September 2, 2014

Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services (CMS)
445-G Hubert H. Humphrey Building
Department of Health and Human Services
200 Independence Ave S.W.
Washington, DC 21201

Re: RIN 0938-AS12; CMS 1612-P; Proposed Rule — Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015

Dear Administrator Tavenner:

The Emergency Department Practice Management Association (EDPMA) is one of the nation's largest trade associations supporting the delivery of emergency medical care to all Americans. Together, **EDPMA's members deliver (or directly support) health care for over half of the 130 million patients who visit U.S. emergency departments each year**. Our members include physician groups, billing and coding companies, and others who support health care provided in the Emergency Department and work collectively to deliver essential services often unmet elsewhere.

The American College of Osteopathic Emergency Physicians (ACOEP) represents over 5,200 Emergency Physicians and provides oversight to 56 Emergency Medicine Residency Programs. ACOEP, founded in 1975, exists to support high quality emergency care, promote and protect the interests of Osteopathic emergency physicians, ensure the highest standards of postgraduate education, and provide leadership in research through the Foundation for Osteopathic Emergency Medicine, in a distinct unified profession.

Our members are often the first point of access for individuals in need of acute care, handling 28 percent of first-contact care in the United States while utilizing only 5 percent of the physician workforce.[1] ED patients include millions of indigent individuals and Medicaid recipients with little or no access to timely primary care. Ensuring the ongoing availability of quality emergency

[1] Pitts, S., Carrier, E., Rich, E., & Kellermann, A. (2010). Where Americans get acute care: Increasingly, it's not at their doctor's office. Health Affairs, 29(9), 1620-1629. doi: 10.1377/hlthaff.2009.1026.

services is an important part of maintaining a safety net for all patients including Medicare beneficiaries. Our position at the nexus of care provides us with a unique perspective on how proposed changes to the Medicare program will affect the ability of Medicare beneficiaries to receive emergency medical services.

On behalf of our members, we appreciate the opportunity to provide comments on the proposed rule for Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015 as published on July 11, 2014 (79 Fed. Reg. 40318). Both organizations understand the significant challenge posed in implementing reforms that will further enable millions of Americans to access medical care through the Medicare program. While many aspects of the Proposed 2015 Medicare Physician Fee Schedule take important steps forward to improve Medicare, EDPMA and ACOEP are concerned about the potential negative effect certain provisions will have on Medicare beneficiaries' ability to receive high quality care in the Emergency Department (ED).

Overview

We support goals of improved care coordination, quality and safety but we believe the Medicare program is bordering on an impractical number and variety of measures and methodologies that have become increasingly complex, expensive and unduly burdensome for providers. We seek opportunities to work with CMS to develop streamlined and less complicated methodologies to achieve well intended goals for improving cost effective outcomes for Medicare beneficiaries. Our comments are predicated with this in mind.

EDPMA and ACOEP support the one percent (1%) increase in reimbursement for emergency medicine that is expected from the proposed RVU revisions so long as Congress successfully addresses the potential reductions in physician reimbursement that are scheduled to occur as a result of the triggering of the flawed Sustainable Growth Rate (SGR) formula, which without Congressional corrective action will result in scheduled 20-21% cuts to Medicare physician reimbursement. Consequently, we also urge CMS to strongly support efforts to permanently repeal and replace the SGR formula. Similarly, we urge you to support efforts to permanently extend the 1.0 work floor for the Geographic Practice Cost Indices (GPCI) to ensure that reimbursement rates in rural communities do not drop too low.

However, **we strongly oppose efforts to phase out claims-based reporting** for the Physician Quality Reporting System (PQRS) and the Value Based Payment Modifier (VBPM). We have serious concerns about how the two quality reporting systems apply to ED physician groups. For instance, because Emergency Department physicians are excluded from the patient attribution mechanism, it may be impossible – or at least extremely difficult – for Emergency Department groups to qualify for the positive value-based adjustment no matter how low the cost the services they provide. Nevertheless, they are exposed to the same deep penalties as other physicians if they do not participate in the program. It would be unfair to require our members to invest significant financial resources to report via registries or other systems when they risk the same

penalty for nonparticipation yet cannot earn the same positive payment adjustment. Therefore, we urge you to retain current claims-based measures until this unfairness is addressed.

I. Quality Programs

EDPMA members have been leaders in quality reporting since the inception of the Physician Quality Reporting Initiative. EDPMA was one of the first associations to strongly advocate for participation in PQRI when it was purely a voluntary program with no financial incentive or disincentive. Emergency physicians originally had - and continue to have - one of the highest participation rates of any specialty in PQRS. In 2012, emergency physicians had the highest rate of participation of any specialty: 64% of emergency physicians participated while the average participation rate for all physicians was only 36%. Moreover, Emergency Medicine had the highest qualification rate, 91% of the ED physicians who participated qualified for the incentive.

However, it is important to note that the majority of physicians – and nearly all emergency physicians – have participated in the program via claims-based reporting. While some of our members may have or will soon be migrating to registry reporting options, many of our members remain in transitional stages and are still dependent on claims-based reporting. EDPMA and ACOEP caution against modifications that impose significant barriers to participation such as phasing out claims-based reporting, especially as the current quality and value reporting programs do not apply in a just manner to emergency physician groups.

The proposed rule would make it significantly more difficult and expensive for ED physician groups to participate in the PQRS and VBPM programs, and would expose ED groups to significant VBPM penalties while there are still significant barriers to qualifying for positive payment adjustments. **The quality programs will lose their effectiveness unless the proposal is improved to ensure that the measure set is appropriate for emergency medicine, that ED physicians continue to participate in large numbers, and that ED physicians who provide the highest quality care are appropriately rewarded.**

A. Efforts to Phase Out Claims-Based Reporting are Premature

In the 2013 Medicare Physician Fee Schedule Final Rule, CMS explained that it would "work to provide group practice reporting via the claims-based reporting mechanism in the future." We support this policy. As we did last year, we oppose the about-face that is included in this proposal to wind down and ultimately eliminate claims-based reporting. The proposed rule replaces a number of claims-based measures with measures that must be reported via registry or EHR.

Physician groups and their partners must invest a great deal of money when choosing a reporting mechanism. Based on historical policies, many of our members already made expensive software enhancements and process adaptations to allow for claims-based reporting, in order to comply with CMS guidance and trajectories. EDPMA and ACOEP members are extremely concerned that a significant change in approach would essentially result in a waste of this important investment, and additional re-investment in other solutions. It would be unfair to

expect the provider community to invest in a new reporting mechanism and take the cumbersome administrative steps (IACS, etc.) without sufficient notice. This would be an unfortunate message to a physician community that has embraced prior CMS quality initiatives, and has also publicly advocated for adoption with other specialty groups since the inception of the PQRI.

Moreover, the alternatives – EHR and registry reporting - are not ready for broad implementation. For hospital-based physicians, such as Emergency Department physician groups, the option to report on an EHR may become an important – and perhaps the most optimal – mechanism for reporting quality measures. But, most EHRs are not yet ready to take on this task. Culling information from the EHR is simply too cumbersome. Moreover, ED physicians do not make the decision on when (or if) to implement an EHR nor what system to use. Despite our efforts and desires otherwise, ED physicians and ED practice management groups do not control the configuration or functionality of hospital-owned EHR. Thus, CMS should avoid a policy that effectively penalizes ED physicians for not reporting on an EHR.

Therefore, the only viable option if the proposed rule were to be finalized would be registry reporting. Historically, many registries were developed for primary care practices and were not available to emergency physicians. Therefore, historically, ED groups focused on retooling for claims-based reporting. Many ED physicians may find that the cost of switching from the claims-based reporting mechanism to a registry at this time is prohibitively expensive. Despite industry-leading adoption and pace-setting performance in the PQRS arena over the past several years, it is not unreasonable to predict that many ED practices will simply stop participating in the programs until the registry option is less expensive, less burdensome, or the EHR reporting mechanism is a realistic option. CMS should <u>not</u> eliminate claims-based reporting until reporting via EHR and registry is more widespread and available to all physicians and physician groups and information can be captured consistently, meaningfully, accurately, and without placing a prohibitive cost and burden on physicians.

Moreover, CMS should not demand that ED physician groups invest these additional funds into a new quality reporting mechanism until the programs are modified to ensure that they apply fairly to ED physician groups. Most importantly, claims-based reporting should not be phased out until quality-tiering methodology ensures that ED physician groups can earn a positive value-based adjustment equal to the amount of funds put at risk for not participating in the program.

B. **<u>Qualified Clinical Data Registries (QCDR) and Hospital-Based Physician Groups</u>**

As mentioned earlier, some of our members are starting to move toward using registries. Unfortunately, under current law, physician groups reporting via the GPRO cannot avail themselves of Qualified Clinical Data Registries (QCDRs). QCDRs are currently limited to submitting quality measures on behalf of eligible providers (EPs). It is our belief that QCDRs have the opportunity to enhance the development of new quality measures, specifically outcome measures; this is limited however, by their restriction to report only on behalf of EPs. We would appreciate CMS evaluating the ability to expand QCDRs' role, and make them a viable reporting option for entities (TINs) submitting via the Group Practice Reporting Option (GPRO) for

groups of two (2) or more. This would enhance the ability of hospital-based physician groups who report via GPRO to work with QCDRs to develop new hospital-based outcome measures, and expand the number of measures that are available for reporting to hospital-based groups.

C. The Proposed Set of ED Measures Should be Improved

The proposed rule would eliminate a number of quality measures that regularly apply in the ED and replace them with measures that **do not apply** to the practice of most ED physicians. For instance, the proposed rule proposes to retire the following measures:

(1) Emergency Medicine: 12-Lead Electrocardiogram (ECG) Performed for Syncope
(2) Emergency Medicine: Community-Acquired Bacterial Pneumonia (CAP): Vital Signs
(3) Bacterial Pneumonia (CAP): Empiric Antibiotic
(4) Aspirin at Arrival for Acute Myocardial Infarction

CMS proposes to replace them with inapplicable quality measures, such as those that apply to children and pregnant women. In practice, ED physicians treat so few Medicare patients who are pregnant or under 18 that they cannot establish meaningful, if any, quality data. Additionally, CMS' rationale for proposing to remove many PQRS measures is due to the fact that they have supposedly "topped out" in that provider reporting performance no longer provides meaningful information to allow CMS to distinguish quality among physicians.

We oppose this rationale and instead request that CMS be more transparent in terms of the methodology used to make this determination and post information about a measure's average performance score, in advance of such determination as a means to provide providers with meaningful information regarding performance gaps. As stated by ACEP, we too also encourage CMS to more carefully weigh the risks versus benefits of discontinuing the collection of "topped out" measures data. We do not necessarily believe the fact that if performance is high across the board it does not carry with it the presumption that that is a negative outcome, particularly if it offers consumers the confidence to select from among an equally high quality set of physicians. Most importantly, given that only **32 percent** of all physicians across the country are reporting PQRS measures, it is difficult to emphatically state that performance on the measures is truly topped out.

1. Newly Proposed Measures

EDPMA and ACOEP support ACEP's recommendation that CMS *not* include *Avoidance of inappropriate use of imaging for adult ED patients with atraumatic low back pain* in the final rule and we request that you withdraw this measure from consideration.

In addition, we agree with ACEP that we appreciate the proposal to include: *Median Time to Pain Management for Long Bone Fracture* in the proposed rule. Emergency physicians worked with the CMS contractor - Oklahoma Foundation for Medical Quality - to develop this measure for the Outpatient Quality Reporting (OQR) program. We understand that ACEP has reached out

to the measure steward to contemplate "retooling" of this measure as a physician level measure for the PQRS program. At this time, it is unclear if or how this measure has been re-tooled.

As a result, EDPMA and ACOEP urge CMS to retain the existing measures currently scheduled for retirement until a strong set of ED measures is fully developed, including measures that apply to elderly Medicare patients and allow for a better reflection of the quality of care provided in the Emergency Department. Alternatively, we support ACEP's stated position that CMS, at minimum, retain these measures for the 2015 PQRS reporting period and adopt a policy whereby it places the measures proposed for removal in a "reserve or "notice" status that provides no less than one additional year before the measure can actually be removed from the program. We agree with ACEP that a measure "grace period" would allow for the gradual phase out of measures rather than immediate removal, giving physicians adequate time to identify and implement alternatives.

2. Cross-Cutting Measures

We also support ACEP's comments regarding cross-cutting measures**.** As noted by ACEP, the majority of these measures are focused on primary screening and prevention services that could be applicable to all Medicare beneficiaries, which we would believe are services which are most appropriately delivered in an outpatient office setting. But, these measures are not an appropriate assessment of the quality of care for unscheduled acute care delivered in the emergency department. As stated by ACEP, we object to your proposal to impose another new reporting burden during the very first year that the PQRS program is no longer voluntary, and in a year when the Value Modifier will put all physicians at risk for significant penalties.

If CMS does intend to mandate such an additional burden, similar to ACEP, we would strongly encourage CMS to include the following measures, which could be considered "cross-cutting" in acute care:

PQRS #	Measure Title and Description
54	12-Lead Electrocardiogram (ECG) Performed for Non-Traumatic Chest Pain
76	Prevention of Catheter-Related Bloodstream Infections (CRBSI): Central Venous Catheter (CVC) Insertion Protocol

Measures for Future Consideration: Additionally, as stated by ACEP, we too would like to remind CMS that *ACEP's Quality Measures Technical Expert Panel* has submitted the following measures for the ***2016*** PQRS reporting period:

2016	Efficiency	Imaging in adult ED patients with minor head injury
2016	Efficiency	Imaging in peds ED ages 2-17 y/o with minor head injury
2016	Efficiency	Pulmonary CT imaging for patients at low risk for PE

2016	Efficiency	Coagulation studies in patients with chest pain no coagulopathy or bleeding

D. CAHPS for PQRS

The proposed rule has a new requirement for groups with 100 or more providers who are reporting PQRS measures via GPRO to report CAHPS for PQRS. Previously this was only required if reporting via the GPRO web interface; however, the proposed rule would make this independent of the GPRO reporting methodology. In the CY 2014 reporting period, groups of 100 or more who elected to report via the web interface method, CMS assumed the responsibility for contracting with a certified survey vendor and ultimately absorbed the obligation for paying for the cost of the survey itself.

The proposed rule now applies this requirement to groups with 100 or more providers including those reporting via a registry, and the cost will now become the sole obligation of the group. This new requirement has a number of unknown factors, which evoke concern. These include:

(a) the unknown cost for this service provided by certified registries;
(b) the unknown list of certified vendors to provide the CAHPS for PQRS, and whether one or more vendors will be available to be chosen from by groups;
(c) the methodology for selecting groups for the survey and how the requirement will apply to hospital-based groups that do not have 20 or more primary care beneficiaries assigned to them, particularly concerning is how those groups will be identified proactively, and how they will the determined to have successfully reported for the PQRS program despite not having surveys completed; and
(d) the weighting of the CAHPS for PQRS quality measure in the Value Based Payment Modifier program for hospital-based practices, when these practices do have a sufficient but small number of primary care beneficiaries assigned to the group, but, while the survey is in effect performed, the beneficiaries assigned to the group are of such a small percentage of the group's overall performance on this measure it is severely over-weighted with respect to other cost and quality measures.

In light of these concerns, we would like to propose a postponement of the requirement for groups with 100 or more EPs to report CAHPS for PQRS when reporting GPRO via methods other than web interface, requesting that the requirement be delayed until CY 2016, and until the list of certified survey vendors is available to the public, the costs of contracting for such survey vendors is established, well known and can be budgeted for, and the methodology for determining which entities (TINs) require the survey is better understood by the group itself, as a particular group entity may or may not have the requisite 20 or more primary care beneficiaries assigned to it during the reporting year. This proposed delay is consistent with CMS' intent to withhold this requirement until CY 2016 for groups with 25 or more EPs based upon the

recognition that the cost of administration "may be significant". We request the same consideration for larger group entities.

In addition, we request that CMS develop and support the ability for groups reporting under GPRO to select to report patient satisfaction surveys that are most relevant to their clinical practice, much as they may with other PQRS measures. We suggest allowing groups to use a certified survey vendor to report either CAHPS for PQRS, S-CAHPS, or ED-CAHPS, based upon the predominance of their clinical practice. We feel that allowing groups to select the survey that most accurately represents their clinical practice will improve the quality and relevance of the information provided by the survey vendors, allow better benchmarking, support improved decision making by the public in selection of their preferred group via access to publically available data, and ensure that groups are being represented in an extremely important quality domain based upon a survey that represents the plurality of their care.

Lastly, we support any surveys that reflect both appropriate survey questions and methodology, such that they reflect the care area of the hospital where the group's providers render care. And while we do not go so far as to reject ED-CAHPS solely on it being mail response driven, we do wish to emphasize that we seek to use a survey instrument that reflects the most appropriate tool specifically designed for hospital-based groups customized for the practice setting in which they render care. As it relates to emergency medicine, we wish to reinforce that CMS has been working with the RAND Corporation to develop a survey instrument that is specifically tailored for use in the Emergency Department, however, this tool will not likely address other hospital-based providers in other specialty areas for which further development is needed. Notwithstanding, until this and other instruments are ready to be used in the ED and other hospital-based practices, patient satisfaction survey information should not be collected or published.

E. Measures Listings

Preferred measure specialty sets are provided as a tool by CMS and created in collaboration with specialty societies. We would encourage CMS to work with specialty societies that are hospital-based to assist in the development of suggested measure sets that are applicable to the care environment specific to hospital-based services. Many hospital-based practices have a paucity of PQRS measures that appear to apply to their clinical practice, and the development of both suggested lists/measure subsets, as well as working with those societies that are specific to hospital-based medicine practice to develop more robust process and outcome measures for PQRS would be of significant advantage.

F. Value-Based Payment and Quality-Tiering Methodology

The tidal wave of changes to quality-based reimbursement has led to a vague and complicated program where even experts disagree on the resulting impact on reimbursement rates. Current attribution methodology prevents ED physician groups from earning half – if not all – positive payment adjustments, yet they must pay the full penalty if they do not participate in the program.

Until this serious flaw in quality-tiering methodology is addressed, ED physician groups should either (1) not be punished for not participating in PQRS and VBPM programs or (2) should not be required to pay the extra cost of registry reporting (ED measures should be claims-based).

EDPMA and ACOEP support the arguments made by ACEP regarding the Value-Based Payment Modifier and urge you to read them.

G. **Assignment of Primary Care Beneficiaries to Hospital-Based Provider Groups**

It is not an unusual occurrence for certain hospital-based provider groups to be structured in such a way that they provide the vast majority of their services in hospital-based environments, but also sufficient volume in other venues to have primary care beneficiaries attributed to the group based upon the current CMS methodology. In those instances, a requisite number of primary care beneficiaries are assigned to that hospital-based group sufficient to qualify for the calculation of those cost and quality measures that apply to primary care management. Because this represents, in our view, an extremely small percentage of the group's overall total number of Medicare patients treated, we believe that the subsequent application of those cost and quality measures to the hospital-based group, when such measures are extrapolated from a small unrepresentative percentage of Medicare patients, can lead to inappropriately weighted and biased cost and quality composites. In these circumstances, this can result in financial incentives or penalties that are discordant with the actual quality and cost of care rendered by the groups.

As an example, the group may be made up of providers performing emergency medicine, hospital medicine and anesthesia services. When this is the case, there may be a small but identifiable practice in the areas of urgent care, skilled nursing facilities, and pain management significant to the extent that it leads to the attribution of primary care beneficiaries to the group overall. These beneficiaries will inherently represent a very small subset of the total patients cared for by the group, as well as likely represent care by a small subset of the providers within the group, and ultimately represent a biased subset of the patients cared for by providers within the group. Applying the cost and quality measures calculated from these specific primary care beneficiaries, and attributing them across the total depth and breadth of care provided by the group, can lead to skewed results that are not truly reflective of the group; potentially suggesting a flawed methodology.

We request in the alternative, that CMS entertain methods to either appropriately weight quality and cost measures calculated from primary care beneficiaries attributable to a group that is primarily hospital-based, including the CAHPS for PQRS quality measure, or instead exclude hospital-based groups from having these measures included in their composite of cost and quality measures. One method to appropriately weight the impact of these measures may be based upon the percentage of allowable Medicare charges, created by the group, for care provided outside of hospital-based place of service codes.

Additionally, we do not support the use of provider specialty types, obtained from PECOS, to be used to attribute hospital-based versus non-hospital-based groups. Provider specialty types

within PECOS are not, in our experience, representative to the location of care where a provider practices. The use of place of service codes we believe is much more accurate.

H. Stratification of Cost Measures

CMS has made an attempt to stratify cost measures by taking into account the specialty of providers as registered within the PECOS system, and we applaud these efforts. We do feel, however, that these efforts are insufficient. When using specialty within PECOS as the primary stratification method for cost, CMS is failing to adequately reflect the cost differential from one location of care to another (for example office care versus emergency department care). We recommend that in addition to the distribution of the specialties for providers within a group, CMS include the place of service as a factor for overall cost of care measures for a given group. In the absence of this additional consideration, it is felt that hospital-based provider groups will be inadvertently penalized on cost of care measures.

I. Hospital VBP Program Performance in VBPM Calculation

We appreciate CMS' solicitation of comments regarding the inclusion of hospital Value-Based Purchasing Program performance as part of a hospital-based group's Value-Based Payment Modifier calculation. We support CMS' effort to more closely tie hospital-based group's quality performance to that of the hospitals within which they work, and agree that hospitals have little ability to affect performance on many of the hospital Value-Based Purchasing program measures without direct participation from hospital-based providers. It is not possible, however, to provide unreserved support for this plan in the absence of an understanding of the specific methodology of how it would be implemented and what portions of the hospital Value-Based Purchasing program would be included for consideration. Given the lack of defined criteria for such a program, we recommend that groups be allowed to self-nominate as to whether they are hospital-based or not, as well as allow such hospital-based groups the option to elect to participate by including the hospital Value-Based Purchasing program scores in the hospital-based groups' quality composite. We do emphasize that we support ACEP's position that reflects an opposition to your proposal to incorporate to the hospital-based group the hospital's complete Value Based Purchasing program score. Furthermore, until a methodology specific to the hospital-based group's role within the hospital is established, which if first reviewed and endorsed by the specialty representatives, such as ACEP, we strongly encourage you to adopt an elective participation in the proposed process.

Allowing groups to self-nominate as hospital-based, as well as allowing them to elect to participate in the inclusion of hospitals' Value-Based Purchasing program performance in their own Value-Based Payment modifier calculation, will provide time for CMS to develop this program, allow for hospital-based groups to better understand the implications and methodology of its implementation, and ultimately, avoid an abrupt and poorly understood implementation of new complexity to the VPBM program.

In consideration of the method to determine which Value-Based Purchasing measures would be included in this process, we support CMS' consideration of the 'third' method. This allows for the inclusion of a subset of the domain measures in the cost and quality composites based upon where hospital-based providers are most likely to be able to exert influence, and as importantly, this enables CMS to only use measures with performance periods aligning with the rest of the Value-Based Payment Modifier measures. We feel that this temporal alignment is critically important as groups try to understand and react to the complexities of these new programs. Having measures from different performance time-periods apply to the overall composite for groups' quality and cost components would be confusing, and likely lead to disengagement by the groups in any attempts to exert change

J. Physician Compare Provisions - Inaccurate or Misleading Information

CMS will begin making quality information public on its Physician Compare website in 2015, based on 2014 data. The public will use the information on the Physician Compare website to choose and evaluate providers. EDPMA and ACOEP caution against making information public until CMS can ensure that providers have ample opportunity to review, correct, and appeal information which the provider or provider group has reasonable basis to believe is inaccurate or misleading. As discussed earlier, in the area of emergency medicine, the CAHPS for PQRS survey results could be misleading because the current survey is not effectively tailored for the unique ED environment.

II. Payment for Complex Chronic Care Management Must Reflect Significant Role of ED Physician Groups

EDPMA and ACOEP strongly support CMS's efforts to reimburse for complex chronic care management ("CCM"). However, we are concerned that the current provisions do not encourage ED physician groups to coordinate care. Under the proposal, it would be difficult for ED physician groups to qualify. For instance, the proposal requires "successive routine appointments" and routine appointments are not provided in the Emergency Department.

Yet, chronically ill patients do regularly visit the Emergency Department and require this aspect of care rendered by an ED physician. ED physician groups are 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).

The proposal encourages the primary care physician for those patients to coordinate care. Yet, ED 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. Yet, the proposal only reimburses one side of the coordination equation – even when

the patient is seen more often by the ED physician than the primary care physician. The proposal should allow ED physician groups who play a significant part in the patient's care and care coordination to be compensated for their employees' care and time and correct this proposed inequity.

Moreover, what happens when the chronically ill patient has 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 urge you to modify the proposal to encourage ED physician groups to continue coordinating care and provide an incentive for these groups to expand the number of services they provide.

EDPMA and ACOEP are pleased that CMS agreed with our comments posted last year and did not implement standards for certification as a medical home before a provider can take part in the CCM program and for clinic staff to be directly employed by a physician or group. However, there are requirements proposed this year that continue to pose barriers to appropriate CCM services in the ED. Despite the fact that emergency physicians provide 24/7 care coverage, typically have access to a patient's medical record, often perform successive examinations and handle a large degree of care transition management and care planning, the final rule must ensure that ED physician groups are encouraged to provide care coordination services.

III. Misvalued Codes and Global Surgical Period

EDPMA and ACOEP support the policy goal of revising and revaluing potentially misvalued codes. While ED physicians generally do not bill many of the codes referenced by CMS as being subject to valuation review, EDPMA encourages CMS to ensure that payments accurately represent the intensity of the services provided. Moreover, given that adjustments to Medicare reimbursement are generally budget-neutral, correction of certain outlier codes, from a reimbursement standpoint, will allow for more equitable distribution of Medicare funds to all enrolled providers. We would caution, however, that CMS consider the effect of revising misvalued codes on physicians billing a substantial percentage of those codes and, in particular, whether changes could have a negative impact on beneficiary access to services represented by those codes.

A. Proposal to Modify the Process for Code Reviews

Additionally, as stated by ACEP, we too appreciate CMS' objective of including proposed RVUs for new, revised and potentially mis-valued services in the annual Medicare Physician Fee Schedule proposed rule (rather than an Interim Final Rule) which would allow full notice and comment before payment rates were established for the subsequent year. We, like ACEP, support the inclusion of payment rates in the MPFS proposed rule but support the AMA-proposed timeline which allows CMS to include the January/February RUC meeting recommendation in the proposed rule. We also, as stated by ACEP, do not recommend the implementation of CMS' proposal for the 2016 payment schedule and agree with the AMA that any schedule change should be implemented in 2017, not 2016. The schedule of meetings for the RUC and CPT

Editorial Panels have already been set for the next year and the result of CMS finalizing its proposal for a 2016 change would introduce unnecessary burdens for physicians by either delaying code changes for an additional year or introducing additional G codes. We also, like ACEP, support the AMA's objection to eliminate the Refinement/Appeals Process. The Refinement panel provides an important opportunity for all physician specialties to have an objective and open appeal process by which they could formally question the proposed values assigned to various codes.

B. Potentially Mis-valued Services

We support review of potentially mis-valued code RVUs and encourage CMS to make use of the RUC process and other valid resources for refinement. EDPMA and ACOEP also support CMS' plan to "unbundle" the global surgical period but again cautions that CMS must ensure that no unintended consequences occur. By withdrawing the global surgical period, we expect that Medicare payments for surgeries, including emergency surgery, will be reduced to account for separate billing of pre- and post-operation evaluation and management services. However, it is important to consider that on occasion, some patients seek certain post-operative treatment from the emergency department. We encourage CMS to reflect on the physician work and practice expenses that may be incurred by hospitals providing post-surgical services, particularly those that may be considered charity care or written off as bad debt.

IV. Secondary Imaging

EDPMA and ACOEP would like to thank CMS for reinforcing that contemporaneous or real-time diagnostic radiology ("DR") and electrocardiogram ("ECG") interpretations are properly categorized as Part B services to Medicare patients. We would also recommend that CMS consider whether subsequent interpretation of such imaging is also a Part B service to Medicare beneficiaries.

In the proposed rule, CMS reminds providers of its general policy of reimbursing for "only one" interpretation and report except in "unusual circumstances." CMS also reiterates that a subsequent interpretation must have a full interpretation and report, be a service provided to the Medicare beneficiary, and may not be merely a quality control function of the hospital. CMS explains that, due to the proliferation of digital media, archiving systems, and health information exchanges, access to existing imaging and studies has greatly expanded.

While we disagree that so-called "payment uncertainty" would inhibit physicians from using existing studies, we believe it is important to consider how imaging is used in a variety of practice settings. For instance, in emergency medicine, physicians do not always have the luxury of obtaining an initial interpretation and report from a specialist given the time constraints unique to the practice. While radiologists may be on duty or on call, it may be beyond the emergency physician's control whether a radiologist can provide a subsequent read of an image in a timely manner. Since all physicians are trained and experienced in reading and interpreting imaging, emergency physicians very often must rely solely on their read to confirm a diagnosis. EDPMA

requests clarification on a number of elements of the proposed rule changes related to subsequent interpretations. These include:

- a list of specific CPT codes that may be subject to the rules of subsequent reading (the proposed rule mentions X-Rays and occasionally ECGs, as well as MRI and CT scans, but does not mention certain technologies such as ultrasound).
- a list or examples of expanded circumstances where subsequent interpretation will be reimbursed by Medicare.

Notwithstanding the aforementioned, EDPMA and ACOEP thank CMS for reinforcing the contemporaneous or real-time nature of diagnostic radiology ("DR") and electrocardiogram ("ECG") interpretations, particularly as they relate to services performed in the emergency department and the recognition that they be properly categorized as Part B services to Medicare patients.

V. Payment Policy for Substitute Physician Billing Arrangements

In the proposed rule, CMS has noted operational and program integrity issues involved when "substitute physicians" or "locum tenens" are used to cover for physicians who are absent in a variety of situations, particularly when substitute physicians are used to fill staffing needs for physicians who have permanently left a medical group or employer. 79 Fed. Reg. 40382. CMS has posed a series of questions and asked for comments on a number of policy issues for possible consideration for future rulemaking.

EDPMA and ACOEP members are familiar with the use of substitute physicians in a number of situations. We applaud CMS for reaching out to better understand current industry practices before proposing changes to the current requirements. We support CMS' goals of ensuring that responsible program integrity protections are met to ensure efficient and proper use of Medicare program resources as well as to protect Medicare beneficiaries. We have addressed several of CMS' questions in the particular context of the 24/7 needs of emergency departments. We stand ready to work with CMS to further consider these issues and any other related areas.

CMS has asked for comments about the situations that give rise to the need for substitute physicians and the type of services that are provided by these physicians. We would emphasize that there are many scenarios which could cause an emergency physician to become unavailable and produce the need for "substitute" physicians for various periods of time including:

- when the "regular" (previously scheduled and/or or full-time) physician becomes ill while on shift or has a last minute family emergency
- when the regular physician takes a sabbatical or needs to take time off to prepare for board certification exams, CME courses, specialty certifications or credentials
- when the regular physician has a long or short term illness, goes on family leave, vacations, deploys or expires

In the context of the emergency department, the type of services that would be provided by the substitute physician would be the same as those of the regular physician.

CMS has asked whether substitute and reciprocal physicians should be required to enroll in the Medicare program. In general, EDPMA and ACOEP believe that the Medicare program should ensure that all physicians providing care to Medicare beneficiaries should be required to be enrolled in the Medicare program. We also support requiring the claims submitted for services furnished by substitute physician to include the identity of the substitute physician. The vast majority of EDPMA members enroll all physicians who provide services in the ED – even for a few shifts -- even though this approach frequently produces significant administrative costs and cash flow delays.

EDPMA and ACOEP do not believe that different requirements should be established for "reciprocal" arrangements between two physicians and for arrangements between a physician group and a substitute physician. We believe the program integrity needs are the same. We also do not think it would be practical to establish different rules depending on the exact circumstances underlying the need for a substitute physician. That said, if CMS considers any changes to the current regulatory approach, we believe that CMS should take into account a number of practical concerns, including physician shortage areas, the frequent enrollment delays at many MACs, and possible differences between hospital-based physicians and office-based physicians.

Conclusion

In light of these important challenges, EDPMA and ACOEP are committed to working toward effective solutions on behalf of the patients we serve. We believe we are in a unique place to assist in the development of a cost-effective delivery system providing high-quality care to Medicare beneficiaries and many Americans across the country. We stand ready to assist CMS in these efforts, and are steadfastly committed to creating solutions in a time of rapid change and evolution.

Thank you again for the opportunity to provide information to assist you in developing this important regulation. Please feel free to contact Elizabeth Mundinger, EDPMA's Executive Director, at 703 610-9033, if we can be of any assistance on this topic or in any other area.

Sincerely,

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