American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

September 11, 2017

The Honorable Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
U. S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicare Payment Policies under the Physician Fee Schedule Proposed Rule for 2018 (CMS-1676-P)

Dear Ms. Verma:

On behalf of more than 37,000 members of the American College of Emergency Physicians (ACEP), I appreciate the opportunity to comment on proposals in the annual proposed rule on Medicare physician payment policies and their effects on the practice of emergency physicians and the Medicare patients we serve.

More than 141 million patient visits take place annually in the Emergency Department (ED), 18 percent of which are for Medicare beneficiaries[1]. The emergency department therefore plays a fundamental role in providing high quality, timely care to millions of our nation's seniors.

In this comment letter, we address the following important issues:

- Determination of Malpractice Relative Value Units
- Telehealth Services
- Potentially Misvalued Services
- Recommendations Regarding Specific Codes
- Appropriate Use Criteria for Advanced Diagnostic Imaging Services
- Quality and Value Program Adjustments
- Patient Relationship Codes
- Recommendation for Flexibility and Efficiency Related to the Opioid Crisis

We were disappointed to see that other than in a short footnote on Addendum D, CMS did not acknowledge that the Work Geographic Practice Cost Index (GPCI) floor of 1.0 required by Section 201 of MACRA is set to expire on December 31, 2017. The Work GPCI floor was set at 1.0 to help address the challenges rural facilities face in recruiting physicians. Since 2010, scores of rural hospitals have closed[2]. The GPCI floor must be continued to recruit and

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[1] 2014 NHAMCS Emergency Department summary tables
[2] A state-by-state breakdown of 80 rural hospital closures. Becker's Hospital Review. Allya Ellison. December 13, 2016. Accessed September 7, 2017.

retain physicians in these areas that are already strained with regard to healthcare resources. With rising practice costs, extension of GPCI payments assists in making rural practice financially viable and allows communities to retain their providers. The payments also provide incentive for those interested in entering rural medical practice. It is vital that these payments are continued and improved, and we encourage CMS to work with Congress to ensure the floor of 1.0 for the work GPCI is extended beyond the end of this year.

Determination of Malpractice Relative Value Units (MP RVUs)

ACEP was surprised by CMS's proposal in this rule to update the specialty-specific risk factors used in calculation of malpractice (MP) RVUs every 3 years, beginning with this year, rather than every 5 years, as had been finalized in the CY 2016 Physician Fee Schedule (PFS). That final rule indicated that the specialty-specific risk factors would continue to be updated through notice and comment rulemaking every 5 years using updated premium data, **but would remain unchanged between the 5-year reviews**.

This early update to the MP risk factors poses a significant impact to emergency medicine, resulting in a reduction of 1.0 percent in Total RVUs—significantly higher than the 0.4 percent reduction that was the average across all specialties. When comparing 2018 to 2017, most of this 1.0 percent appears to originate from the **15.2 percent reduction** in MP RVUs for our specialty. Yet what is more disturbing is the lack of transparency used by CMS in implementing this proposed change. The CY 2017 proposed rule asked for input on whether CMS should consider such a change, and the final rule only noted that CMS received just a single comment in support of this proposal, and would perhaps consider using updated MP risk factor data to update MP RVUs prior to the next 5-year update in future rulemaking.

It would therefore have been far more appropriate to propose and (if determined warranted by public input) fully finalize a shortening of the 5-year timeline in the first year, including proposed changes in the methodology, and then implement it to calculate MP RVUs only in the following year. This would have given impacted specialties and stakeholders an appropriate amount of time to prepare for any anticipated changes prior to the originally expected 2020 update year. **ACEP therefore opposes the proposed reduction to three years for the cycle for updating MP risk based on premium data—instead, CMS should maintain the current 5-year cycle, putting the next update in 2020 (rather than 2018)**.

As well, **ACEP also opposes the changes used in calculating the total RVUs and MP RVUs by CMS's contractor, Acumen.** The calculations are based on a new method for ascertaining the national average, and use population instead of work RVUs. As well, Acumen itself notes limitations it faced in the number of states from which it was able to collect premium data, and therefore in such absences instead calculated blended rates for certain specialties that had previously and appropriately had separate and distinct risk factors for the surgical and non-surgical categories. CMS should instead have Acumen obtain more complete data and work with specialty societies to obtain more specific state data. In addition, it would be important to know the specific states the premium data is from and not just the overall number of states used by Acumen.

Lastly, ACEP is disappointed by the lack of transparency that overall is reflected in these proposed changes to the determination of MP RVUs. Almost none of the considerations and data used in making these changes are discussed in the proposed rule itself by the agency. Instead, stakeholders must seek it out in Acumen's interim report, which is, of course, authored by the contractor and not the agency. This leaves stakeholders at a disadvantage as we are unable to respond directly to the changes and assumptions that Acumen used through the public notice and comment process.

Medicare Telehealth Services

Adding Services to the List of Medicare Telehealth Services

For 2018, CMS is considering the potential benefit of adding CPT codes 90839 and 90840, "Psychotherapy for crisis," to the list of Medicare telehealth services. There is a severe shortage of mental health resources in the United States, and as a result emergency departments are seeing significant increases in mental health-related visits. In 2013, about 1.5 million emergency department visits were seen by a mental health provider, and for about 1.1 million ED visits, the result was admission to the mental health unit of a hospital. Emergency departments face increasing wait times and crowded conditions due to a lack of hospital inpatient beds, a growing elderly population and nationwide shortages of nurses, physicians, and support staff. Often after stabilization, emergency patients must be held while they wait for available inpatient beds to be admitted to the hospital. This need for inpatient beds is particularly acute for psychiatric emergency patients, and therefore psychiatric patients may wait *days* in an emergency department until an appropriate bed becomes available.

ACEP therefore supports the addition of CPT codes 90839 and 90840 to the list of Medicare telehealth services, as this addition can increase access to urgently needed psychotherapy. This can be particularly helpful in rural and underserved communities, where access issues for mental health services can be even more acute. ACEP also supports the validity of CMS's assumption that a distant site practitioner would be able to mobilize resources at the originating site "to defuse the crisis and restore safety when applicable," as included in the CPT prefatory language of the service.

Comment Solicitation on Medicare Telehealth Services

CMS seeks input on how it might "further expand access to telehealth services with the current statutory authority and pay appropriately for services that take full advantage of communication technologies". The use of telemedicine has increased recently in the private sector due to the rapid pace of technology improvements, clear recognition of the benefits it can offer to patients, and opportunities for savings by payers. Yet Medicare coverage of telehealth services has lagged, likely out of concerns that costs to the program will increase too quickly if coverage isn't tightly controlled. ACEP supports CMS providing additional flexibility in coverage of telehealth services in order to study the impact it could have in Medicare in terms of access and cost. At minimum, loosening the requirement that any new proposals to add codes must fit into two narrow categories could increase opportunities for innovative use of telehealth.

Over the years, ACEP has requested on several occasions (and will again this year prior to the December 31 deadline) the addition of telemedicine for emergency department services (CPT codes 99281-99285), and observation services (CPT codes 99217-99220; 99224-99236; and, 99234-99236). Yet CMS has declined each time. There are established examples of high quality, cost-effective telemedicine programs in the ED setting that allow greater access to an emergency physician in inner city or rural emergency departments that would not normally be able to economically support that level of provider. Additionally, telehealth access from the ED setting to other medical specialists such as neurologists or psychiatrists can help provide faster access to specialty care and reduce delays in critically needed treatment and the time patients are boarding in the emergency department. As more and more small and rural hospitals close, emergency departments close too, leaving a gap in unscheduled acute care in a region. To fill these gaps, emergency physicians housed in what may be a state's only large or teaching hospital provide telemedicine services to patients in smaller rural or community hospitals that are staffed by RNs and Advance Practice Nurses (APNs). These valuable services provide clinical expertise in real time to stabilize patients who may need to be transferred long distances, or may be observed at timely intervals over several hours by the emergency physician team at the academic medical center before a decision is made to transfer, admit locally, or release.

Proposed Potentially Misvalued Services Under the Physician Fee Schedule

CY 2018 Identification and Review of Potentially Misvalued Codes

CMS states that it has "received information suggesting that the work RVUs for emergency department visits may not appropriately reflect the full resources involved in furnishing these services," and therefore is seeking comment on whether CPT codes 99281-99385 (Emergency department visits for the evaluation and management of a patient) should be reviewed under the misvalued code initiative. The proposed rule goes on to say "Specifically, stakeholders have expressed concerns that the work RVUs for these services have been undervalued given the increased acuity of the patient population and the heterogeneity of the sites, such as freestanding and off-campus emergency departments, where emergency department visits are furnished."

ACEP strongly agrees there has been an increase in intensity in reported ED services as a whole over the past years, due in part to successful attempts to guide non-emergency patients to other sites of service, as well as the increasing complexity of transition or coordination of care under episode-based or ACO models. As well, practice intensity has increased in EDs because EDs are treating older and sicker Medicare beneficiaries, and therefore emergency physicians must utilize more sophisticated diagnosis methods to manage the problems of these more-challenged beneficiaries[3].

But CMS offers little further detail on this concern it received from stakeholders, whether as to its source (no comments to this effect appear to have been in previous years' PFS final rules), or any

[3] Pitts SR. Higher-complexity ED billing codes—sicker patients, more intensive practice, or improper payments? N Engl J Med 2012; 367:2465-7. DOI: 10.1056/NEJMp1211315

additional context for the stated concerns that the work RVUs might not reflect the full resources involved in furnishing these services. In addition, although CMS references the various sites for receiving care (e.g. freestanding and off-campus emergency departments), it is not clear the relationship between the various settings and the work RVUs of ED services. For example, if the heterogeneity of the sites of care delivery are the crux of the original stakeholders' concern, further recognizing those distinctions with distinct "places of service" could be one way to address these concerns. Without such additional information, it is difficult for us to directly respond more specifically. As well, in this same proposed rule, CMS is proposing to consider reforming E/M documentation guidelines to "reduce the associated burden, and better align E/M coding and documentation with the current practice of medicine." Given the significant changes to documentation guidelines for E/M services that may be forthcoming, it is premature and somewhat difficult to advise on potential revaluation of any E/M codes – pending details on how the documentation guideline revisions are resolved. Should CMS determine the emergency medicine codes to be misvalued in the meantime, the emergency medicine community will actively and committedly participate in developing recommendations through the RUC process.

Proposed Valuation of Specific Codes

Control Nasal Hemorrhage (CPT Codes 30901, 303903, 30905, 20906)

07. Control Nasal Hemorrhage (CPT codes 30901, 30903, 30905, and 30906)

CPT Code	Long Descriptor	CMS Proposed/ RUC Recommended Work RVU
30901	Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method	1.10
30903	Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method	1.54
30905	Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; initial	1.97
30906	Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; subsequent	2.45

ACEP wishes to comment on the CMS valuation of the controlling nasal hemorrhage codes 30901, 30903, 30905 and 30906. As the most dominant provider of code 30905 in the Medicare database, we oppose lowering the work value from 1.97 to 1.73. We echo the RUC's comments that the alternate work RVU considered for 30903 is incorrect. CMS is ignoring the physician work, time, and intensity required to perform this service and is breeding flawed methodology to establish work RVUs by using the current incremental difference in work. The RUC noted that the previous intra-service time was excessive and fully explained the increased intensity of providing this service. Many more people are now on some form of a blood thinner, given that so many are commercially available today. This makes the epistaxis more difficult to control, and the procedure more intense, which provides a rationale for the increase in intensity given the reduced intra time. In reviewing CMS's alternative RVUs and crosswalks, the alternative value's incremental increase between 30903 and 30905 does not take into account the significant difference between the etiology of the clinical situation, as well as the significantly increased work required to correct the

issue. Posterior bleeding is arterial in origin, and therefore requires much more rapid attention. Also, because it is posterior, blood travels into the nasopharynx, oropharynx and larynx first, instead of out the nostrils. This leads to coughing, choking and aspiration. The procedure to stop these bleeds is also much more intense, requiring much deeper and noxious nasal packing. **For these reasons, we ask CMS to accept the RUC recommended valuations for these codes as listed in the table.**

Physician Coding for Insertion and Removal of Subdermal Drug Implants for the Treatment of Opioid Addiction (HCPCS codes GDDD1, GDDD2, and GDDD3)

Our nation is facing a growing and persistent opioid epidemic, and Medicare can play a vital role in addressing it. In 2015, over 2 million people were addicted to prescription opioids. The total number of drug-related emergency visits nearly doubled from 2004 to 2010. Of those visits, about half — or 2.3 million — involved misuse or abuse of prescription drugs. Emergency visits involving misuse or abuse of prescription drugs increased by 115 percent between 2004 and 2010, from 626,472 visits in 2004 to 1,345,645 visits in 2010. By contrast, ED visits for illicit drugs increased by only 18 percent during the same period.[4] Buprenorphine and other forms of Medication Assisted Treatment (MAT) have been shown to be effective in treating opioid use disorder. There are study results showing promise for ED-initiated buprenorphine[5,6]. While subdermal buprenorphine implants are still relatively new, having been approved by the FDA for use last year, this delivery method has significant potential for helping those with opioid use disorder begin the path toward recovery. **ACEP therefore supports CMS's proposal to separately pay for insertion and removal of subdermal drug implants for the treatment of opioid use disorders. As well, we support CMS's proposal to use the direct PE inputs and work RVUs requested by ASAM for HCPCS codes GDDD1, GDDD2, and GDDD3.**

Evaluation and Management (E/M) Guidelines and Care Management Services

E/M Guidelines

ACEP greatly supports CMS's recent efforts to identify and address unnecessary, obsolete or excessively burdensome regulations. As well, we are very appreciative and supportive of the notion of reducing administrative burdens involved in documenting medical encounters to satisfy payer requirements for a level of service. Yet due to the unique and unpredictable environment of emergency departments and interactions with our patients, we are especially cognizant of the importance of and need for a clear record of services rendered and the medical necessity for each

[4] ACEP Fact Sheet

[5] D'Onofrio G, O'Connor PG, Pantalon MV, Chawarski MC, Busch SH, Owens PH, Bernstein SL, Fiellin DA. Emergency Department–Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence A Randomized Clinical Trial. JAMA. 2015;313(16):1636–1644. doi:10.1001/jama.2015.3474

[6] Busch, S. H., Fiellin, D. A., Chawarski, M. C., Owens, P. H., Pantalon, M. V., Hawk, K., Bernstein, S. L., O'Connor, P. G., and D'Onofrio, G. (2017) Cost-effectiveness of emergency department-initiated treatment for opioid dependence. Addiction, doi: 10.1111/add.13900.

service, procedure, diagnostic test, and medical decision making performed for every patient encounter.

We therefore urge the Agency to exercise caution when undertaking a reform effort on E/M documentation guidelines for Medicare. Unlike in many other care settings, there is generally not an established patient relationship in ED encounters, and presenting symptoms can suggest multiple differential diagnoses, some of which could be life threatening. This can therefore frequently necessitate a significant amount of history and physical exam for clinical, legal, operational, and coverage reasons.

As one potential reform approach, CMS seeks comment on whether it should leave it largely to the discretion of individual practitioners to what degree they should perform and document the history and physical exam. **ACEP would be supportive of such an approach, but would suggest CMS encourage use of standardized guidelines, which are based on the minimum documentation required, in order to both facilitate post-treatment evaluation and analysis of records for various purposes.**

Appropriate Use Criteria for Advanced Diagnostic Imaging Services

The 2014 law, "Protecting Access to Medicare Act" (PAMA) directed CMS to set up a process for using AUC by April 1, 2016; implement AUC consultation and reporting process by January 1, 2017; and identify outliers for services furnished after January 1, 2017. This federal effort was designed to further reduce "inappropriate" advanced imaging use and will affect nearly all practicing physicians. Requirements of PAMA include:

- Advanced Diagnostic imaging: CT, MRI, PET, etc. (X-ray, ultrasound, and fluoroscopy are excluded)
- Applicable settings: a physician's office, a hospital outpatient department (including ED) and an ambulatory surgical center. Inpatient hospital services are excluded.

Proposals for Continuing Implementation--Consultation and Reporting by Professionals

Given the complexity of creating new mechanisms to support this provision, CMS had last postponed implementation until January 2018. In this year's proposed rule, CMS has further postponed until January 1, 2019 the requirement for ordering professionals to consult specified applicable AUC through qualified Clinical Decision Support Mechanisms (CDSMs) for applicable imaging services. **ACEP strongly supports this delay.** Implementation of the Merit-Based Incentive Payment System (MIPS) in 2017, and further expansion of its transition year requirements in 2018, provides an overwhelming number of challenges to physicians and CMS should be doing everything possible to minimize any additional burdens over the coming year.

In ACEP's response last year to the Physician Fee Schedule for CY 2017 Proposed Rule, we urged CMS to first pilot AUC reporting in 2018. **We are therefore pleased to see that CMS proposes to make the first year of the program (2019) an educational and operations "testing period"**,

citing a recognition of the complexity of the new consultation and reporting requirements for professionals, facilities, and for CMS's own claims processing system, and the potential for error. This testing period would have ordering professionals consult AUC and furnishing professionals report consultation information on the claim, but CMS would continue to pay claims whether or not they correctly include such information.

CMS also seeks comment on whether to delay the program beyond the proposed start date of January 1, 2019, and/or whether the testing period should be delayed longer than a year. Given our concerns with the AUC program which follow below, **ACEP supports further delaying implementation of this program.** At minimum, ACEP calls on CMS to extend the testing period through 2020.

For those professionals who might be prepared to participate in the AUC program prior to the proposed start date, CMS proposes a voluntary reporting period (anticipated to begin July 2018, depending on CMS readiness). This would be separate from the proposed *testing* program that would begin for all on January 1, 2019. ACEP supports a voluntary reporting period to allow those who are prepared sooner to begin to participate in the AUC program, and appreciates CMS not committing to a start date for it until the Agency has confirmed its readiness. But we have concerns that despite such an assessment by CMS before beginning the voluntary program, there will be additional layers of unresolved issues that won't emerge until voluntary reporting begins. Will impacted claims using the new codes be inadvertently rejected if Medicare contractors for each region are not fully prepared? If they are rejected, how does CMS intend to address the claims? **It is critical that CMS's claims processing system can properly adjudicate claims before this program advances beyond the "testing period."**

Reporting Requirements

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

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

CMS notes that this information is required across claim types to the extent feasible (including both the furnishing professional and facility claims) and across all three applicable payment systems (PFS, HOPPS, and ASC). CMS proposes to establish a series of HCPCS level 3 codes to implement this reporting requirement, which would each describe the specific CDSM that was used by the ordering professional. If a code is not yet available for a newer CDSM, a generic G-code will be available for temporary use. Finally, CMS notes that it expects that one AUC consultation G-code would be reported for every advanced diagnostic imaging service on the claim. If there are two codes billed for advanced imaging services on a claim, CMS would expect two G-codes.

CMS also proposes to develop a series of modifiers to provide necessary information as to whether:

- The imaging service would adhere to the applicable appropriate use criteria;
- The imaging service would not adhere to such criteria; or
- Such criteria were not applicable to the imaging service ordered; and if,
- The imaging service was ordered for a patient with an emergency medical condition; or
- The ordering professional has a significant hardship exception

ACEP has very strong concerns with the proposed processes laid out in this rule by CMS for the AUC program. As described above, the furnishing professional must report, using the applicable G-code(s), which CDSM the ordering physician consulted prior to placing the order. But nowhere has it been described, nor a process established, for the furnishing professional to obtain these details from the ordering professional. CMS itself even notes (emphasis added), "Additional considerations for **the complex communication of AUC consultation information from the ordering professional to the furnishing professional and facility that must include that information when billing for the service are warranted.**" And yet, no guidance is provided on such "warranted" additional considerations. Regardless of the eventual process(es) developed, this additional information further emphasizes the significant administrative burden and workflow disruption the AUC system as described in this rule will pose on ordering physicians. While the stated documentation requirements and associated burdens for the AUC program are assigned to the furnishing professional, he or she will not be present at the time of the order. Therefore, all information that the furnishing professional is required to document will *also* need to be somehow documented by the ordering professional, so that it can be somehow communicated to the furnishing professional.

This lack of detail or thought out processes become even more alarming with regards to the modifier CMS says it plans to develop for furnishing professionals to document if the "imaging service was ordered for a patient with an emergency medical condition." Under whose purview will this determination be—the ordering or the furnishing professional? **It is alarming that as described, when an emergency physician in the ED orders advanced imaging for a patient, the furnishing professional will have ultimate responsibility for this determination and its communication to CMS.** How will the furnishing professional know? And if the ordering professional somehow communicates to them that it is in fact an instance of an emergency medical condition, will this determination be subject to audit? If so, will the furnishing professional be responsible for any audit results that find it was *not* in fact an emergency medical condition?

<u>Significant Hardship Exceptions to Consulting and Reporting Requirements</u>

PAMA exempts emergency services defined as an "applicable imaging service ordered for an individual with an emergency medical condition" (as defined by EMTALA). ACEP appreciated the recognition that the federal EMTALA law imposes a duty to provide a medical screening exam to any individual who comes to the ED. But Congress, through an inadvertent drafting error, referenced the section of EMTALA Sec.1867 (e)(1) that *defines* an emergency medical condition, rather than referencing Sec. 1867 (a) which codifies the requirement to provide a medical screening exam. Aside from cases of obvious trauma or severe visible medical symptoms, in most cases a

medical screening exam is required before definitively establishing that an emergency medical condition exists.

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

> *"While the acuity of some patients in the emergency department might be the same as in a physician's office, in general, more acutely ill patients are more likely to be seen in the emergency department, and that difference is part of the reason there are separate codes describing evaluation and management visits in the Emergency Department setting. Given that the practice of emergency medicine often requires frequent and fast-paced patient reassessments, rapid physician interventions, and sometimes the continuous physician interaction with ancillary staff and consultants, it differs from the pace, intensity, and acuity associated with visits that occur in the office or outpatient setting."* -pg 46182 of the Federal Register

This is in contrast to CMS's explanation of the AUC section in the same rule that stated (emphasis ours) "furthermore, we recognize that **most encounters in an emergency department are not for an emergency medical condition** as defined in section 1867(e)(1) of the Act" (page 46393 of the Federal Register). It is also runs directly counter to the annual emergency department survey data collected by the CDC.

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

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

CMS responded to Chairman Pitts earlier last summer noting that "we will consider this issue as we work on implementing the AUC program." Instead, several months later the Agency in the CY 2017 Physician Fee Schedule Final Rule said (emphasis ours), "We do not have a reason at this time to believe that a categorical exception granted to emergency departments would foster

inappropriate use of advanced imaging services. However, **we believe such a categorical exception would not be consistent with the statutory requirement under section 1834(q)(4)(C)(i) of the Act, which is framed in terms of individual services.**" This directly contradicts what Chairman Pitts, who was involved in PAMA's drafting himself, has stated on Congressional intent.

We therefore again ask CMS to revise the language of 42 CFR. 414.94 to clarify that the AUC exception also applies for the purposes of conducting the required medical screening exam in cases where an emergency medical condition is suspected, not "determined" (a term not found in EMTALA). This needed change will address Congress' request as well as the logic that certain advanced imaging tests may need to be quickly ordered to establish whether an emergency medical condition exists or not.

Given the additional codes and modifiers that have now been proposed for furnishing professionals to submit with claims (and by virtue of the AUC system as described, for ordering professionals in the ED to document in some manner to transmit to the furnishing professional), it is even more important for the exception for suspected emergency medical conditions to be codified. Emergency physicians will simply not have the time to record or document these new factors when they are assessing a patient who potentially faces a life-threatening emergency medical condition. Requiring an ordering professional in the ED to make a distinction between patients that require AUC and those that have an AUC exemption is an additional burden that will directly impact provision of timely needed care.

Alignment with Other Medicare Quality Programs

CMS seeks comment regarding the potential development of a quality measure that is linked to AUC under the MIPS quality performance category. While ACEP is supportive of any attempts to streamline reporting programs and reducing provider documentation burdens, given our above-stated concerns with the AUC program as currently depicted by CMS, it would be difficult for us to support development of a quality measure for MIPS that is linked to it. By creating a quality measure (rather than an improvement category as proposed in this year's MACRA QPP proposed rule), CMS would be moving closer to more directly tying AUC to payment for the ordering professional (through MIPS performance scoring), rather than for the furnishing professional, as PAMA intended.

Proposed Modifications to the Satisfactory Reporting Criteria for Individual EPs and Group Practices for the 2018 PQRS Payment Adjustment

CMS proposes to make several changes to the PQRS reporting criteria for the 2018 adjustment year in response to the clinician community's concerns that the 2016 PQRS requirements were too complex and did not align well with MIPS. CMS notes that these changes are intended to set reporting criteria that are simpler, more understandable, and more consistent with the first years of MIPS. **ACEP strongly supports the lowering from 9 measures across 3 domains, to only 6 measures, with no domain requirement or required cross-cutting, outcome or "high**

priority" measure. As well, ACEP supports CMS maintaining as optional participation in the CAHPS for PQRS survey for group practices.

Physician Compare Downloadable Database – Addition of Value Modifier (VM) Data

CMS proposes to not release the 2016 VM data through the Physician Compare downloadable database later this year. CMS notes that 2016 is the last year of the Value Modifier program, and therefore there may be less value in publicly releasing and posting data related to only one year of a program. **ACEP strongly supports CMS not releasing this data through the Physician Compare system,** though unlike CMS, our reasoning is not related to only having a single year of data to release. We have expressed our concerns on numerous occasions with the VM and inaccuracies in its calculations due to inappropriate measures and methodologies, which lack reliability and unfairly penalize physicians treating more complex and disadvantaged patients. We therefore would be opposed to release of VM results to Physician Compare even if the VM program were continuing.

Reducing MSSP Application Burden

CMS proposes several changes that will reduce the administrative burdens for physicians participating in Medicare's Shared Savings Program (MSSP) ACOs.

SNF 3-Day Rule: Waiver Application Requirements

CMS proposes to eliminate requirements for ACO applicants seeking a three-day waiver for Skilled Nursing Facilities (SNF). CMS is proposing to remove the requirement that ACOs include a narrative describing any financial relationships that exist between the ACO, SNF affiliates, and acute care hospitals on the SNF three-day waiver application. CMS also proposes to remove the requirement that an ACO must submit documentation demonstrating that each SNF on their list of SNF affiliates has an overall rating of three stars under the CMS Five-Star Quality Rating System. **ACEP supports the removal of these documentation requirements.**

MSSP Initial Application

CMS also proposes to improve the process used to validate ACO quality data reporting by lowering the threshold for audit matches needed to avoid score adjustments from ninety to eighty percent. **ACEP supports this change, as it will reduce the documentation burden for physicians participating in MSSP ACOs.** CMS also proposes to eliminate many of the requirements on the MSSP application form, and instead proposes to require ACOs to certify that they meet the applicable eligibility and documentation requirements. **ACEP supports this elimination**. Lastly, CMS is proposing to allow flexibility around Tax Identification Numbers (TINs) being exclusive to one ACO if their claims are used in the patient attribution process. **ACEP supports this added flexibility, and appreciates CMS proposing to eliminate all of the above-described burdens—we believe doing so can encourage more physicians to join APMs and continue Medicare's transformation to value-driven care.**

Value-Based Payment Modifier and Physician Feedback Program

CMS proposes to reduce the penalties for physicians who do not meet the 2018 PQRS reporting criteria from year from -4 to -2 percent for groups of more than ten eligible professionals, and from -2 to -1 percent for groups of 2-9 and solo practitioners. In addition, CMS proposes to hold harmless from downward payment adjustments under the Value Modifier's quality tiering in 2018 all physicians who meet the criteria to avoid the 2018 PQRS payment adjustment. **ACEP strongly supports the proposed changes to 2018 PQRS and VM requirements.**

MACRA Patient Relationship Categories and Codes

Subsequent Revisions to the Operational List of Patient Relationship Categories

In preparation for potential revisions to it due by November 1 of 2018, CMS seeks comment on the operational list of patient relationship categories. Despite numerous comments submitted by ACEP on each iteration of the draft patient relationship categories required to be developed under Section 101(f) of MACRA, we still do not have a single category that fits emergency medicine roles with patients and other physicians.

Unfortunately, CMS took the patient relationship categories included in the MACRA statute and created broader, more definitive categories targeted largely to primary care:

1. **Continuous/broad services:** For reporting services by clinicians who provide the principal care for a patient, with no planned endpoint of the relationship. Services in this category represent comprehensive care, dealing with the entire scope of patient problems, either directly or in a care coordination role. Reporting clinician service examples include primary care services and specialists providing comprehensive care to patients in addition to specialty care.
2. **Continuous/focused services:** For reporting services by clinicians whose expertise is needed for the ongoing management of a chronic disease or a condition that needs to be managed and followed for a long time. A reporting clinician service example would be a rheumatologist taking care of the patient's rheumatoid arthritis longitudinally but not providing general primary care services.
3. **Episodic/broad services:** For reporting services by clinicians who have broad responsibility for the comprehensive needs of the patients, that is limited to a defined period and circumstance, such as a hospitalization. A reporting clinician service example would include a hospitalist providing comprehensive and general care to a patient while the patient is admitted to the hospital.
4. **Episodic/focused services:** For reporting services by specialty focused clinicians who provide time-limited care. The patient has a problem, acute or chronic, that will be treated with surgery, radiation, or some other type of generally time-limited intervention. A reporting clinician service example would be an orthopedic surgeon performing a knee replacement and seeing the patient through the postoperative period.

5. **Only as ordered by another clinician**: For reporting services by a clinician who furnishes care to the patient only as ordered by another clinician. This patient relationship category is reported for patient relationships that may not be adequately captured in the four categories described above. A reporting clinician service example would be a radiologist interpretation of an imaging study ordered by another clinician.

The following two categories originally defined in Section 1848(r)(3)(B) of MACRA statute could have been used by emergency physicians for some of their patients, had CMS chosen to adopt them as requested by ACEP:

ii. Considers themself [sic] to be the lead physician or practitioner and who furnishes items and services and coordinates care furnished by other physicians or practitioners for the patient during an acute episode;

- This would be appropriate in certain circumstances as the ED is the logical first stop for patients whose symptoms may result in diagnosis of acute myocardial infarction, Abdominal Aortic Aneurysm, chronic heart failure, heart failure exacerbation, cellulitis, kidney and/or UTI, stroke, GI bleed, cholecystitis, asthma/COPD, pneumonia, and upper respiratory infection to name a few.

iv. Furnishes items and services to the patient on an occasional basis, usually at the request of another physician or practitioner.

- A growing number of primary care physicians send their patients to the ED for more extensive workups/rule outs than can be performed in the office setting. In fact, according to a 2013 RAND report[7], busy office-based primary care physicians are increasingly relying on emergency physicians to evaluate and, if necessary, hospitalize their sickest and most complex patients. Therefore, the acute care episode may be comprised of an office visit where the patient complains of chest pain, patient is then sent to the ED for testing, and may spend several hours in a protocol-driven observation (or critical decision unit), with the result that he/she is ultimately released or admitted – all within a 24-hour period.

However, these were not included in the proposed lists at each step of the way, and those now in the operational list are still not applicable to our specialty. This contradicts CMS's policy principle to "ensure that the *majority* of clinician relationships are captured with the patient relationship codes." **ACEP therefore urges CMS to add a category for acute episodes as described in item iv above, since they occur with great frequency, especially in the Medicare population.**

There is also insufficient information about how the patient relationship codes will be used. It is important for CMS to evaluate the use and effectiveness of these codes, and refine as necessary, before proposing the use of these codes for quality or payment purposes.

[7]Gonzalez Morganti, Kristy, Sebastian Bauhoff, Janice C. Blanchard, Mahshid Abir, Neema Iyer, Alexandria Smith, Joseph Vesely, Edward Okeke and Arthur L. Kellermann. The Evolving Role of Emergency Departments in the United States. Santa Monica, CA: RAND Corporation, 2013. https://www.rand.org/pubs/research_reports/RR280.html.

Request for Information on CMS Flexibilities and Efficiencies

In light of the continuing opioid crisis referenced earlier in this letter, we ask that CMS pay separately and in addition to an E/M service for counseling with each opioid prescription written, to include accessing and reviewing information in the state's prescription monitoring program, followed by a discussion with the patient of the pain management options, the pros and cons of narcotic use, and the risks (both psychologic and physiologic) of addiction. As part of this counseling, the provider will also discuss the option of a partial fill of the prescription with a careful review of the signs and symptoms of overdose, and addiction. The counseling includes instructing the patient on the indications for use of naloxone for addressing overdose, demonstrating its use, and writing a prescription for naloxone if requested.

We appreciate the opportunity to share our comments and continue to look forward to working with you and your staff. If you have any questions, please contact Laura Wooster, MPH, ACEP's Associate Executive Director of Public Affairs at lwooster@acep.org or (202) 370-9298.

Sincerely,

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