanism for distributing MP RVUs. Malpractice premiums are impacted by the services that physicians provide, not the population estimates of the communities in which they serve. As previously mentioned, this inexplicably relies on a rationale that is completely independent of how medical liability insurance rates are actually set. Therefore, ***we believe that weighting for creating specialty-specific national averages should be done by using work RVUs, which are a better proxy for the services that are being provided by physicians because they incorporate important elements such as complexity, time, and intensity***.

Geographic Practice Cost Index (GPCI) Floor Extension

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) extended the GPCI floor through December 31, 2017. EDPMA understands that there have been no further statutory extensions beyond that date. However, we believe it is extremely important to highlight the risk of eliminating the GPCI floor. Allowing the "work" GPCI floor to go below 1.0 has the potential to significantly reduce the reimbursement rate for physicians in many areas, especially in rural communities where healthcare access is often the most limited. Maintaining the 1.0 work floor would help ensure that emergency physicians, especially those in rural areas, do not face inordinately deep cuts. Again, we are aware of the legislative component to this issue, but we urge you to support efforts to permanently extend the 1.0 work floor for the Geographic Practice

[1] Acumen, LLC, *Interim Report on the Malpractice Relative Value Units for the CY 2018 Medicare Physician Fee Schedule* (July 2017).

Cost Indices (GPCI) to ensure that reimbursement rates in rural communities do not drop too low.

Medicare Telehealth Services

CMS seeks input on how the Agency might "further expand access to telehealth services within the current statutory authority and pay appropriately for services that take full advantage of communication technologies." As we have stated in the past, we support the inclusion of ED visits to the Medicare telehealth list. Improving patient access to important emergency medical care through the use of telehealth would have a tremendous benefit for patients, particularly those in rural areas where hospitals are closing at unprecedented levels. CMS' failure to add ED visits to the telemedicine list places this already underserved and vulnerable population at even greater risk, which is unconscionable given there are available technological solutions that could provide these patients with meaningful access to emergency medical care. ***We urge that CMS add ED visits to the telehealth list on a Category 1 basis.***

CMS also notes that current rules require that claims include the appropriate CPT or HCPCS code for the professional service along with the telehealth modifier GT (via interactive audio and video telecommunications systems). However, in CY 2017, CMS finalized a new place of service (POS) code describing services furnished via telehealth. CMS believes that the POS code and modifier requirement are redundant and, therefore, CMS proposes to eliminate the required use of the GT modifier on professional claims. ***EDPMA supports CMS' decision to eliminate the use of the GT modifier given that a separate telehealth POS code is in use.***

Comment Solicitation on Remote Patient Monitoring

CMS seeks comment on whether to make separate payment for CPT codes that describe remote patient monitoring. CMS notes that these, by definition, would not be Medicare telehealth services. According to CMS, the services contemplated involve "the interpretation of medical information without a direct interaction between the practitioner and the beneficiary" and are therefore paid the same as in-person services without additional requirements of originating sites and the use of the telemedicine POS code. ***EDPMA agrees that CMS should begin to develop policy that recognizes the value that remote patient monitoring services can bring to patients***. As technology evolves and the physician shortage grows more acute, we believe remote patient monitoring provides the potential to efficiently engage with patients and ensure that patients who are in need of care, but might not otherwise seek care, are in contact with the medical professionals that can help ensure access to quality, efficient care.

Potentially Misvalued Services

CMS states that it has received input (but does not disclose from where) that the work RVUs (wRVUs) for ED visits may not reflect the full resources involved in furnishing these services and are undervalued "given the increased acuity of the patient population and the heterogeneity of the sites." (e.g. freestanding and off-campus emergency departments). CMS therefore seeks

input on whether CPT codes 99281-99385 (*Emergency department visits for the evaluation and management of a patient*) should be reviewed as potentially misvalued codes.

We appreciate CMS' interest in ensuring that services provided in the emergency department are sufficiently reimbursed. And we appreciate that CMS recognizes that there is an increased average acuity of the patient population in the ED and reimbursement may not reflect this fact. This increased average acuity is due to more nonemergent patients receiving care at other sites of service and the proportional increase in sicker patients with more comorbidities receiving care outside of a hospital admission. EDPMA believes this problem of under-reimbursement for the growing proportion of high acuity patients is better addressed by streamlining the process for documenting the higher level of care. Providers should not be subjected to onerous documentation requests in order to avoid inappropriate down-coding.

As we have noted to CMS in the past, emergency medicine occupies a unique position in the continuum of care, and as such, we believe warrants policies that recognize this unique role. In 2013, the RAND Corporation released a study entitled "The Evolving Role of Emergency Departments in the United States," that, among other things, explains why the emergency department is often the most appropriate venue for many patients. It found that emergency department physicians are the major decision makers in over half of an average hospital's admissions and are critical in helping hospitals fulfill their statutory obligation to provide emergency care without regard to the ability to pay (EMTALA). Primary care physicians increasingly rely on the emergency department to evaluate complex patients with potentially serious problems, conduct workups, and provide overflow and after-hours primary care. Increasingly, the emergency department is seen not as a health care resource to be avoided, but a key stabilization and decision point for patient disposition, which increasingly involves finding alternatives to hospital admission or observation stays for high-focus patient populations.

In order to appropriately care for patients with serious conditions, providers often need access to diagnostic and monitoring equipment and staff to monitor the patient over a period of time. They also need ready access to specialists. This equipment and staff are often only available in a hospital setting. Patients often cannot save the healthcare system money by scheduling an appointment with their primary care provider (or specialist for that matter) and waiting a day or two for that appointment if they are facing a potentially life-threatening problem. In many cases, the patients' practical and timely options are either readmission or evaluation, stabilization, and discharge from the emergency department. And the emergency department is the less expensive option of the two. The RAND report found that "an average inpatient admission costs ten times more than an ED visit." In many cases, a visit to the emergency department is not only appropriate – but the least costly alternative. And increasingly, emergency department providers are finding alternatives to hospitalization (either inpatient or observation stays).

Ultimately, we ask CMS to recognize that care delivered timely in an emergency department can deliver long-term cost saving opportunities to the overall system by preventing and staving off costly hospital admissions and the treatment of exacerbated medical conditions that go unchecked and untreated by virtue of the lack of readily available primary and specialty care. By efficiently treating conditions in the emergency department, rather than delaying care, patients are treated before furthering complications and complexities arise, resulting in long term savings to the system and to help achieve the laudable goals these programs desire.

However, in seeking to achieve these goals, EDPMA believes that the main issue is not that the ED visit codes themselves are undervalued. Rather, the issue is that a greater percentage of ED visits are at a higher acuity level yet payers often do not reimburse at the higher level of care. In essence, the main issue is that the ED visit is often inappropriately down-coded based on retrospective review and that the documentation needed to prove the higher level of care is too burdensome or subjective. The process needs to be streamlined so it is easier for physicians to show the level of care is appropriately coded. Therefore, ***EDPMA believes that CMS and stakeholders should work together on a collaborative process to ensure that the services provided in the emergency department are reimbursed at the level commensurate with the service actually provided and the value that the health care system accrues because of the care delivered in the emergency department.*** In addition, EDPMA believes that there are patients in the emergency department who do not necessarily meet the description of the 'typical patient' associated with the ED visit codes who require resources beyond that for which the ED visit codes are designed. We refer CMS to our input provided in this letter directed at the Care Management Comment Solicitation.

Evaluation and Management (E/M) Guidelines for Emergency Medicine

CMS seeks input on the specific changes CMS should undertake to reform the guidelines, reduce the associated burden, and better align E/M coding and documentation with the current practice of medicine. CMS specifically seeks comment on whether it's appropriate to remove documentation requirements for the *history and physical exam* for all E/M visits at all levels. CMS notes that, as long as a history and physical exam are documented and generally consistent with complexity of medical decision making (MDM), there may no longer be a need for CMS to maintain such detailed specifications for what must be performed and documented for the history and physical exam. CMS also welcomes comments on specific ideas that stakeholders may have on how to update medical decision-making guidelines to foster appropriate documentation for patient care commensurate with the level of patient complexity, while avoiding burdensome documentation requirements and/or inappropriate up-coding.

EDPMA supports efforts to streamline documentation requirements. However, the current system has been in place for a very long time. We urge caution and recommend in-depth discussions with stakeholders before making any major changes. There is information currently provided in the history and physical which is essential to determining treatment and reimbursement.

Prudent Layperson Standard

In emergency care, treatment and reimbursement are impacted by the Prudent Layperson Standard (PLP). The PLP standard provides that the emergency department is the appropriate venue for care when there are acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably believe there may be a health emergency, including a risk of serious impairment of body functions or dysfunction of any bodily organ. **We ask you to reiterate the importance of the PLP standard in the final rule. And we implore you to ensure that any changes to the documentation guidelines do not negatively impact this important standard. If you eliminate documentation requirements for the history and physical, we ask that you ensure that documentation on the nature of the presenting problem clearly requests the necessary information on the patient's concerns to illustrate that the standard is met.** Further, the guidelines should ensure that the relevant information is gathered and there is rarely a need to supplement the record to determine the level of care.

H&P and Medical Decision Making in the Current Guidelines

One of the observations made by CMS is that the documentation guidelines are an administrative burden due to documentation complexity. While we can respect that the specific guidance provided in the documentation guidelines appears to be based on sound clinical history and exam practice, scoring for these to achieve a defined visit level is complicated and given to myths and misunderstandings as to what documentation is specifically required to achieve the scores for each of the elements and components of an E/M level. **EDPMA believes there is a way to reduce documentation of history and physical by simultaneously strengthening documentation requirements on the medical necessity component so key information is not lost.** In doing so, the guidelines should avoid a focus on diagnoses since that is not an appropriate approach to care in the emergency department. As CMS noted last year "we believe there is no way a [diagnosis] list can capture every scenario that could indicate an emergency medical condition. … The final determination of coverage and payment must be made taking into account the presenting symptoms rather than final diagnosis. The purpose of this rule is to ensure that enrollees have unfettered access to health care for emergency medical conditions, and that providers of emergency services receive payment for those claims meeting that definition without having to navigate through unreasonable administrative burden."

In addition, CMS asserts that the documentation guidelines are outdated and, in addition, the use of EHRs allows for upcoding from autocoding. We would highlight that templates, in use before EHR implementation was incentivized and mandated by CMS, incorporated methods of prompting providers toward the necessary elements of the highest E/M level.

The previous documentation guidelines scoring system placed equal value on content in the history and exam and MDM. EDPMA believes that this placed undo emphasis on the amount of

information contained in the history and physical exam, thus undervaluing the importance and value of medical decision making and care process. We have observed that coding audits by commercial and Medicare auditors in recent years have largely ignored scoring for the history and physical exam while focusing on medical necessity documentation, trying to determine whether the patient's problem required the level of workup performed.

We believe that history and exam components are important contributors to medical necessity and proper management of a patient's presenting problems, but that they do not, in general, deliver equal value to the diagnoses and management options, data and tests, and clinical risks to the patient. Emphasizing bullet points of H&P, the documentation guidelines were co-opted by EHR developers to prompt for information that, in most care events, is too often only marginally useful clinically in the management of the patient. Physicians focused on high risk and complex conditions were burdened to report content outside of the reason for the encounter that might be of interest to a later reviewer in continuation of care but that did not always contribute to the present encounter. ***Therefore, EDPMA encourages CMS to revise the 3-component documentation scoring system (history, exam, MDM) in favor of a two-component scoring system: "Number and Complexity of Presenting Problems" and MDM***.

Policies for Updating the Documentation Guidelines with "Presenting Conditions"

While we believe a thorough process of meeting with stakeholders is necessary to engage in updating modernizing the documentation guidelines, we believe that the inclusion of Presenting Condition documentation should contain content relevant to the following:

- Constellation of presenting problems, patient's concerns, signs, and symptoms,
- Number and types of comorbidities,
- Pertinent positive and negative ROS findings,
- Medical history, medication, and related treatment history, attempted or in progress, and
- Relevant physical examination findings.

The existing DGs explain quite well the general principles of medical records documentation and why documentation is important to providers and payers. EDPMA affirms these first two sections of the documentation guidelines but seeks to have the specific content requirements for the history and exam reduced to what is clinically relevant to the patient's Presenting Conditions. Scoring for the above elements of this component could be developed to better reflect current clinical management approaches that focus on decisions not just on content transmission.

Again, EDPMA believes that differences in MDM are the biggest determinants in visit levels and that these should be predominant in visit level choice. **The documentation guidelines should be streamlined to ensure that the information needed to show a higher acuity level and a higher level of care are included but do not place an onerous burden on the provider.**

While we believe that time is still a contributing element for E/M choice, it must not be a proxy for work nor is it a key determinant. In the emergency department, the intensity of service is the distinguishing value of work. By way of example, in emergency care, a patient is not advantaged by the treating emergency physician taking more time. It would be improper to revise the documentation guidelines based on time, particularly when there are other more relevant elements to consider. The rule should not discourage emergency physicians from treating patients as quickly as possible in order to timely address the next emergency.

Care Management Public Comment Solicitation
CMS seeks comment on ways it might further reduce the burden on reporting practitioners for care management services, including through stronger alignment between CMS requirements and CPT guidance for existing and potential new codes.

We appreciate CMS' request for input and strongly believe that existing codes do not accurately describe services directed at the value that ED physician groups can bring to coordinating care. Chronically ill patients regularly visit the Emergency Department and require care by an emergency physician. Emergency medicine is in a unique position to offer care coordination services for the chronically ill because they are often the ones who treat these patients when they first become aware of a chronic condition and continue to provide services when these patients need to return to the ED. We regularly work with post-acute providers as patients' transition out of the ED and actively seek alternatives to otherwise costly hospital admissions (when patient outcomes are expected to be equivalent or better). While we fully acknowledge the role that primary care physicians can play in coordinating care, as CMS contemplates future rulemaking and potential new codes, it is extremely important that CMS recognizes the emergency physicians are also expected to coordinate more effectively with those primary care physicians to ensure a robust flow of information about a particular patient to and from the Emergency Department. This will result in added time and expenses for Emergency Department personnel. ***EDPMA urges CMS to ensure that future proposals reimburse both sides of the care coordination equation, particularly in those instances when the patient is seen more often by the emergency physician than the primary care physician***. Such proposals should allow emergency physician groups who play a significant part in patient care and care coordination to be compensated for their employees' care and time. We also believe that in certain situations, the best way to ensure patients receive this type of care is through new alternative payment models (APMs). We continue to support the development of APMs in which the value that emergency medicine brings to patient care is fully recognized. We encourage CMS to develop mechanisms that will be able to efficiently utilize its waiver authority for these models so that patients will be able to have access to services such as telehealth and post-discharge home visits, which will be important components to APMs being developed for emergency medicine.

In addition, there will be instances in which chronically ill patients have no primary care provider or the primary care provider is not offering care coordination services. These patients require even more care coordination from the ED physicians. ***We encourage CMS to explore***

options that encourage emergency physicians groups to continue coordinating care and provide an incentive for these groups to expand the number of services they provide. EDPMA looks forward to continuing to discuss options and proposals that can help to achieve these goals.

Appropriate Use Criteria for Advanced Diagnostic Imaging Services

The Protecting Access to Medicare Act of 2014 (PAMA) directs CMS to create a program to promote the use of appropriate use criteria (AUC) for advanced diagnostic imaging services. In past rulemaking, CMS has defined qualified clinical decision support mechanisms (CDSMs) where the AUC would be consulted and has identified "clinical priority areas" for inclusion in the program for purposes of determining clinician outliers relative to rates of consulting AUC when appropriate.

During this rulemaking cycle, CMS proposes that furnishing professionals report the following information on Medicare claims for applicable imaging services ordered on or after January 1, 2019:

- Which qualified CDSM was consulted by the ordering professional;
- Whether the service ordered would adhere to specified applicable AUC, would not adhere to specified applicable AUC, or whether specified applicable AUC were not applicable to the service ordered; and
- The NPI of the ordering professional (if different from the furnishing professional)

To implement this, CMS proposes to establish a series of HCPCS level 3 codes. CMS also proposes to develop a series of modifiers to provide necessary information as to whether:

- The imaging service would adhere to the applicable AUC;
- The imaging service would not adhere to such AUC; or
- Such criteria were not applicable to the imaging service ordered.

EDPMA is extremely concerned about the burden this will impose and urges CMS to use its potential authority to make these AUC reporting responsibilities voluntary in 2019. While we understand that PAMA sets date requirements for reporting these data, we believe it is extremely important that CMS ensure that it does not impose undue burdens that potentially interfere with patient care. While CMS seems to refer to 2019 as a "test" year for the AUC reporting requirement, CMS also seems to suggest that something must be reported in order for the reporting requirements. Not only will this impose an unnecessary burden on practices, but it will also result in CMS receiving potentially inaccurate and incomplete data. Again, we urge CMS to delay these requirements.

In addition, CMS proposes to create additional modifiers to describe situations where an exception applies and a CDSM was not used to consult AUC:

- Imaging service was ordered for a patient with an emergency medical condition; or

- The ordering professional has a significant hardship exception

EDPMA continues to believe that CMS should create a blanket exception from the AUC reporting requirement for services that are provided in the emergency department. Nearly universally, beneficiary visits to the emergency departments squarely fit the definition of an emergency medical condition as defined at 1867(e)(1) of the Act, which states:

> *(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—*
> *(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,*
> *(ii) serious impairment to bodily functions, or*
> (iii)*serious dysfunction of any bodily organ or part;*

Specifically, according to the Centers for Disease Control and Prevention (CDC)[2], there were more than 20.3 million visits to the emergency department by patients 65 and older in 2011; more than half of these visits were classified under the Emergency Severity Index (ESI) as Level 3 – Urgent. As an example, a patient who presents with abdominal pain in the right lower quadrant, nausea, and no appetite, would require 2 or more resources, such as an exam, laboratory studies, IV fluid, abdominal CT and possible surgery consult. Based on this clinical vignette, which is predicated under the identification and consumption of not less than 2 resources and could be identified on claims associated with the date of service for the visit, it is reasonable to assume that absent immediate medical attention the medical condition could reasonably be expected to result in serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

We further note that the CDC estimates, out of the total estimated 136.3 million visits to the emergency department in 2011, an overwhelming 96 percent of patients were triaged as very sick and needing medical treatment within 2 hours,[3] up from 92 percent in 2010. In fact, according to a separate CDC data brief, in 2009-2010, 36.5 percent of emergency department visits made by persons aged 65 and over resulted in hospital admission, and the percentage of emergency department visits that resulted in hospital admission increased as age increased: 32.4 percent of visits by those aged 65–74, 37.2 percent by those aged 75–84, and 43.4 percent by those aged 85 and over.[4] These figures alone should be compelling enough for CMS to recognize that rather than place an undue reporting burden on care delivered in the Emergency Department, that CMS would be confident that a blanket emergency department exception would meet the intent of the

[2] http://www.cdc.gov/nchs/data/ahcd/nhamcs_emergency/2011_ed_web_tables.pdf
[3] http://www.cdc.gov/nchs/data/ahcd/NHAMCS_2011_ed_factsheet.pdf
[4] http://www.cdc.gov/nchs/data/databriefs/db130.htm

statutorily created exception for emergency medical conditions particularly in the population for which the majority of the Medicare program covers.

Pursuant to EMTALA, Emergency Departments are required to stabilize and treat any patient that presents to the emergency department regardless of that patient's insurance status or ability to pay for such costs. In addition, the "Prudent Lay Person" (PLP) requirements of the Balanced Budget Act of 1997 (BBA '97) mandates coverage of emergency services based on a patient's symptoms upon presentation, not the patient's final diagnosis. Therefore, any CMS imposed program that would require an emergency medicine physician to delay treatment in order to consult a CDSM prior to providing advanced imaging services, and make such a query a condition of payment to the interpreting radiologist, contradicts both EMTALA and PLP requirements and serves no immediate benefit to the well-being of the patient in an emergency setting.

Emergency physicians and providers generally provide care in hospital-based emergency departments. Health information technology and Emergency Department Information Systems (EDIS) are purchased by hospital systems and generally made available to the emergency physicians and providers for their clinical use and billing and financial records. CMS has long recognized, both through the Medicare and Medicaid EHR Incentive Program and more recently through proposed requirements associated with the Merit-Based Incentive Payment System (MIPS) (more specifically through proposed exclusions for hospital-based physicians from the Advancing Care Information Performance Category), that requirements for the use of technology can only be made by the acquiring entity, not the "hospital-based" physician who has no control of the design and operability of that system. CDSM is a form of health information technology that is routinely incorporated into electronic health record systems, which are not purchased by Emergency Department physicians. In this proposed rule, CMS even goes so far as to amend the AUC significant hardship exception regulation to specify that ordering professionals who are granted re-weighting of the ACI performance category to zero percent under MIPS

earlier (except for "practicing less than 2 years") would also be excepted from the AUC consultation requirement during the same year that the re-weighting applies for purposes of the MIPS payment adjustment, *but relies on statutory references that do not include those who have ACI reweighted to zero because they are "hospital-based."* We find it astounding that CMS would recognize that those who have ACI reweighted to zero for other reasons should be exempted from the AUC requirements because of a lack of control over CEHRT but would not include hospital-based physicians in that exemption. Therefore, as CMS is considering further implementation of the AUC program, ***EDPMA believes CMS must take into account that emergency physicians and providers would not be in the position to purchase at CDSM platform, nor adopt a free CDSM platform, for implementation in the hospital because it does not have the appropriate authority to make such purchases nor implement a new CDSM tool as part of the delivery of emergency medical care provided in the hospital emergency department setting***.

In light of the above concerns, ***we again urge CMS to reconfigure the emergency medical condition exception so that it would automatically exclude claims with a Place of Service (POS) code of 23, Emergency Department, from the AUC program*.** As an alternative, ***EDPMA urges CMS to include the statutory references to "hospital-based" physicians in its exception from AUC requirements for MIPS eligible clinicians who have their ACI Performance Category reweighted to zero.***

Physician Quality Reporting System (PQRS) Criteria for Satisfactory Reporting for Individual EPs and Group Practices for the 2018 PQRS Payment Adjustment

CMS makes several proposals to the previously finalized reporting requirements to ensure that clinicians can be assessed for purposes of the 2018 payment adjustment based on satisfactory reporting criteria that are simpler, more understandable, and more consistent with the beginning of MIPS. These proposals are related to how CMS will evaluate what practices have reported (but not alter the reporting practices for anything that has not yet been reported):

- CMS proposes to revise the previously finalized satisfactory reporting criteria for the 2016 reporting period to lower the requirement from 9 measures across 3 NQS domains, where applicable, to only 6 measures with no domain requirement. ***EDPMA is extremely supportive of these changes, particularly to lower the evaluation criteria to 6 measures.***
- CMS proposes that individual EPs and group practices reporting via claims or qualified registry would no longer be required to report a cross-cutting measure. EDPMA has requested for years that CMS remove the requirement that practices report on a cross-cutting measure. ***We have been extremely supportive of CMS' decision to remove the cross-cutting measure requirement from MIPS, and we are extremely supportive of CMS proposal to remove the requirement from the 2018 PQRS evaluation criteria.*** In the past, only one measure on the list of cross-cutting measures was even applicable to emergency medicine, yet as specified was problematic. It was our experience under the prior PQRS program's cross-cutting requirement that quality measures appropriate and written for the ambulatory care space became accountability measures for hospital-based specialties. This resulted in significant work-flow, administrative, and facility based operational challenges for implementation. Therefore, EDPMA is extremely supportive of this proposal.

Value-Based Payment Modifier (VM) and Physician Feedback Program

In congruence with its current proposals related to the 2018 PQRS penalty, CMS proposes the following modifications to the VM policies for the CY 2018 payment adjustment period:

- CMS proposes to reduce the automatic downward adjustment for groups and solo practitioners (i.e., those who do not meet the criteria to avoid the 2018 PQRS payment adjustment as individual solo practitioners, as a group practice, or groups that have at least 50 percent of the group's EPs meet the criteria as individuals) to -2.0% for groups with 10 or more EPs and at least one physician, and -1.0% for groups with between 2 to 9 EPs, physician solo practitioners, and for groups and solo practitioners that consist only

of non-physician EPs. ***EDPMA strongly supports CMS' proposal to reduce the 2018 automatic downward adjustment.***

- CMS proposes to hold all groups and solo practitioners who meet the criteria to avoid the 2018 PQRS payment adjustment as individual solo practitioners, as a group practice, or groups that have at least 50 percent of the group's EPs meet the criteria as individuals harmless from downward payment adjustments under quality tiering for the last year of the program. ***EDPMA strongly supports CMS' proposal to hold groups that meet PQRS reporting requirements harmless under the VM.***

EDPMA has routinely expressed concern about the VM program and its ability to fairly assess and attribute beneficiary costs and resource use to emergency medicine physicians. In fact, we specifically requested that CMS use its discretion and limit the application of downward performance-based payment adjustments under the VM in CY 2017 and CY 2018. As such, we are extremely supportive of these proposals.

MACRA Patient Relationship Categories and Codes

MACRA requires CMS to develop classification codes to identify patient relationship categories that define and distinguish the relationship and responsibility of a clinician with a patient at the time of furnishing an item or service. These codes are intended to be part of the effort to improve methodologies for measuring resource use and are intended to be implemented in conjunction with episode-based cost measures that are currently under development.

CMS posted the operational list of patient relationship categories in May 2017:

- Continuous/Broad Services
- Continuous/Focused Services
- Episodic/Broad services
- Episodic/Focused Services
- Only as Ordered by Another Clinician

CMS proposes that Medicare claims submitted for items and services furnished by a physician or applicable practitioner on or after January 1, 2018, should include the applicable HCPCS modifiers that correspond to the categories listed above, as well as the NPI of the ordering physician or applicable practitioner (if different from the billing physician or applicable practitioner). CMS proposes that for an initial period clinicians may voluntarily report these codes on claims.

EDPMA supports the CMS proposal to make initial reporting of Patient Relationship Categories voluntary and urges CMS to continue its developmental work in this area to recognize the unique role of the emergency department. It is clear that none of these categories is generally applicable to the services provided by emergency medicine professionals. We continue to believe it is imperative for CMS to develop a Patient Relationship Category that captures care delivered in the emergency department. In emergency medicine, we are the acute diagnostician and manager of severe illness and injury. In addition, we are called on to be the

corrector of acute changes in chronic diseases. Because of this, we understand that the services in emergency medicine are not easily categorized. A significant amount of the resources is often attributable to services received in the emergency department and those resources are often well utilized in preventing further unnecessary health care spending and improving patient quality of care and outcomes. We believe that the value that accrues to the system because of care delivered by emergency medicine should be captured in episode group methodology and resource use measurement, and a key to being able to do that is developing an appropriate Patient Relationship Category for emergency medicine.

We also believe that CMS efforts to establish Patient Relationship Codes provide a unique opportunity to address the variation in resources available in a particular community setting. Depending on location, emergency departments are often called upon to provide additional services and marshal greater resources for patients seen in the emergency department due to limited availability of primary care physicians and specialists in the surrounding area (e.g. in the case of a Health Professional Shortage Areas (HPSA)). The relationship between the emergency medicine professionals and patients in those areas is almost certain to be different than in an area able to provide greater access to physicians and community resources. In fact, a recent study showed that there was a decrease in ED visits for all-cause, non-emergency care that was "primary care treatable" when paired with access to a primary care appointment within one day.[5] This helps demonstrate the increased pressure placed on emergency departments when adequate access to primary care services is lacking. In addition, the resources expended by emergency departments in treating patients can also vary significantly based on the hospital's academic status, whether it offers trauma services and at what level, and whether it is in a rural setting. We believe that in addition to the creation of the Patient Relationship Categories, CMS must find a mechanism that will take into account the availability of community resources. At the very least, we urge CMS to ensure that it makes resource use comparisons only between those practices that are similarly-situated, including whether there is a similarity in the availability of physicians and community resources, factors which can greatly affect the care that must be delivered in the emergency department. The existence of these codes will not achieve that goal.

The EDPMA appreciates the opportunity to provide input on the proposed rule. If you have any questions, please contact Elizabeth Mundinger, Executive Director of EDPMA, at emundinger@edpma.org if we can be of further assistance.

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[5] Yoon, Jean, Kristina M. Cardasco, Adam Chow, and Lisa V. Rubenstein. "The Relationship between Same-Day Access and Continuity in Primary Care and Emergency Department Visits." PLOS ONE (2015): Web. 11 Feb. 2016. <10.1371/journal.pone.0135274>.

Sincerely,

Andrea Brault, MD, FACEP, MMM, Chair of the Board
Emergency Department Practice Management Association (EDPMA)