June 24, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5517-P
P.O. Box 8013
Baltimore, MD 21244-8013

Submitted electronically

Re. Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician Focused Payment Models

Dear Acting Administrator Slavitt:

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.

SUMMARY

EDPMA applauds the end of the flawed Sustainable Growth Rate formula and encourages CMS to pursue a thoughtful and efficient transition to the new formula created under Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) under the newly named Quality Payment Program (QPP). However, we believe it is important for CMS to remember that emergency medicine is unique in the health care system and, in some instances, warrants special consideration for the implementation of programs under MACRA.

As a general rule, EDPMA would like the final rule to better clarify how the proposed MIPS provisions will be implemented so we can better prepare for the program. Further, we need a great deal more guidance on how specialties – especially emergency physicians – can develop physician-focused payment models. The current provisions give very little insight into how this will work for

specialties who have no control over their patient population like emergency physicians. Further, we ask CMS to recognize the importance and value and delivery of emergency care as a critical component to a cost effective delivery system. Emergency medicine is unique in the health care system and, in some instances, warrants special consideration for the implementation of programs under MACRA.

EDPMA is concerned with performance incentives for any providers (including APMs) that assume that receiving care in the emergency department should be avoided. 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.

Performance measures that address issues with too broad of a brush – such as measures or goals that discourage emergency care – could significantly increase costs. Furthermore, they could run contrary to the Prudent Layperson Standard which establishes the emergency department as a reimbursable venue for care when a prudent layperson reasonably believes there is a health emergency. The RAND Study noted that the patients' "prudence may be justified. The three most common symptoms of Medicare patients who are ultimately *discharged* from EDs—abdominal pain, chest pain, and shortness of breath—can represent benign conditions or life-threatening disorders, such as acute myocardial

infarction, bowel perforation, or a pulmonary embolus." It makes little sense to discourage emergency care for these patients.

EDPMA is also concerned that, in an effort to develop a performance score that can apply to all physicians, it has failed to address many of the unique aspects of emergency care. Emergency physicians provide care to all patients without regard to the ability to pay because of EMTALA. They often must perform expensive labs and tests to determine the underlying cause of the patient's symptoms. These labs and tests would need to be done at some point in the patient's care; however, if the goal is to provide a high level of care at low cost, these labs and tests should be hospital-based where specialists and technology are accessible and should be addressed early in the patient's care. In other words, it is most cost-effective to address these issues in the emergency department. Given this fact, it would be unfair to compare the performance of an emergency physician with other physicians. It would be like comparing apples to oranges. **Thus, it should be clear, that with regard to all aspects of the performance score, emergency physician performance should be compared to others in the same specialty.** Moreover, as you will see from our comments below, **there are many aspects of the score as described by CMS that should not be applied to unique circumstance of the emergency physician**.

Some other important requests addressed in this letter include:

MIPS Recommendations:

- ***With regards to Timing: Allow more time for providers to prepare for the new formula; shorten the 2017 performance period to either six (6) months (with the reporting period starting on July 1, 2017) or nine (9) months (with the reporting period starting on April 1, 2017),***
- ***With regard to Clinician Identifiers: provide feedback in a way that helps identify opportunities for improvement, helps providers understand allocations of payment updates, and captures the place of service (POS) code in feedback reports,***
- ***With regard to Reporting Options: allow for reporting flexibility, including allowing group reporting via registry or QCDR, remove the proposal requiring QCDR's to report a cross-cutting measure; do not require emergency physicians to report a cross-cutting measure until CMS develops one that is appropriate for the specialty, provide further guidance on group-level reporting in the clinical practice improvement category, quickly establish a process for reporting via Virtual Groups, and maintain claims-based reporting – including adequate claims-based measures for emergency care,***
- ***With regard to Reporting Requirements: maintain the reporting threshold for claims-based and registry reporting at 50 percent of patients for which a measure is applicable,***
- ***With regard to Weighting Performance Categories: reduce the threshold for "hospital-based" status under the Advancing Care Information Performance category to clinicians who furnish more than 80 percent in place of service POS 21 or 23 (emergency) and when a MIPS performance category is inapplicable, reassign weights proportionally to applicable categories until the Clinical Practice Improvement category reaches 25 percent,***
- ***With regard to Specialty Measure Sets: remove the requirement that specialties reporting under a specialty measure set report a cross-cutting measure; clarify the process for reporting when there are fewer than 6 measures in a specialty measure set for that reporting***

option; and remove Measure #414 Evaluation or Interview for Risk of Opioid Abuse from the emergency medicine measure set,

- ***With regard to Physician Compare: appropriately describe a 0 score for Advancing Care Information for hospital-based physicians (who cannot obtain a higher score) – or any other score on a measure that may be inapplicable - so that the consumer understands these 0 scores are not a reflection of poor performance; do not publish raw data files on physician compare if they are unsuitable for physician profile pages, and recognize that emergency care is unique with regard to public reporting because of EMTALA,***
- ***With regard to Quality Reporting: ensure that CAHPS for MIPS is not required for emergency care, ensure a more robust set of measures for emergency medicine, remove measures #254 and #255 under the claims-based reporting option, and maintain Measure #54,***
- ***With regard to Resource Use: do not rely on broad cost measures currently used in Value-Based Payment including the MSPB measure; add back in the specialty adjustment for the MSPB measure; reinstate specialty benchmarking methodology under the MSPB measure; provide protection from inadvertent case attributions by maintaining a 125 case minimum for the MSPB measure, further reduce reliance on the Resource Use performance category score, include specialty benchmarking under episode-based resource use measurement and calculate separate benchmarks for each specialty, exclude ABC™ methodology in benchmarking and public reporting proposals, and ensure resource use is appropriately risk adjusted,***
- ***With regard to Advancing Care Information: create a future pathway for hospital-based providers to get credit for EHR utilization under the Clinical Practive Improvement performance category and create a mechanism whereby participants in MIPS APMs meet ACI requirements through attestations that their hospital meets meaningful use for 50 percent of Medicare Part B claims during the first reporting period and 75 percent during the second performance period,***
- ***With regard to Clinical Practice Improvement: clarify attestation requirements for groups and create a future pathway for hospital-based providers to get credit for EHR utilization under the CPIA performance category, and***
- ***With regard to Physician-Focused Payment Models: provide more guidance on developing a specialty-focused PFPM and create a fast-track process that allows approved PFPMs to become CMMI Demos that would qualify for the APM incentive payment.***

APM Recommendations

- ***Define "nominal financial risk" broadly to allow Emergency Department (ED) groups the opportunity to develop practice models that will allow the ED to reduce costs (by, for example, reducing readmissions) without becoming part of an accountable care organization (ACO) which does not lend itself well to emergency medicine,***
- ***Create a mechanism for newly approved Advanced APMs to qualify for the 5 percent bonus payment for 2019 by (1) submitting measures under the MIPS program during the 2017 performance year; (2) meet the revenue or patient count threshold required for Advanced APMs in 2019 (3) bear more than nominal financial risk in 2019 as defined in the final regulations and (4) meet the ACI criteria as described below. If qualifying under this mechanism, the 5 percent bonus could be applied to all Part B payments received by the provider in 2019 if CMS approves the APM as an Advanced APM by 2019, and***

- ***Recognize that the APM Incentive Payment is a coordinated effort among the Eligible Clinicians and other aligned providers and participants, including the Eligible Clinician's associated group; consequently, CMS should deliver the APM Incentive Payment directly to the affiliated Eligible Clinicians' group TIN by which the group entity and the Eligible Clinician will collectively determine its distribution in accordance with the participants respective employment terms and contractual relationships.***

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

EDPMA understands that CMS has been tasked with implementing a complex piece of legislation that set the initial new payment updates for 2019 and presented a tight rulemaking timeline. However, EDPMA is very concerned with the short amount of time before the expected release of the final rule and the near immediate start of the first performance year on January 1, 2017. We believe this prevents practices from being adequately prepared to make decisions about how to report into MIPS, and as we discuss in more detail below, is even more intensified by CMS' proposal to increase quality reporting thresholds to 80 percent of applicable Medicare patients under claims-based reporting and 90 percent of *all* applicable patients, regardless of payer, under the EHR, registry, and QCDR reporting options. Because of the enormity of the MIPS program, its importance to the entire system of Medicare financing, and its impact on patient care,

EDPMA recommends that CMS shorten the 2017 performance period to either six (6) months (with the reporting period starting on July 1, 2017) or nine (9) months (with the reporting period starting on April 1, 2017). In either case CMS should make corresponding and proportional reductions to the minimum number of cases on which a measure must be reported (or in the case of resource use measures the minimum number of cases on which a practice must be attributed in order to be scored).

MIPS PROGRAM DETAILS

Eligible Clinician Identifiers For the purpose of administering MIPS, CMS makes the following proposals:

- CMS proposes to use a combination of billing tax identification number (TIN)/National Provider Identifier (NPI) as the identifier to assess performance of an individual Eligible Clinician where each unique TIN/NPI combination would be considered a different MIPS eligible clinician, and MIPS performance would be assessed separately for each TIN under which an individual bills.
- CMS proposes to use a group's billing TIN to identify a group.
- CMS proposes that each eligible clinician who is a participant of an APM Entity would be identified by a unique APM participant identifier.

In addition to these proposals related to identifiers, CMS also proposes to initially provide feedback to MIPS eligible clinicians who are participating in MIPS using historical data sets.

We understand CMS's reliance on existing identifiers, including the use of TINs. However,

EDPMA requests that CMS more easily provide feedback to eligible clinicians and the associated groups (regardless of whether they are reporting as individuals or as part of a group) in a way that more easily allows both access to information that will help identify opportunities for improvement

and understand allocations of payment updates. We also believe this is true for providing feedback at the TIN level.

For example, a large system TIN might include three separate emergency departments. A common entity should have access to performance data in each setting (even if all are under a single TIN) for the data to be meaningful for quality improvement purposes as well as to internally allocate the payment update (positive or negative) based on performance on all four MIPS categories. The existing TIN and NPI numbers (including subpart NPIs if utilized) could be utilized to achieve these goals. In addition, it will also be imperative for individual Eligible Clinicians to see whether outcomes change in different settings. Therefore, to allow for utilization of the data in the most meaningful way, it will likely be possible that CMS provide performance information that incorporates already existing identifiers to account for specialty, place of service (POS), geography (including state and Medicare locality), health system NPI, the subpart NPI where the services were delivered, and the NPI of the entity receiving assignment for professional services, as well as the ability to incorporate additional identifiers in the future if the need arises.

EDPMA also specifically requests that CMS take steps to capture the place of service (POS) code for services delivered.

In emergency medicine, it will be important to know whether the care was provided in POS 23. In order for a quality reporting system to work, a service delivered in an emergency department should not be compared to an otherwise similar service delivered in another setting. While we further discuss this below in the context of benchmarking, we believe that incorporating the POS identifier into MIPS reporting will be critical to ensuring that feedback reports and opportunities for improvement are meaningful. CMS should also review the current list of POS codes to ensure that the list is adequate given today's current practice settings and to provide for appropriate comparisons. For example, currently hospital-based emergency departments and free-standing emergency departments (FSED) BOTH share POS 23. This represents an opportunity to grant the FSED a new POS or possibly a sub-code within the POS taxonomy (POS-a, POS-b) in order to evaluate whether quality differs for the same kinds of patients in either setting.

<u>Reporting Options</u>

EDPMA applauds the reporting flexibility that CMS maintains in its proposals related to group reporting, including its proposals for allowing registry or QCDR group reporting.

Group reporting, including registry or QCDR group reporting, helps to ensure that the reporting protocol matches with the organization of so many emergency physician group practices. However, we are very concerned about CMS' proposal to extend the cross-cutting measure reporting requirement to QCDRs. As we discuss in more detail below, the list of cross-cutting measures currently includes only one measure that is even applicable to emergency medicine, yet as currently specified is problematic. CMS threatens to extend this problem into the QCDR reporting option with this proposal. Not only does this lessen the utility of QCDRs for specialties that do not have directly applicable measures on the cross-cutting measure list, but it also threatens to undermine the intent of the creation of QCDRs in the first place. QCDRs were intended to provide the flexibility for specialties to develop their own measures to ensure that registry participants were reporting on truly meaningful quality measures and not tethered to measures in the traditional measure set. Therefore,

EDPMA strongly recommends that you remove the proposal to require QCDRs to report a cross-cutting measure.

As independent emergency medicine group practices, we also seek additional clarification on CMS' proposals related to the group reporting option as it relates to the Clinical Practice Improvement Activities category. Past experience with group practice quality reporting makes the Quality performance category easier to understand given the ability of a measure denominator to expand or contract based on group size (and the CPT codes billed by the group). However, for the CPIA category, it is unclear from the proposed rule whether CMS (a) envisions some sort of group standard or (b) CMS is proposing that each Eligible Clinician would engage in CPIAs similarly regardless of whether they are reporting as an individual or via a group and then each report individual CPIAs which, in the case of groups, CMS would use to calculate a single CPIA score for the group's TIN. While we assume it is the latter, we believe CMS has not adequately described its process for deriving a group CPIA score from the individually reported CPIAs. Conversely, if CMS is contemplating a CPIA group standard, we seek more information regarding what that is. Must the group achieve the number of potential CPIA points multiplied by the number of Eligible Clinicians in the group regardless of which Eligible Clinician achieves them? In order to achieve full CPIA credit, is a group only required to achieve 60 points through the listed number of activities, no matter the size of the group?

Further, in the proposed rule, under the small practice (defined as 15 or fewer Eligible Clinicians) CPIA exception, CMS states,

> *For MIPS eligible clinicians and groups that are small, located in rural areas or geographic HPSAs, or non-patient-facing MIPS eligible clinicians or groups, in order to achieve the highest score of 100 percent, two CPIAs are required (either medium or high) For MIPS eligible clinicians or groups that are small, located in rural areas, located in HPSAs, or non-patient-facing MIPS eligible clinicians or groups, in order to achieve a 50 percent score, one CPIA is required (either medium or high).*

Is CMS suggesting that if one physician in a group of 10 Eligible Clinicians completes the requirements associated with MOC Part IV (a medium priority CPIA) and no other CPIAs are submitted on behalf of anyone in the group, the entire group achieves a 50 percent CPIA score?

In another example, CMS states in its MIP APM Scoring Standard proposals that Next Generation ACO participants as MIPS eligible clinicians would <u>submit CPIA individual level data to MIPS and not group level data. It is not clear to us what "group level" CPIA data is unless the group level data is just the collection of every individual group member's CPIA(s) attestation(s).</u>

<u>In order to provide the best guidance to practice groups seeking to meet the requirements, we request further guidance on CMS' proposals related to group-based reporting under the CPIA category.</u>

In addition, MACRA provides for the establishment of voluntary virtual groups for certain assessment purposes. The statute requires the establishment and implementation of a process that allows an individual MIPS eligible clinician or a group consisting of not more than 10 MIPS Eligible Clinicians to elect to form a virtual group with at least one other such individual MIPS Eligible Clinician or group of not more than 10 MIPS eligible clinicians for a performance period of a year. However, CMS determined that implementation of virtual groups for the 2017 performance period is infeasible. CMS will instead aim to implement a web-based registration system for 2018, which it believes would

provide the necessary time to establish and implement an election process and requirements applicable to virtual groups. As we have stated in past comments, EDPMA believes CMS must organize the data collection and reporting mechanisms in a way that allows for calculating performance congruent with the multiple ways that providers (physicians and hospitals alike) are organized.

EDPMA, therefore, believes it is imperative that CMS establish its process for reporting via Virtual Groups as soon as practicable.

We understand that there are operational issues to creating a new reporting option, mechanism, or entity. However, we believe it is important that CMS allow for groups to organize for reporting purposes in ways that make sense for patient care and quality improvement, and implementing a policy regarding Virtual Groups could provide the flexibility needed to allow practices to better align their quality improvement and resource use management efforts.

EDPMA, in addition, applauds CMS' decision to maintain claims-based reporting in the quality performance category.

This has been an important reporting mechanism in emergency medicine, and we appreciate CMS maintaining it under MIPS, particularly in the early transition years where practices will struggle to understand and meet the new requirements. The preservation of the claims-based reporting option will help those emergency medicine practices that have relied on this reporting option in the past make the transition to the new MIPS requirements. In addition, there is additional administrative burden to reporting under other available reporting options such as the registry reporting option which can carry registration fees and is now proposed to require reporting on 90 percent of *all* patients applicable to a given quality measure. For these reasons, we believe it is important that CMS continue to preserve the claims-based reporting option. Although CMS has retained this option, we are concerned that CMS is not allowing many EM measures to be reported via claims.

Reporting Requirements

Claims-Based Reporting 80 Percent Threshold When reporting quality measures under the claims-based reporting option, CMS proposes to raise the reporting threshold from 50 percent to 80 percent of patients on which a measure is applicable. EDPMA has previously stated that the CMS reporting thresholds are unnecessarily onerous. Because of the large volumes associated with emergency medicine practices (it is not unusual for a well-established urban setting hospital-based emergency medicine practice to render care to upwards of 100,000 emergency department patient visits per year), we believe that even the current 50 percent threshold under PQRS far exceeds the number needed to accurately obtain a statistically valid sample. Even if a system could extract all of this data, it is still a huge (and unnecessary expense), especially for high-volume providers such as emergency physicians.

Therefore, ***EDPMA strongly recommends that CMS reduce the 80 percent claims-based reporting threshold under the quality performance category***.

As stated, we believe that in order to obtain a statistically valid sample, CMS can rely on a much lower reporting threshold. In addition, as we transition to a completely new Medicare physician payment system, requiring claims-based reporting on 80 percent of the Medicare patients to which a measure applies provides very little preparation and transition time for practices.

CMS seems to counter concerns about the speed of implementation of the program by citing the March

2018 data submission deadlines for the 2017 performance year. However, this submission deadline for quality data is only relevant to non-claims based reporting options. According to CMS' most recently available PQRS data, in 2014, 68.1 percent of eligible emergency medicine providers utilized claims-based reporting.[1] While we appreciate the move toward registry reporting, as many of our member organizations have moved or are moving this direction, a substantial portion of emergency medicine physicians will continue to rely on claims-based reporting for quality, and we are very concerned that requiring reporting on 80 percent of relevant Medicare patients will essentially mandate that, in emergency medicine, providers will need to be fully transitioned to the new reporting methodologies by January 1, 2017 to ensure the requisite number of cases. Those who report measures via claims do not have the luxury of waiting to batch report data into a registry in early 2018.

EDPMA strongly urges CMS to reduce the claims-based reporting threshold both because that high of a reporting threshold is an unnecessarily administrative burden that is not necessary to obtain valid data and performance results and to allow Eligible Clinicians reporting via claims additional time to develop a 2017 reporting strategy by not requiring reporting on nearly all patients.

<u>Other Reporting Options' 90 Percent Reporting Threshold</u> Under EHR, registry, and QCDR reporting, CMS proposes to increase the reporting threshold to 90 percent of all payer patients to which a measure applies.

EDPMA strongly urges CMS to reduce this reporting threshold.

Requiring that Eligible Clinicians report on 90 percent of all patients to which a measure is applicable unnecessarily and substantially increases the reporting burden associated with MIPS. CMS can obtain valid and meaningful results from a much lower threshold.

EDPMA, therefore, recommends that, at the very least, CMS maintain the current 50 percent reporting requirement.

We find the proposed increase to 90 percent to be particularly difficult in the cases of QCDRs. Under current operations, non-PQRS measures developed by QCDRs have not been finalized by CMS until Spring of the performance year. We understand this delay given the January performance year deadline for QCDR self-nomination and subsequent CMS review process. However, if CMS is indeed encouraging expanded QCDR use, we do not find a 90 percent reporting threshold reasonable for measures that are not even finalized until the Spring of the performance year. We understand that QCDR data is not required to be submitted until the Spring *after* the performance year, but in order to abstract the data needed to report on measures, practices must ensure that charts are thoroughly collecting all of the information needed to accurately report on a given measure during the entire performance period, and practices cannot know that they are collecting all of the necessary in the charts throughout the performance year unless they have the specifications for the measures. It will be nearly impossible to meet the 90 percent threshold if the specifications are not received until a quarter of the way through the performance year.

In addition, we believe that in the future CMS should establish reporting requirements that are specific to the measures based on information available about the specific required sample size. In addition, we

[1] Centers for Medicare and Medicaid Services, *2014 Reporting Experience Including Trends (2007-2014) Physician Quality Reporting System*, Appendix Table A9 (April 2016).

believe that QCDRs should be given the flexibility to determine the most appropriate mechanism for determining a statistically valid sample of patients for a measure on a case-by case basis.

Performance Category Weighting

- CMS proposes to assign a weight of zero to the Advancing Care Information performance category for purposes of calculating a MIPS Composite Performance Score (CPS) for MIPS Eligible Clinicians meeting the "hospital-based" clinician standard (as wells as those meeting the hardship exemption requirements). CMS proposes to continue to define a MIPS eligible clinician who furnishes 90 percent or more of his or her covered professional services in sites of service identified by the codes used in the inpatient hospital or emergency room setting in the year that precedes the year of the performance period (i.e., the year three years preceding the MIPS payment year). CMS seeks input on whether the previously established 90 percent threshold of payments for covered professional services associated with claims with Place of Service (POS) Codes 21 (inpatient hospital) or 23 (emergency department) is appropriate.

    - ***EDPMA believes a 90 percent threshold of payments for covered professional services associated with claims with Place of Service (POS) Codes 21 (inpatient hospital) or 23 (emergency department) is appropriate.***

    CMS also requests input on whether CMS should consider lowering this threshold to account for hospital-based MIPS eligible clinicians who bill more than 10 percent of claims with a POS other than 21 or 23. In emergency medicine, many physicians also deliver services in urgent care settings (which, of course, carry a different POS code). However, we do not believe that these physicians are any better situated to control the purchase and implementation of EHR technology. To ensure that these Eligible Clinicians are not inappropriately scored under the Advancing Care Information performance category,

    - ***EDPMA also supports CMS consideration of reducing the threshold to a "MIPS eligible clinician who furnishes <u>80 percent</u> or more of his or her covered professional services" in POS 21 or 23.***

- If a MIPS eligible clinician does not receive a Resource Use or Advancing Care Information performance category score and has at least three scored measures[2] (either submitted measures or those calculated from administrative claims) in the quality performance category, CMS proposes to reassign the weights of the performance categories without a score to the quality performance category. CMS also includes an alternate proposal in which it would not reassign all the weight to the quality performance category, but rather reassign the weight proportionately to each of the other performance categories for which the MIPS eligible clinician has received a performance category score.

    - ***EDPMA strongly believes that CMS should implement the alternate proposal whereby the weight is reassigned proportionately to the remaining performance categories. EDPMA also recommends that CMS implement a version of this to align the weights with its proposal under the MIP APM Scoring Methodology where the CPIA score can increase in some situations to 25 percent of the CPS.***

[2] If the MIPS eligible clinician has fewer than three scored measures in the quality performance category score, then CMS proposes to reassign the weights for the performance categories without scores proportionately to the other performance categories for which the MIPS eligible clinician has received a performance category score.

- In scenarios where a MIPS Eligible Clinician receives a 0 percent weight under the Advancing Care Information or Resource Use performance categories, we believe that CMS should shift the weight to the CPIA category until the CPIA performance category reaches 25 percent and then reassign the remaining weight proportionately. We believe that this not only aligns with the CMS proposals made under the MIPS APM Scoring Standard, but also puts an emphasis on physician investment in quality improvement activities included under the CPIA category.

Specialty Measure Set Proposals. CMS developed specialty measure sets designed to direct specialty-specific measures available as well as identify specialties that might not have enough specialty-specific measures on which to report in order to meet the baseline reporting requirement of six (6) measures. CMS proposes to allow specialties with fewer than 6 measures to report on the measures available under that specialty measure set. CMS also states that regardless of the number of measures that are contained in a specialty-specific measure set, clinicians reporting on a measure set would be required to report at least one cross-cutting measure and either at least one outcome measure or, if no outcome measures are available in that specialty- specific measure set, report another high priority measure.

CMS lists the following measures (and available reporting options) as part of the specialty measure set for emergency medicine:

Measure	Reporting Option		
	Claims	EHR	Registry
PQRS #066: Appropriate Testing for Children with Pharyngitis		X	X
PQRS #091: Acute Otitis Externa (AOE): Topical Therapy	X		X
PQRS #093: Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use	X		X
PQRS #116: Antibiotic Treatment for Adults with Acute Bronchitis: Avoidance of Inappropriate Use			X
PQRS #254: Ultrasound Determination of Pregnancy Location for Pregnant Patients with Abdominal Pain	X		X
PQRS #255: Rh Immunoglobulin (Rhogam) for Rh-Negative Pregnant Women at Risk of Fetal Blood Exposure	X		X
PQRS #414: Evaluation or Interview for Risk of Opioid Misuse			X
PQRS #415: Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older	X		X
PQRS #416: Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 through 17 Years	X		X

EDPMA makes the following recommendations related to this proposal:

- ***EDPMA strongly urges CMS to remove PQRS Measure #414 Evaluation or Interview for Risk of Opioid Abuse***

We are extremely supportive of efforts to stem the opioid abuse epidemic facing the United States. However, upon review of the specifications for PQRS #414, it is unfortunately inapplicable to the emergency department setting. First, the ED visit codes are not listed in the encounter CPT codes so the measure would never be triggered when patients are seen in the emergency department. In addition, even if the ED visit codes were added, the measure refers to "prescribed opiates for longer than six weeks duration." It is an extremely rare occurrence that an emergency physician would ever provide an opiate prescription for that length of time, if ever. We look forward to

providing input on the development of an opioid measure applicable to the emergency department but request that CMS remove PQRS #414 from the Emergency Medicine Specialty Measure Set.

- ***We strongly recommend that CMS remove the requirement that specialists reporting under the specialty measure set report a cross-cutting measure***.
    - As detailed further below, the only somewhat applicable cross-cutting measure in emergency medicine is PQRS #317: High Blood Pressure Screening and Follow Up. However, even this measure is problematic for our specialty because follow-up is required for any patient outside of the "normal" range (see below).

- ***EDPMA strongly urges CMS to revise the proposal to report on fewer than 6 measures to state that it applies to the specialty measure set <u>by reporting option</u>.***
    - Given that CMS proposes to continue its policy that an Eligible Clinician or group can only report quality data utilizing a single reporting option, the current proposal does not take into consideration that an eligible clinician of a particular specialty will only have access to the measures that are available under the particular reporting option. For example, in looking at the list of measures under the Emergency Medicine specialty medicine set proposed (as recreated in the table above), an emergency physician who reports via EHR will only have access to a single emergency medicine-specific measure. CMS' proposal should account for this given that it is not as though the physician reporting EHR would be able to report any of the other measures on the emergency medicine specialty measure set.

- ***EDPMA requests that CMS provide additional clarification on its proposal to report on fewer than six (6) measures when there are fewer than six (6) available under the specialty measure set, particularly to ensure that Eligible Clinicians are not unfairly penalized under such circumstances where an insufficient number of reporting measures are made available to the Eligible Clinician***.
    - While we understand that CMS is proposing to *allow* reporting on fewer than six measures under this scenario, it is not clear from the proposed rule whether these eligible clinicians would still be able to qualify for the full potential score available under the scoring methodology as Eligible Clinicians who report on 6 measures. The fact of the matter is that the emergency physician who reports via claims cannot report on 6 measures.

<u>Public Reporting/Physician Compare</u>

CMS proposes public reporting of an eligible clinician's MIPS data; in that context, CMS, for each program year, would post on a public Website, in an easily understandable format, information regarding the performance of MIPS eligible clinicians or groups under the MIPS.

More specifically,

- CMS plans to publicly report on Physician Compare the composite score for each MIPS eligible clinician, performance of each MIPS eligible clinician for each performance category, and periodically post aggregate information on the MIPS, including the range of composite

scores for all MIPS eligible clinicians and the range of performance of all the MIPS eligible clinicians for each performance category.

- CMS proposes that these data will be added to Physician Compare for each MIPS eligible clinician or group either on the profile pages or in the downloadable database as technically feasible.

- Currently, there is a minimum sample size requirement of 20 patients for performance data to be included on the Website. CMS previously sought comment on moving away from this requirement and moving to a reliability threshold for public reporting. CMS now proposes to institute a minimum reliability threshold for public reporting on Physician Compare. Once an appropriate minimum reliability threshold is determined, the reporting of reporters' performance rates for a given measure will be restricted to only those meeting the minimum reliability threshold.

    - ***EDPMA strongly supports CMS' proposal to set a minimum reliability threshold based on the specifics of the underlying measure.***

  We encouraged CMS in our RFI comments to adopt a higher minimum case threshold for publicly reported measures since a 20 patient minimum is insufficient to ensure the validity of the data. We are pleased to see that CMS is attempting to address this issue.

- CMS proposes to make all measures under the MIPS Resource Use performance category available for public reporting on Physician Compare.

- CMS proposes to make all activities under the MIPS CPIA category available for public reporting on Physician Compare.

- CMS proposes to include more information on eligible clinician's performance on the objectives and measures under the Advancing Care Information performance category on Physician Compare.

    - ***EDPMA requests that CMS carefully consider how hospital-based physicians will be listed on Physician Compare given the 0 percent weight will be assigned to the Advancing Care Information category for hospital-based providers and encourage them to ensure that the public understands that a zero score is not an indication of poor performance.***

- CMS previously finalized that it would add utilization data to the Physician Compare downloadable database and proposes to continue this practice.

    - ***EDPMA continues to request that CMS carefully reconsider whether it is appropriate to make data available through a downloadable raw data file that has already been deemed unsuitable for physician profile pages***.

  EDPMA supports transparency but we have concerns about this data being misused or misinterpreted by a variety of stakeholders claiming to be arbiters of quality. Entities such as Healthgrades, Vitals, and even Angie's List could take this raw data, label it as "official

government data," and then interpret it multiple different and potentially inaccurate ways. This could not only confuse the public but mislead them as well. It is absolutely critical that CMS work closely with professional societies and their clinical experts throughout this process and to be as transparent as possible regarding the outcomes of these analyses, including consumer testing to determine which measures are most meaningful to the public.

- ***EDPMA also requests, in instances where insufficient performance data exists, that CMS provide clear disclaimers in easily understood and decipherable language which explains to patients why certain physicians lack relevant measure data and how this should not be interpreted as an indicator of poor performance.***

Finally, while CMS's mention of the star rating methodology is limited to its discussion of how to approach measurement of historic performance scoring, EDPMA again cautions CMS regarding the application of ratings of quality and value to a health care service (specifically, the emergency department) with an entirely unique statutory requirement (in this case, the Emergency Medicine Treatment and Labor Act (EMTALA), or other similar legal requirements that support patient access and frequently require the delivery of care under specifically nuanced standards (in this case, the prudent layperson definition of an emergency medical condition, a/k/a the prudent layperson standard), or, within the setting of an acknowledged health care safety-net (in this case, full access to a provider irrespective of insurance or ability to pay) versus a private practice setting where patient selection is permitted (patient selection), recognizing that an emergency department is a setting that is unlike any other component of the health care system.

Using the same or similar methodologies is inherently problem-prone, will likely be misleading, and result in significant unintended consequences for providers, patients, and the health care system. We remind CMS that the unique nature of the emergency department setting makes it even more challenging to accurately and appropriately publicly report performance data. Emergency departments are required under EMTALA to stabilize and treat any patient that presents to the ED, regardless of their insurance status or ability to pay. This unfunded mandate greatly limits an ED physician's ability to influence costs and quality (especially when these measures are not adequately risk-adjusted).

Furthermore, one of the primary goals of Physician Compare is to assist consumers with selecting a physician. However, most patients seeking emergency care do not have the opportunity to choose their emergency provider and even when they do, a policy designed to present those patients with aggregated data might result in that patient choosing to second-guess their decision to go to the emergency department which would seem to contradict CMS' overarching policy goals of securing Medicare beneficiaries' unencumbered access to the emergency department.

EDPMA therefore asks CMS, that because of EMTALA and the unique nature of the emergency department it is necessary that CMS take into consideration these anomalies as it finalizes its public reporting proposals under MIPS relative to emergency medicine.

MIPS PERFORMANCE CATEGORIES

Quality Performance Category

- CAHPS for MIPS

  CMS proposes to allow registered groups of two or more MIPS eligible clinicians to *voluntarily* elect to participate in the CAHPS for MIPS (formerly CAHPS for PQRS) survey. Although CMS is not requiring groups to participate in the CAHPS for MIPS survey, it proposes a scoring incentive in bonus points for those groups who report via the CAHPS for MIPS survey.

  - ***EDPMA appreciates that flexibility that CMS proposes related to election to report CAHPS for MIPS data***.

  EDPMA has long had concerns about CMS mandating the use of the CAHPS for PQRS, in general, since this instrument does not accurately capture experience of care in the emergency department setting. Further, weighting performance on patient satisfaction could encourage the use of opioids for pain relief which is may not be the best solution given that it can create a problem with addiction.

  This concern is compounded by the fact that groups must bear the cost of contracting with a CMS-certified survey vendor to administer the instrument.

  - ***EDPMA continues to believe that CAHPS for MIPS should not be mandated for emergency-focused group practices due to the currently designed inapplicability of the survey to our practice setting and urge CMS to finalize its proposal to make CAHPS for MIPS participation voluntary***.

- Emergency-Specific Measures**.**

  ***EDPMA continues to express concern about the availability of relevant, meaningful measures for emergency medicine under PQRS and as proposed under MIPS*.**

  The transition to quality reporting under MIPS presents CMS with a unique opportunity to incorporate more meaningful measures for emergency medicine. We continue to support the inclusion of the following specific quality measures:

  - Imaging in Adult Emergency Department (ED) Patients with Minor Head Injury: EDPMA supports efforts to minimize patient exposure to ionizing radiation through the use of evidence-based and clinically relevant validated decision tools, on which this measure is based
  - Imaging in Pediatric ED Patients Aged 2 through 17 years with Minor Head Injury: EDPMA supports efforts to minimize patient exposure to ionizing radiation through the use of evidence-based and clinically relevant validated decision tools, on which this measure is based.
  - Coordinating Care- Emergency Department Referrals: *Percentage of patients (1) of any age with asthma or (2) ages 18 and over with chest pain who had a visit to the emergency department (not resulting in an inpatient admission), whose emergency department*

provider attempted to communicate with the patient's primary care provider or their specialist about the patient's visit to the emergency department. EDPMA strongly urges CMS to add this measure to the MIPS measure set ONLY when and if the electronic health record systems are concurrently held accountable for implementing the functionality(s) necessary to support this provider-based measure. Consistent with our comments above, we support the intent of this care coordination measure, but as often is the case, emergency department physicians often lack the tools and functionalities that allow physicians to satisfy this measure. ED physicians have little to no control over EHR systems as these are typically owned and managed by hospital and hospital systems. Emergency physicians, despite significant attempts otherwise, are allowed little control or input in the design or functionality of the contracted EHR vendor or programming team.

- Cross-Cutting Measure Requirement.

  CMS proposes to continue its reporting requirement that Eligible Clinicians report on a cross-cutting measure.

  - ***EDPMA continues to be concerned about the applicability of the concept of "cross-cutting measures" to emergency medicine and caution CMS from continuing it as currently proposed under MIPS and recommend that the requirement be removed unless CMS can ensure and demonstrate that the list includes measures that are truly applicable to all specialties, which is not currently the case.***

  There is currently only one cross-cutting measure that is relevant to emergency medicine and is even only somewhat relevant at that: PQRS #317: High Blood Pressure Screening and Follow Up. However, even this measure is problematic for our specialty because follow-up is required for any patient outside of the "normal" range, which is defined as Systolic BP >120 mmHg and Diastolic BP >80.

  While the measure does include exclusion for patients in "emergent or urgent situations where time is of the essence and to delay treatment would jeopardize the patient's health status," a substantial number of our patients are inadvertently included in the universe addressed by this measure, requiring burdensome documentation, follow-up, and even unnecessary downstream medical care (since reporting is required on 50 percent of all eligible Medicare patients).

  By requiring the use of a "cross cutting measure" in reporting, CMS has forced an entire specialty to report on a measure that does not entirely fit.

  - ***EDPMA urges CMS to reconsider its cross-cutting measure proposal and instead propose a system that allows specialties to select the measures that are most appropriate to the care delivered or ensure that measures that are truly applicable to all specialties are included on the list of cross-cutting measures***.

- PQRS Measure #254 (Ultrasound Determination of Pregnancy Location for Pregnant Patients with Abdominal Pain) PQRS #255 (Rh Immunoglobulin (Rhogam) for Rh-Negative Pregnant Women at Risk of Fetal Blood Exposure).

After several years of reporting experience, we have found measures 254 and 255 to be largely inapplicable in the Medicare population as there are few pregnant Medicare patients. However, a significant amount of effort goes into determining whether there are cases on which these measures must be reported. Therefore,

- ***EDPMA recommends that CMS remove measures #254 and #255 under the claims-based reporting option given that claims-reporting is only done for Medicare patients to whom a measure applies.***

EDPMA believes that this would remove the administrative burden of reporting largely inapplicable measures, while maintaining the measures as part of registry reporting would provide practices with access to reporting on the measures but, because registry reporting now requires reporting on all patients, (regardless of payer), ensure that the use of the measure is directed at the patients on whom the measures are most meaningful.

- PQRS Measure #54: Emergency Medicine: 12-Lead Electrocardiogram (ECG) Performed for Non-Traumatic Chest Pain Percentage of patients aged 40 years and older with an emergency department discharge diagnosis of non-traumatic chest pain who had a 12-lead electrocardiogram (ECG) performed.

  This measure is currently included under PQRS for claims and registry-based reporting. CMS proposes to remove this measure under MIPS because it is considered low bar and is part of standard clinical practice and because it believes there is no significant performance gap for this measure as indicated by high performance rates. CMS goes on to state that removal of this measure does not impact the number of adequate measures for Emergency Department physicians.

  - ***EDPMA strongly requests that CMS maintain PQRS Measure #54***.

  First, as discussed regarding the specialty measure sets, we believe it is important for CMS to review the list of available measures *by reporting mechanism*. If CMS agrees with our recommendation to make the pregnancy measures in the Emergency Medicine specialty measure set (#254 and #255) available only under registry-based reporting because of the inapplicability of the measures to Medicare patients, that would mean under claims-based reporting, Emergency Medicine would only have four (4) measures available if CMS finalizes its proposal to remove PQRS Measure #54.

  In addition, in several other instances, CMS acknowledged that while it believed that there were some PQRS measures that saw little variation in performance among those reporting that measure, CMS chose to maintain the measures under MIPS but assign those measures a lower priority for reporting and scoring purposes.

  Given that there are still significant numbers of Eligible Clinicians not reporting into PQRS, it would be premature to conclude that the measure is low bar based on the current performance rates, and even if so, we request that CMS treat the measure similar to others in the proposed rule where it addresses this concern via prioritization of the measures.

- Global/Population Health Measures

CMS proposes to move the following administrative claims measures (currently in use under the Value-Based Payment Modifier program) into the Quality Performance Category:

- All-cause readmissions
- AHRQ acute preventive quality indicator composite (bacterial pneumonia, UTI, dehydration)
- AHRQ chronic preventive quality indicator composite (COPD, HF, DM)

These measures would be included in an Eligible Clinicians' Quality Performance score without the need for data submission based on CMS access to claims data and utilizing its attribution methodology.

- ***EDPMA strongly encourages CMS to remove these administrative claims-based measures from the MIPS Quality Performance Category***

We are concerned that this proposal incorporates administrative claims measures that are not risk-adjusted. In addition, incorporating them into MIPS is taken a measure that was specified at the facility level and now using it at the physician level without adjusting the measure for the new level of assessment.

Resource Use Performance Category

- ***EDPMA is disappointed that in the proposed rule CMS continues its reliance on the broad cost measures currently used under the Value-Based Payment Modifier (VM).***

As CMS implemented the VM and expanded its application to smaller practices, we expressed concerns about the approach being used. The VM cost measures rely on methods to attribute patients to physicians that are of limited relevance to emergency practices. However, they are especially irrelevant to smaller group practices and solo practitioners (i.e., they are not populated by primary care physicians that might carry the weight for the practice). Yet CMS is proposing to continue many of the same policies, and as we discuss below related to the Medicare Spending Per Beneficiary measure, expanding the scope of these methods that will result in further inappropriate attribution. Broad cost measures assess the total amount billed per patient and not the treatment of the individual provider. While tracking costs (and quality) across the care continuum is important for developing policies to improve our care delivery system, these general assessments are not appropriate for individual physician or group practice accountability since they incorrectly assume that physicians have control over the entire care plan and treatment decisions of other providers, often in other settings, who also treat the patient over the reporting period. We offer our assistance in helping provide input to encourage CMS to do more appropriate resource use measures that take into account longitudinal assessments of acute episodic care often delivered with rotating groups of providers.

- ***EDPMA believes the Secretary should rely on the authority provided under MACRA to redistribute the weights of the performance categories to further reduce the reliance on the Resource Use performance category score until such time that the Secretary determines that the measures utilized under the Resource Use performance category (including their attribution mechanisms) are more reliable and actionable.***

Medicare Spending Per Beneficiary Measure (MSPB)

- ***EDPMA continues to be concerned about the application of the MSPB measure***.

EDPMA believes that CMS has used unclear language up until this point to define the population that may be attributed to this measure. However, CMS proposes to use attribution logic that is similar to what is used in the VM.

The MSPB episode is supposed to be attributed to the one TIN responsible for the plurality of services performed by EPs during the episode's index hospitalization. On numerous occasions and in multiple contexts (i.e., through rulemaking, guidance documents, press releases, educational slide sets, etc.), CMS has referred to this index stay using the terms "inpatient," "admission," and "hospitalization," which seemed to imply that emergency physicians could not be attributed to an episode under this measure because they do not bill for Part B services during the inpatient portion of the patient's admission.

However, emergency physicians have, in fact, received QRURs that tag their practice as primarily responsible for the costs associated with these episodes. Therefore, even if the attribution issue is addressed, EDPMA still strongly objects to the use of the MSPB measure under MIPS due to ongoing concerns regarding its validity, risk-adjustment methodology, and utility.

At present, the data that results from this measure is viewed by EDPMA and emergency department physician stakeholders as confusing, complex, and of questionable value to both physicians and their patients.

- ***EDPMA believes that these concerns are further exacerbated by CMS' proposal to remove the specialty-adjustment from the MSPB measure's calculation***.

As discussed below, it is imperative that when calculating resource use attributable to particular groups or individual physicians that CMS is comparing similarly-situated practices. While we believe this to be an important tenet for any resource use measurement, we believe it to be particularly important given the inappropriate case attributions to emergency medicine practices under the MSPB measure.

- ***EDPMA strongly urges CMS to reinstate the specialty benchmarking methodology under the MSPB measure.***

In addition, EDPMA is extremely concerned with the CMS proposal to drop the minimum case threshold for inclusion and calculation of the MSPB measure from 125 cases to 20 cases.

- ***EDPMA firmly believes that, given the cited attribution problems with the MSPB measure, CMS should provide protection from inadvertent case attributions by maintaining a 125 case minimum for the MSPB measure to be included in a practice's resource use score.***

<u>Resource Use Measure Alignment with Quality Measure Reporting</u>

As we shared in our MIPS/APM RFI comments, EDPMA reiterates its concerns regarding the flawed value equation that operated under PQRS and the VM that is now being carried over into MIPS. The current set of cost measures can have little relevance to the more condition/procedure-specific quality measures used under the quality performance category. If quality and cost measures focus on different elements of care, they cannot be used to draw accurate conclusions about overall value.

Episode-Based Resource Use Measurement

EDPMA appreciates CMS' move to include more focused episode-based cost measures. We believe episode based resource use measurement holds the potential to more accurately evaluate care over which a physician has control and allow for more valid comparisons of patient populations. We understand that episode development will be an ongoing process, and we reiterate our request that CMS consult relevant clinical stakeholders throughout this process. However, we believe that CMS should reconsider two elements of its proposal related to episode-based resource use measurement:

- In the proposed rule, CMS states that it does not believe specialty adjustment is necessary for the episode-based measures. Again, we believe it is imperative that when calculating resource use attributable to particular groups or individual physicians that CMS is comparing similarly situated practices.
    - ***EDPMA strongly urges CMS to include specialty benchmarking under episode based resource use measurement***.
- CMS' proposal to include episode-based resource use is supplemental to the broad cost measures already used under the VM.
    - ***EDPMA believes that episode based resource use measurement should replace these broad cost measures that provide very little actionable data for practices seeking to manage resource use.***

Benchmarking

As briefly discussed above, it is imperative that when calculating resource use attributable to particular groups or individual physicians that CMS is comparing similarly-situated practices. Physicians from various specialties with very different patient populations often rely on the same quality measures. Because of the limited number of current cost measures, this is even more so the case when analyzing resource use. When calculating benchmarks to evaluate performance, CMS should not lump physicians together and consider them the same.

- ***EDPMA continues to believe that CMS should either calculate separate benchmarks for each specialty (and in some cases, each subspecialty) or otherwise adjust performance calculations to ensure fair comparisons among similar physicians***.
- ***EDPMA also believes expenditures should also be adjusted based on resources available at a facility (i.e. stroke, trauma, burn center etc.)***

In many instances emergency physicians are preventing potential readmissions and the system of benchmarking under resource use must incorporate these value-added services without making that physician look unfairly expensive. CMS should recognize that a significant amount of resources is often attributable to services received in the emergency department and that those resources are often well utilized in preventing further unnecessary health care spending and improve patient quality of care and outcomes.

EDPMA believes there is also value in benchmarking based on group or individual performance historical improvement given our concerns about ensuring that performance is only compared to the performance of similarly situated practices. Under improvement benchmarking looking at annual

personal improvement/cost containment rather than pitting physicians against each other, CMS has the opportunity to rationalize its benchmarking methodology and ensure that it is avoiding inappropriate comparisons. CMS must also take into account that in some instances annual increases in spending are appropriate. For example, if CMS were to hold a physician accountable for outpatient costs alone, a physician might be spending more and more money each year to prevent an admission. Specific costs might be going up, but overall/total costs to the system might be going down.

In addition, CMS has previously sought comment on the proposed application of a measure-level benchmarking methodology known as the Achievable Benchmark of Care (ABC™) to set benchmarks for publicly reported MIPS measures.

- ***EDPMA appreciates the CMS decision to exclude the ABC™ methodology in its benchmarking and public reporting proposals.***

EDPMA remains very concerned with the ABC™ methodology. It is critically important that any future proposed methodology would ensure apples-to-apples comparisons of similar physicians treating similar patient populations in similar practice settings. It has always been unclear how the ABC™ methodology would take into account the level of complexity of patients treated, as well as other risk factors, and whether geographic and regional variations would be considered. In addition, appropriate risk adjustment is absolutely necessary to ensure that providers are not unfairly benchmarked for treating more complicated patient populations or treating patients in areas with fewer resources.

There also appears to be a lack of alignment between the ABC™ methodology and the methodology that CMS currently uses to benchmark quality measure data reported in the Quality and Resource Use Reports (QRURs) and used to determine payment adjustments under the Value Modifier (VM). To ensure uniform performance evaluations and minimize confusion, we strongly urge CMS to adopt consistent methodologies across programs, especially under MIPS where performance in different categories of measures will be combined to generate a single performance score.

Risk-adjustment

CMS proposes the same methodologies for risk adjustment included under the VM. CMS had previously sought comments on potential future approaches to risk adjusting given public concerns that the CMS hierarchical condition categories (HCC) Risk Adjustment methodology.

In the past, CMS has also discussed stratifying cost measure benchmarks by beneficiary risk score in the future so that groups and solo practitioners are compared to other groups and individual practitioners treating beneficiaries with similar risk profiles. In this way, within a given grouping (for example, a quartile or decile), there remains an opportunity to gain efficiencies in care and lower costs, while beneficiary severity of illness and practice characteristics may be more fully recognized at a smaller, and likely less heterogeneous, attributed beneficiary level.

- ***EDPMA is disappointed that CMS has not introduced additional mechanisms to ensure that resource use measures are appropriately risk-adjusted and urges CMS to change its position in the final rule.***

Due to the unique nature of the emergency department setting, EDPMA supports efforts to achieve more accurate risk adjustments to both cost and quality measures. Pursuant to the Emergency Medical Treatment and Labor Act of 1986 (EMTALA), emergency departments are required to stabilize and

treat any patient that presents to the emergency department (ED), regardless of that patient's insurance status or ability to pay for such costs. This unfunded mandate greatly influences an ED physician's performance on both cost and quality measures and is significantly different than other statutory requirements incumbent on other physicians in other settings.

As a result, this must also be taken into account. However, due to the unique nature of our practice, we are also concerned that stratifications could result in CMS posting data on "high cost EDs" vs. "low cost EDs" based on these criteria. Unless this view was balanced by a meaningful adjustment for communities where health care resources are sufficient (adequate access to primary care and alternatives to ED care) versus those where community health care resources are insufficient (inadequate access to primary care and no alternatives to ED care), such measurements would not accurately reflect the value of emergency care in a large variety of health care environments.

In addition, we continue to urge CMS to apply socioeconomic status adjustments to cost measure. A large body of evidence demonstrates that sociodemographic factors such as income and insurance status affect many patient outcomes, including readmissions and costs.

Failing to adjust measures for these factors can lead to substantial unintended consequences, including harm to patients and heightened health care disparities by diverting resources away from providers treating large proportions of disadvantaged patients. It also can mislead patients, payers, and policymakers by blinding them to important community factors that contribute to the reported outcomes.

Advancing Care Information Performance Category

As CMS is aware, emergency physicians' abilities to utilize EHRs are tied to the investments and decisions made at the hospitals in which we practice. In implementing MIPS, it will be difficult for many emergency medicine providers to receive credit under the Advancing Care Information performance category given the physicians' status as "hospital-based" physicians. CMS seeks input on how the Advancing Care Information performance category could be applied to hospital-based MIPS eligible clinicians in future years of MIPS, as well as the types of measures that would be applicable and available to these types of MIPS eligible clinicians.

- ***EDPMA believes, in seeking to encourage provider utilization of EHRs in those settings where hospitals have made the investment in EHRs for use by hospital-based physicians, CMS could create a future pathway for hospital-based providers to get credit for EHR utilization under the CPIA performance category***.

This will serve to continue to support further use of EHRs while recognizing that hospital-based physicians are not in a position to make EHR purchasing and utilization decisions. In addition, by moving hospital-based physician EHR use out of the Meaningful Use category and into the CPIA category, CMS will not be putting hospital-based physicians whose hospitals have not implemented EHRs at a disadvantage as those hospital-based physicians will likely have other activities available to them to meet the CPIA category requirements.

Emergency physicians are key players in ensuring the information is shared between providers and ensuring coordination of care. It is important to have measures that ensure that emergency physicians are utilizing the EHRs that are at their disposal.

We also believe that CMS could further promote use of CEHRT by introducing additional flexibility to its MIPS proposals related to the APM Scoring Standard. In order to be assessed under MIPS, CMS continues to require participants in MIPS APMs to report under the Advancing Care Information Performance Category. Under the Shared Savings Program CMS proposes that the Eligible Clinicians would submit data for the Advancing Care Information performance category through their respective ACO participant billing TINs independent of the Shared Savings Program ACO; CMS proposes for the Next Generation ACO model and all other MIPS APMs that Eligible Clinician participants would submit individual level data to MIPS and not group level data.

- ***EDPMA recommends that CMS create a mechanism whereby participants in MIPS APMs meet ACI requirements through attestations that their hospital meets meaningful use for 50 percent of Medicare Part B claims during the first reporting period and 75 percent during the second performance period***.

We believe this would be similar to the CMS proposal that an Advanced APM must require at least 50 percent of eligible clinicians who are enrolled in Medicare to use the CEHRT functions for the first QP Performance Period (2017) and increases to 75 percent beginning with the second QP Performance Period (2018).

Clinical Practice Improvement Activities (CPIAs) Category

CMS proposes to allow for CPIAs to be reported via an attestation reporting option. ***EDPMA requests that CMS provide further guidance on the attestation mechanisms.*** We seek to ensure that in order to make the submission compliance burden as low as possible that CMS will provide for physician billing and coding staff to submit the attestation on behalf of Eligible Clinicians that have otherwise met the reporting requirements. We would appreciate CMS clarification that this is allowed. We also request that the clarification provide detailed information on the documentation that will be required as part of the attestation. As the CPIA list is mostly a list of descriptions of activities, we assume that CMS will require some level of documentation for CMS to assess whether the submitted activity meets the individual CPIA description.

In addition, we would like to reiterate the comment made under the Advancing Care Information section above.

- ***EDPMA believes that CMS take advantage of an opportunity to promote valuable use of EHRs under the CPIA category***.

CMS should create a future pathway for hospital-based providers to get credit for EHR utilization under the CPIA performance category. This will serve to continue to support further use of EHRs while recognizing that hospital-based physicians are not in a position to make EHR purchasing and utilization decisions. In addition, by moving hospital-based physician EHR use out of the Meaningful Use category and into the CPIA category, CMS will not be putting hospital-based physicians whose hospitals have not implemented EHRs at a disadvantage as those hospital-based physicians will likely have other activities available to them to meet the CPIA category requirements.

PHYSICIAN-FOCUSED PAYMENT MODELS (PFPMs)

EDPMA continues to be concerned about the lack of APM participation options available to emergency medicine and models for specialist participation in general. While we appreciate the PFPM

submission criteria discussion that CMS puts forth in the proposed rule, we are concerned that there is not further guidance from CMS regarding how it views the development of specialist-focused APMs and whether CMMI proposes changes that will increase the availability APMs for specialists and, in particular, emergency medicine. Stakeholders continue to invest tremendous resources in developing specialty APMs, yet we are concerned that CMS has not communicated more regarding their view of these types of APMs and the likelihood that CMMI will test these types of models. We continue to encourage CMS to be more transparent about its plan for increasing APM participation for specialists.

PTAC Recommendations & CMMI

CMS acknowledges RFI responses recommending that all proposed PFPMs selected for testing by the PFPM Technical Advisory Committee (PTAC) and subsequently CMMI should be Advanced APMs without needing to meet the additional criteria for Advanced APMs.

However, CMS states that MACRA makes a clear distinction between APMs and Advanced APMs, thus, CMS does not believe the statutory requirements for Advanced APMs can or should be waived for proposed PFPMs. Simultaneously, CMS acknowledges the desire for Advanced APMs to expand participation opportunities, and therefore encourages applicants to provide information in proposals about whether their proposed PFPM might be an Advanced APM.

EDPMA would like to reiterate that the clear Congressional intent was that PFPMs were included in MACRA as a way to support Eligible Clinician participation in APMs. Even if CMS has determined that PFPMs are not by definition Advanced APMs,

- ***EDPMA continues to urge CMS to create a fast track process that allows for approved PFPMs to become CMMI demos that would qualify for the APM incentive payment***.

PTAC Submission Review Criteria

EDPMA is supportive of PFPM submission review criteria that adopt a broad set of criteria that would be inherent to any APM recognized by the agency.

- ***EDPMA believes that the criteria included in the proposed rule are sufficiently broad and flexible***.

This provides the needed flexibility for EDPMA members to develop APMs that make the most sense for their practices. We continue to believe that CMS should define services furnished through a PFPM as alternative payments for covered professional services that are not paid based solely on a fee-for-service. As reflected in CMS' proposals, the criteria should include quality measurement, continuous data collection, shared decision-making, care coordination, and patient reported outcomes. We believe that the proposals support the flexibility for PFPMs to incorporated reliable quality measures and cost utilization that are specific to the care delivered by emergency providers.

We do believe that CMS should explore additional ways in which it can share more utilization data and launch pilot projects so that stakeholders have the necessary information to assist in the development of costs savings models.

In addition, CMS proposes to include a requirement that the PFPM must either aim to solve an issue in payment policy not addressed in the CMS APM portfolio at the time it is proposed or include in its

design APM Entities who have had limited opportunities to participate in APMs. Physicians and practitioners whose opportunities to participate in other PFPMs with CMS have been limited to date include, for example, those who have not been able to apply for any other PFPM because one has not been designed that would include physicians and practitioners of their specialty. However, CMS notes that the PFPM must not be limited to only that gap in opportunity: CMS proposes that a PFPM that includes multiple specialties may meet the PFPM criteria where a minimum of one of the specialties in the proposed PFPM is not currently being addressed by another APM.

- ***EDPMA believes this criterion appropriately encourages development of APMs where emergency medicine could participate, given the few existing participation options, without overly restricting model designs or innovation.***

We believe it is reasonable for CMS to inquire whether there are other APM models addressing a particular condition or health system need or including a particular provider type. However, we request that the PTAC not use this criterion as an overly exclusionary factor for the PFPM under consideration.

For instance, ***if an emergency physician developed model for reducing unnecessary hospital readmissions is submitted for review, we do not believe it should be turned down simply because there is another APM in existence for reducing unnecessary hospital readmissions that is administered by a payer or hospital***.

EDPMA would again request that in reviewing submissions, the PTAC beware of models that narrowly review reductions of emergency department visits. First, we again remind CMS of the unique nature of the emergency department given the unfunded mandate of EMTALA, which first requires EDs to see all patients and also greatly influences an ED physician's performance on both cost and quality measures and is significantly different than other statutory requirements incumbent on other physicians in other settings. But also, when tracking emergency department visits is an appropriate measure for a PFPM or APM, EDPMA firmly believes that the measurement relies on the reduction of *avoidable* emergency department visits. In addition, we believe that CMS should encourage benchmarks in PFPMs and APMs that can begin to identify the costs that are avoided because of care that was delivered in the emergency department.

ALTERNATIVE PAYMENT MODEL (APM) INCENTIVE

Generally, EDPMA appreciates the efforts made by CMS in its proposals to not overregulate the APM Inventive Payment in a way that could stifle innovation and development of APMs. However, we believe that CMS will need to redouble its efforts to ensure that resources are dedicated to facilitate the introduction of additional APMs given that so few Medicare physicians have access to APMs appropriate to their respective specialties. This is especially true in emergency medicine.

Debunking the Notion that the Emergency Department is Costly and Leads Toward Unnecessary Utilization

While we understand that CMS does not directly address the specific measures that must be utilized by APMs, MIPS APMs, or Advanced APMs, we also wish to reiterate a concern about the fact that many APMs propose a reduction in emergency department visits as a metric of success. This metric assumes that the emergency department is a costly and inefficient venue to receive care. This is patently false.

In 2013, the RAND Corporation released a study entitled "The Evolving Role of Emergency Departments in the United States, "which 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.

The emergency department is not only open 24/7/365; it is often the most efficient location to receive the in-depth work-ups and tests many patients need. It would be a costly mistake to discourage APMs from making appropriate use of the emergency department thereby ensuring that the patient receives high quality care at all hours of the day.

- ***EDPMA believes that the emergency department plays a critical role in the delivery of cost-effective care and can continue to do so as a participant of APM and risk-based models of care by providing timely, cost-saving care, resulting in decreasing costly hospital admissions and preventing further complications and the exacerbation of complex and ultimately costly cases.***

ADVANCED APM CRITERIA

Use of Certified EHR Technology (CEHRT) CMS proposes that an Advanced APM must require at least 50 percent of eligible clinicians who are enrolled in Medicare to use the CEHRT functions "to document and communicate clinical care with patients and other health care professionals."

- ***EDPMA supports the use of CEHRT standard as proposed to qualify as an Advanced APM.***

First, setting the standard as documentation and communication rather than achieving the objectives utilized under the Advancing Care Information performance category acknowledges that emergency medicine professionals contribute to the electronic transfer of clinical information but often not via the objectives set up under the Advancing Care Information category for non-hospital-based physicians. In this way, emergency medicine can contribute toward the achievement of the CEHRT criteria in a way that would never have been possible if the anchors were the Meaningful Use objectives.

Second, by setting the level at 50 percent in the first QP Performance Period (and 75 percent in subsequent performance periods), CMS acknowledges that some Eligible Clinician participants might not be in the types of practices that rely on the use of CEHRT in the same ways as others. While we believe the definition of "use" here encourages the inclusion of emergency medicine, we also believe that by requiring that less than 100 percent of participants meet the requirement, it will also allow for APM Entities to seek out the participation of emergency medicine in APMs without concern that because many in emergency medicine have not been in the practice of reporting under the EHR Meaningful Use Incentive Program there would be some sort of negative impact on an APM's ability to qualify as an Advanced APM.

Quality Measures Comparable to MIPS. CMS proposes that the quality measures on which the Advanced APM bases payment must include at least one (1) of the following types of measures (provided that the measures have an evidence-based focus and are reliable and valid):

- Any of the quality measures included on the proposed annual list of MIPS quality measures;
- Quality measures that are endorsed by a consensus-based entity;
- Quality measures developed under section 1848(s) of the Act (i.e. quality measures as part of the Secretary's Quality Measure Development Plan)

- Quality measures submitted in response to the MIPS Call for Quality Measures; or
  Any other quality measures that CMS determines to be evidence-based, reliable, and valid.

CMS notes that it believes that quality measures that are endorsed by the NQF would meet these criteria.

CMS also proposes to establish an Innovation Center quality measure review process for those measures that are not NQF-endorsed or included on the final MIPS measure list.

- ***EDPMA appreciates the flexibility CMS incorporates into Advanced APM quality measurement with this proposal.***

EDPMA believes it would be unnecessary to increase the reporting burden for Advanced APMs. In addition, we believe CMS would not achieve its articulated goals should it choose to overregulate the Advanced APM quality reporting requirements, which in turn, would micromanage the APM development process, potentially stifling innovation of APMs in which emergency medicine professionals can participate.

<u>In Excess of Nominal Financial Risk</u>.

First, CMS proposes to apply the financial risk criterion to the design of the APM financial risk arrangement between CMS and the participating APM Entity (i.e., if the structure of the arrangement meets the proposed financial risk requirement, then the criterion has been met). The proposal does not impose any additional performance criteria related to bearing financial risk (i.e., Eligible Clinicians under an Advanced APM Entity do not individually need to bear any risk under the APM so long as the APM Entity bears that risk).

- ***EDPMA is supportive of this proposal as we believe it will encourage innovation in the development of APMs and allow for the best-situated individuals or entities participating in an APM to assume the risk of that model.***

CMS proposes to include financial risk criteria that eliminate one-sided risk arrangements as well as to measure three (3) dimensions of risk to determine whether an APM meets the "in excess of a nominal amount" standard by relying on calculations related to Marginal Risk, Total Risk, and the Minimum Loss Rate.

- ***EDPMA believes that the CMS proposals address EDPMA concerns stated in our response to the RFI that "nominal financial risk" should be defined broadly to allow Emergency Department (ED) groups the opportunity to develop practice models that will allow the ED to reduce costs (by, for example, reducing readmissions) without becoming part of an accountable care organization (ACO) which does not lend itself well to emergency medicine.***

Given the EMTALA obligations imposed on emergency departments and their inability to have a defined beneficiary group assigned to its practice, we believe that the established criteria would not unnecessarily restrict development of models in which ED groups can participate.

In addition, we also requested that CMS appropriately distinguish between requiring APM's to incorporate financial risk related to *performance* rather than requiring that the entities carry any type of *insurance* risk. We appreciate CMS's attention to this distinction.

QUALIFIED ADVANCED APM PARTICIPANT (QP) DETERMINATIONS

CMS proposes that a clinician's QP status for a given payment year would be based on a collective evaluation of a group consisting of all Eligible Clinicians participating in an Advanced APM Entity.

- ***EDPMA is extremely supportive of this proposal.***

We believe that this proposal presents an opportunity to facilitate development of APMs in which emergency medicine partners with other providers to establish comprehensive APMs that qualify as Advanced APMs where the participants can meet the established QP thresholds based on the important contributions of all of the participants.

Allowing for the participants to collectively meet the QP thresholds ensures the cooperation of all parties even though, for some, meeting the QP thresholds individually could be very difficult, not because of level of effort but possibly because of the characteristics of that physician's specialty.

Because of the unique circumstances of the emergency department and EMTALA mandates where all cases are seen regardless of payer, emergency medicine professionals could be in the position where it is difficult to ensure that APM qualifying thresholds are met with regard to any one payer. By collectively assessing participants in an Advanced APM, CMS avoids this scenario and ensures that emergency medicine is not unfairly marginalized in the Advanced APM proposals.

CMS also proposes to assess QP status either by meeting specified percentage of their aggregate Medicare Part B payments for covered professional services or patients who received covered professional services through the Advanced APM.

- ***EDPMA is extremely supportive of CMS' proposal to utilize the authority granted in MACRA to include the patient count methodology.***

As stated in our RFI comments, since EMTALA greatly limits our choice of patients, it also limits the manner in which we can satisfy the definition of "qualifying APM participant," which is based on a significant share of revenues. For this reason, and the fact that the ED deals with hundreds of different private payers across the nation, it is critical that CMS preserve the choice that allows physicians to qualify for an APM based on a significant share of Medicare revenue alone (versus a mix of private and Medicare revenue). While we believe that this could continue to be of concern under the patient count methodology, we appreciate CMS' decision to adopt flexibility and allow for qualification based on either revenue or patient counts.

CMS proposes for the QP Performance Period to be the calendar year 2 years prior to the payment year in order to align it with the MIPS performance period. The QP determination will then occur each year following the QP Performance Period. While we understand CMS' desire to align the Advanced APM Performance Period with MIPS reporting, we request CMS add an additional qualification period. Any new specialty APMs recommended by the PTAC likely would not be approved by the 2017 Performance Period in order receive payment in 2019. We are concerned that the two-year lag in performance period unnecessarily creates a disadvantage to specialists who do not already have models approved by CMMI even though the initial payment year is not until 2019. Therefore,

- ***EDPMA recommends that CMS create a mechanism for newly approved Advanced APMs to qualify for the 5 percent bonus payment for 2019 by (1) submitting measures under the MIPS program during the 2017 performance year; (2) meet the revenue or***

patient count threshold required for Advanced APMs in 2019 (3) bear more than nominal financial risk in 2019 as defined in the final regulations and (4) meet the ACI criteria as described below. If qualifying under this mechanism, the 5 percent bonus would be applied to all Part B payments received by the provider in 2019 if CMS approves the APM as an Advanced APM by 2019.

ADVANCED APM QP PAYMENTS

CMS proposes that the APM Incentive Payment shall be equal to 5 percent of the estimated aggregate amounts paid for Medicare Part B covered professional services furnished by the eligible clinician from the preceding year across all billing TINs associated with the QP's NPI. In addition, CMS proposes that for eligible clinicians that are QPs, CMS would make the APM Incentive Payment to the TIN that is affiliated with the Advanced APM Entity through which the eligible clinician met the threshold during the QP performance period.

- ***EDPMA supports the suggestion that the APM Incentive Payment is a coordinated effort among the Eligible Clinicians and other aligned providers and participants, including the Eligible Clinician's associated group; consequently, EDPMA supports CMS's willingness to deliver the APM Incentive Payment directly to the affiliated Eligible Clinicians' group TIN by which the group entity and the Eligible Clinician will collectively determine its distribution in accordance with the participants respective employment terms and contractual relationships.***

CONCLUSION

In closing, the EDPMA looks forward to providing additional feedback as CMS further refines its proposals. While we understand that CMS must issue regulations that apply to physicians across the board, we urge CMS to consider the particular impact of its proposals on patients who visit emergency departments and the practices of emergency medicine professionals who deliver that care given the unique circumstances of this care setting. If you have any questions, please contact Elizabeth Mundinger, Executive Director of EDPMA, at emundinger@edpma.org if we can be of further assistance.

Sincerely,

Timothy Seay, MD, FACEP
Chairman, EDPMA Board of Directors