September 6, 2022

Chiquita Brooks-LaSure, MPP
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, Maryland 21244

Submitted electronically via www.regulations.gov

RE: ***CY 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicare and Medicaid Provider Enrollment Policies, Including for Skilled Nursing Facilities; Conditions of Payment for Suppliers of Durable Medicaid Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); and Implementing Requirements for Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts*** **(CMS-1770-P)**

Dear Administrator Brooks-LaSure:

On behalf of the Emergency Department Practice Management Association (EDPMA), I appreciate the opportunity to provide comments on the Centers for Medicare and Medicaid Services' calendar year (CY) 2023 Medicare Physician Fee Schedule proposed rule. EDPMA is the nation's largest professional physician trade association focused on the delivery of high-quality, cost-effective care in the emergency department. EDPMA's membership includes emergency medicine physician groups of all ownership models and sizes, 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 146 million patients that visit U.S. emergency departments each year.

MEDICARE PHYSICIAN FEE SCHEDULE REIMBURSEMENT PRESSURES

EDPMA urges the Agency to consider our comments in the context of the unique circumstances in which emergency physicians are practicing. Emergency medicine occupies a unique position in our health care system, which we believe warrants policies that recognize this unique role. Emergency departments fulfill their statutory obligation to provide emergency care without regard to the ability to pay due to the Emergency Medical Treatment & Labor Act (EMTALA). 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. The role that emergency departments play in delivering health care and ensuring patient access is pivotal in supporting the country's medical safety net.

EDPMA is extremely concerned by the proposed cut to the CY 2023 MPFS conversion factor of nearly 4.5%. While we understand that the bulk of this reduction is due to the lapsing of a Congressional provision that boosted the CY 2022 conversion factor, the impact on our practices will be significant. Amidst the numerous, ongoing economic challenges that emergency departments are facing during the COVID-19 public health emergency (PHE), this reimbursement reduction is slated to occur after the reintroduction of the 2% Medicare sequestration cut from the *Budget Control Act* and a new potential sequestration reduction of 4% due to PAYGO rules that could be implemented as early as this December. These mounting cuts and financial pressures are short-sighted and wholly unwarranted. In addition to these known factors, CMS is also proposing a CY 2023 implementation of a *significant* overhaul of the emergency department evaluation and management (E/M) documentation guidelines. Our members are concerned that these changes will require a greater amount of time to prepare for implementation than is being provided and could result in shifts in revenue unanticipated by CPT and CMS. We believe these concerns call into question CMS' assumption that emergency medicine will experience a 1% increase in allowed charges for CY 2023 under these new policies.[1] All of these changes are compounding to place immense pressures on emergency medicine practices, all while on the front lines of the ongoing public health emergencies. The COVID-19 PHE has stretched resources for these practices and will continue to put pressure on their financial stability. Despite facing dire financial circumstances, emergency physicians continue to provide EMTALA-mandated care; however, they have far fewer tools at their disposal to remain solvent during the pandemic than other specialties because of the EMTALA mandate. We acknowledge the role that Congress plays in avoiding these cuts, but ***we urge you to consider these comments in this context***.

[1] Table 138: *CY 2023 PFS Estimated Impact on Total Allowed Charges By Specialty*, 87 Fed. Reg. 46,388 (July 29, 2022).

EVALUATION & MANAGEMENT (E/M) SERVICES

1. **Emergency Department E/M Codes**

In CY 2021, CMS implemented the revised code descriptors, documentation guidelines, and relative value units (RVUs) for the office and outpatient E/M code sets. CMS has previously expressed its intention to align the remaining E/M code set documentation guidelines with the revised office and outpatient E/M guidelines. For CY 2023, CMS proposes to adopt the new CPT descriptors and documentation guidelines for the remaining E/M code sets. Importantly for our members, we would note that these CY 2023 proposals apply to the following E/M code sets:

- *Emergency Department Visits*
- *Hospital Inpatient or Observation Care*
- *Hospital or Observation Discharge Day Management*

We appreciate CMS' acknowledgement of the CPT recommendations for ED visits acknowledging that services provided in the emergency department are not well described or valued by time. Medical-decision making and intensity are the key components of emergency department services. We urge the Agency to continue its efforts to reduce administrative burden and acknowledging the key characteristics of ED E/M visits is key to this. However, some EDPMA members are concerned that the changes to the ED E/M documentation guidelines will require a greater amount of time to prepare for implementation than is being provided and could result in shifts in revenue unanticipated by CPT and CMS. Given this reality, we respectfully request the Agency explore flexibilities regarding the timing of compliance for those practices unprepared for January 1, 2023 implementation.

CMS also addresses the relative value units (RVUs) for ED E/M codes. As part of these policies, CMS proposes to:

- Accept the RUC-recommended work RVUs (wRVUs) for ED visit codes, CPT 99281, 99282, 99283, and 99285
- Maintain the CY 2022 wRVUs for an ED level 4 visit, CPT 99284.

EDPMA supports CMS' proposed wRVUs for the emergency department visit code set. Regarding the proposal to maintain the current wRVUs for a level 4 ED visit, EDPMA is in complete agreement with CMS "that the levels 4 and 5 ED visits are more accurately valued higher than the levels 4 and 5 new patient [office and outpatient] E/M visits to reflect their higher typical intensity." We believe this historic relativity remains intact under the new coding structure, and it is imperative, in a relative value system, that this be preserved. We appreciate CMS' recognition of our past comments emphasizing this and commend the Agency on its decision to ensure that a level 4 ED visit maintains its current value.

2. Split (or Shared) Services

As part of the CY 2022 rulemaking cycle, CMS finalized a policy addressing billing for split (or shared) services. CMS defines a split (or shared) service "*as an E/M visit in the facility setting that is performed in part by both a physician and an NPP [non-physician practitioner] who are in the same group*." CMS also finalized an approach to defining the "substantive portion" of split (or shared) services for purposes of identifying the billing practitioner. While CMS allowed a CY 2022 transition to the new policy, for CY 2023, CMS finalized a definition for the "substantive portion" of split (or shared) services as "more than half of the total time spent by the physician and non-physician practitioner performing the visit."

Prior to issuance of this proposed rule, EDPMA submitted comments to CMS expressing its concern with the CY 2023 policy. In response to stakeholder concerns as those expressed by EDPMA, CMS proposes to delay the implementation of the "time only" "substantive portion" policy to January 1, 2024. ***EDPMA applauds CMS' decision to maintain the current definition of "substantive portion" under the split (or shared) visits policy, which allows the billing practitioner to be selected based on the practitioner that performs the medical decision making (MDM) for the services.***

Further, ***EDPMA opposes any future implementation of a definition of "substantive portion" that is based solely on time, particularly as it applies to ED E/M visits.*** Time is not a key component of the ED E/M code set given the nature of the services described by those codes, nor should it be. Requiring that "substantive portion" be defined based on time to a code set that is not defined by time would add administrative burden to the practitioners billing those codes and undermine the services that those codes are intended to represent***.***

If CMS were to proceed with implementation of a "time only" definition for "substantive portion," we believe the Agency should consider a separate definition of "substantive portion" as it applies to ED E/M visits. We believe that a CMS policy based on comparative clock time is flawed. A requirement for tabulating individual practitioner time on each patient in a busy emergency department, where multiple patient care actions are actively in process on numerous patients concurrently is simply not reasonable. In this environment – one that requires rapid multi-tasking – a "time only" policy will clearly add significant administrative burden. The cadence and flow of an emergency department involves parallel cognitive processing over multiple patients, areas in the department, and is reassessed/modified on a minute-by-minute basis. It is not unusual for a single physician or NPP to care for 8-12 patients at a time, and even with an electronic health record (EHR), a new requirement for logging cumulative time will significantly reduce the efficiency of an already strained system. Therefore, using time to define a split (or shared) visit creates a cognitive distraction and administrative burden in direct contradiction to CMS' *Patients Over Paperwork* initiative. In an attempt to accurately account for time measurement solely for purposes of determining the "substantive portion," there is potential for a patient safety event and poor accuracy of the work performed.

In the CY 2022 MPFS proposed rule, CMS even acknowledged the "unique construct" of ED E/M visits and requested comments on whether they should be subject to separate policies. EDPMA provided comments highlighting the need to address the ED E/M code set separately. We believe that CMS' current policy should be maintained and provides the flexibility necessary for identifying the "substantive portion" for ED E/M visits. ***But if CMS proceeds with a "time only" approach, EDPMA urges CMS to put forward a proposal to address the unique ED setting and acknowledge "time only" is not applicable in the ED setting***. For ED E/M visits, EDPMA continues to believe that the most appropriate standard for determining which practitioner furnished the "substantive portion" of the service is the practitioner who performed and was responsible for the medical decision-making associated with the service.

Even if CMS were to retain the time component in some form, CMS' list of "qualifying activities" is not appropriate for ED E/M services and fails to recognize that all time spent as counted by the clock is not equivalent. A physician's time is most frequently spent in significant medical decision-making, consideration of differential diagnoses, assuring that evaluations, treatments, and recommendations optimize patient safety, and review of co-morbidities and the potential for medication interaction. These activities also take time and reflect the years of advanced training and experience the physician brings to the clinical care team. However, the time spent on these functions should not in any way be equated to other elements of time, such as history-taking, ordering medication, or documenting in the EHR. In addition, activities that are not captured by EHR data elements would go "uncounted" even while being medically necessary and just as important for patient care as other items that are recorded in the EHR.

More importantly, the value of individual patient care activities that require time are decidedly not the same. The policy of simply adding up minutes or hours spent by physicians and NPPs, and comparing whoever spent more time is inherently flawed, and perversely encourages inefficiency, especially for time-consuming but low-value activities.

For example, if one practitioner spent 40 minutes gathering a history, recording current medications, and documenting the patient encounter in the electronic health record, and another did the physical exam, reviewed key lab and x-ray results, performed significant medical decision-making, and determined appropriate treatment – but only took 30 minutes – the "substantive portion" would be premised on the much lower value services if a "time only" standard was implemented.

EDPMA favors a system that reflects the value of time spent, not simply time itself. Therefore, ***EDPMA recommends that, for purposes of determining the "substantive portion" in the context of the ED E/M code set, CMS maintain its current policy and refrain from implementing a "time only" in CY 2024***. Merely counting time in the emergency department setting could shift the billing provider to the clinician who is not responsible for the ultimate MDM that is determined for that particular patient. The clinician responsible for the ultimate MDM that is determined for the patient should be the clinician billing for the split (or shared) ED E/M visit.

In summary, ***EDPMA appreciates that CMS delayed the CY 2023 shared (or split) services policy and urges the Agency to maintain its current policy permanently***.

3. **<u>Technical Correction for Split (or Shared) Critical Care Services</u>**

In this year's rule, CMS revisits policies that it finalized as part of CY 2022 rulemaking for critical care services described by the following codes:

- **CPT 99291** (*Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes*))
- **CPT 99292** *(each additional 30 minutes)*

CMS states,

> *At 86 FR 65162, we stated in error, "Similar to our proposal for split (or shared) prolonged visits, the billing practitioner would first report CPT code 99291 and, if 75 or more cumulative total minutes were spent providing critical care, the billing practitioner could report one or more units of CPT code 99292." We intended to state that CPT code 99292 could be billed after 104, not 75, or more cumulative total minutes were spent providing critical care. As correctly stated elsewhere in the CY 2022 PFS final rule (regarding critical care furnished by single physicians at 86 FR 65160, and regarding concurrent care furnished by multiple practitioners in the same group and the same specialty to the same patient at 86 FR 65162), our policy is that CPT code 99291 is reportable for the first 30-74 minutes of critical care services furnished to a patient on a given date. CPT code 99292 is reportable for additional, complete 30-minute time increments furnished to the same patient (74 + 30 = 104 minutes). We clarify that our policy is the same for critical care whether the patient is receiving care from one physician, multiple practitioners in the same group and specialty who are providing concurrent care, or physicians and NPPs who are billing critical care as a split (or shared) visit.*

EDPMA is opposed to this uncalled for change and urges CMS to withdraw this major policy shift as it is confusing and would result in guidance that departs from well-recognized, long-standing CPT critical care "time" policy. According to the 2022 CPT book regarding time, "The following standards shall apply to time measurement, *unless there are code or code-range–specific instructions in guidelines, parenthetical instructions, or code descriptors to the contrary*" (emphasis added) and defines "median time" as "A unit of time is attained when the mid-point is passed. For example, an hour is attained when 31 minutes have elapsed (more than midway between zero and sixty minutes)." However, critical care has precisely the code-range specific instructions that are referenced as an exception to the "median time" standard.

On page 333 of the 2022 CPT book, CPT describes time as it relates to critical care services and provides a critical care time grid.

Total Duration of Critical Care	Codes
less than 30 minutes	appropriate E/M codes
30-74 minutes (30 minutes - 1 hr. 14 min.)	99291 X 1
75-104 minutes (1 hr. 15 min. - 1 hr. 44 min.)	99291 X 1 AND 99292 X 1
105-134 minutes (1 hr. 45 min. - 2 hr. 14 min.)	99291 X 1 AND 99292 X 2
135-164 minutes (2 hr. 15 min. - 2 hr. 44 min.)	99291 X 1 AND 99292 X 3
165-194 minutes (2 hr. 45 min. - 3 hr. 14 min.)	99291 X 1 AND 99292 X 4
195 minutes or longer (3 hr. 15 min. - etc.)	99291 and 99292 as appropriate (see illustrated reporting examples above)

The CPT time grid gives explicit guidance that CPT 99292 should be coded at 75 minutes. This is longstanding CPT and CMS policy. The genesis of all of these changes to E/Ms by CMS was a stated goal of decreasing administrative burden. By making this unwarranted change, CMS will be making documentation more burdensome by unnecessarily requiring clinicians to follow different rules for Medicare. The change is also flawed because it is premised on faulty logic, as critical care CPT codes do not follow the "median time" rule.

MEDICARE APPROVED TELEHEALTH SERVICES LIST

We appreciate the CMS effort to continue addressing service delivery via telehealth during the ongoing COVID-19 PHE. In the CY 2023 proposed rule, CMS reviewed its Medicare Telehealth Services Category 3 designation, which it created for adding services to the Medicare telehealth services list on a temporary basis during the public health emergency (PHE) for the COVID-19 pandemic. This category describes services that were added during the PHE for which there is likely to be clinical benefit when furnished via telehealth, but there is not yet sufficient evidence available to consider the services for permanent addition to the approved Medicare Telehealth Services List. According to previously finalized policies, codes designated at Category 3 telehealth services would be eligible to be delivered as telehealth services through the end of CY 2023.

CMS previously designated the following codes as Category 3 telehealth services:

- **CPT 99281** (*Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor*)
- **CPT 99282** (*Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low*

complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity)

- **CPT 99283** (*Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity*)
- **CPT 99284** (*Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function*)
- **CPT 99285** (*Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function*)
- **CPT 99291** (*Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes*)
- **CPT 99292** (*Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service*)

EDPMA supports the continued status of these codes as approved Medicare Telehealth Services through at least 2023. However, ***EDPMA encourages CMS to permanently add CPT 99281 – 99285 and CPT 99291 and 99292 (and their revised 2023 code descriptors) to the Medicare Approved List of Telehealth Services.***

QUALITY PAYMENT PROGRAM (QPP)

1. **Merit-Based Incentive Payment System (MIPS)**

MIPS Value Pathways (MVPs)
EDPMA appreciates that CMS finalized the "*Adopting Best Practices and Promoting Patient Safety within Emergency Medicine*" MVP last year for voluntary use beginning with the 2023 performance year. However, we are concerned that the Emergency Medicine MVP only includes five non-QCDR measures. If an emergency medicine clinician or group wants to participate through an MVP and does not want to invest in a QCDR (e.g., because they already work with a trusted Qualified Registry), their options are limited in terms of identifying four relevant measures. ***To ensure that emergency medicine clinicians can take advantage of this new and more focused participation pathway without having to use a QCDR, EDPMA requests that CMS add additional non-QCDR measures to the Emergency Medicine MVP.*** The Emergency Medicine specialty measure set currently includes 11 non-QCDR measures, and CMS is proposing to add five more non-QCDR measures to the set for 2023. Since these measures have already been tagged by CMS as relevant to emergency medicine, it seems reasonable that all, or at least a larger portion of them, could be included as options under the MVP. ***EDPMA suggests adding measure #65: Appropriate Treatment for Upper Respiratory Infection (URI) to the Emergency Medicine MVP to expand the availability of relevant measures.*** CMS proposes to add this measure to the Emergency Medicine specialty measure set for 2023, citing the high rates of patients who are assessed, treated, and managed for this condition in the emergency settings.

EDPMA also recommends that CMS update the Emergency Medicine MVP to include the following Improvement Activities:

1) ***IA_BMH_12: Promoting Clinician Wellbeing***
2) ***IA_AHE_8: Create and Implement an Anti-Racism Plan***

Emergency physicians are subject to exceptionally high levels of stress and burnout, making the prioritization of mental health and well-being especially critical. Additionally, emergency rooms and emergency physicians are often the first point of entry into the healthcare system for our nation's most vulnerable patients, highlighting the need to encourage the adoption of anti-racism planning tools.

MIPS Specialty Sets
CMS proposes modifications to existing specialty measure sets, including the Emergency Medicine specialty set. CMS proposes to add the following measures to the Emergency Medicine specialty set starting in 2023:

- **#65: Appropriate Treatment for Upper Respiratory Infection (URI)**: Percentage of episodes for patients 3 months of age and older with a diagnosis of URI that did not result in an antibiotic dispensing event.
- **#134: Screening for Depression and Follow-Up Plan**: Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days

prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the eligible encounter.

- **#226: Tobacco Use: Screening and Cessation Intervention**: Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within the measurement period AND who received tobacco cessation intervention on the date of the encounter or within the previous 12 months if identified as a tobacco user.
- **#431: Unhealthy Alcohol Use: Screening & Brief Counseling**: Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 12 months AND who received brief counseling if identified as an unhealthy alcohol use.
- **#TBD: Screening for Social Drivers of Health** (*new measure*): Percent of beneficiaries 18 years and older screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.

EDPMA recognizes that MIPS specialty sets are simply recommended subsets of measures that CMS identifies as most relevant to a specialty and that specialists are not required to report on measures in a specialty set if they are not applicable to their practice. ***Nevertheless, we question why CMS is proposing to re-incorporate measures #226: Tobacco Use: Screening and Cessation Intervention and #431: Unhealthy Alcohol Use: Screening & Brief Counseling after it had previously determined that these measures were inappropriate for Emergency Medicine and removed them from the Emergency Medicine specialty set in 2018***.

Additionally, we have concerns about CMS' proposal to include measure #134: Screening for Depression and Follow-Up Plan in the Emergency Medicine specialty set. In addition to requiring the clinician to screen a patient for depression, this measure requires the clinician to document a follow-up plan if the patient screens positive.

While EDPMA supports the intent and value of these screening measures, they are not truly reflective of emergency care compared to other measures. Most emergency medicine encounters are temporal with little opportunity to track the patient's care over time. Similarly, all of these screening measures are time-based. It has long been established through CMS coding policies, including through the emergency E/M codes, that time-based codes are not applicable in the emergency setting.

MIPS Performance Threshold

Beginning with the 2022 performance year, section 1848(q)(6)(D)(i) of the Act requires CMS to set the MIPS performance threshold at the mean or median of the final scores for all MIPS eligible clinicians with respect to a prior period specified by CMS. In the CY 2022 PFS final rule, CMS selected the mean as the methodology for determining the performance threshold for the 2022-2025 performance years. In this rule, CMS proposes to rely on the mean final score from the CY 2019 MIPS payment year, which is 75 points, for the 2023 performance year.

EDPMA appreciates CMS' decision to choose this value since it represents the lowest of the possible threshold values that CMS may select in accordance with the statute. This proposal also would maintain the current performance threshold, which will help to ensure stability and predictability in the program, particularly at a time when practices are still feeling the strain of COVID-19-related disruptions***.***

Complex Patient Bonus

In the CY 2018 QPP final rule, CMS finalized a complex patient bonus for MIPS eligible clinicians, groups, APM Entities, and virtual groups that submit data for at least one MIPS performance category during the applicable performance period, which is added to the final score. In that same rule, CMS also established facility-based measurement for certain MIPS eligible clinicians, which provides that CMS may use measures used for a payment system other than for physicians, such as measures for inpatient hospitals, for purposes of the quality and cost performance categories. At that time, CMS did not address whether facility-based MIPS eligible clinicians would be eligible to receive the complex patient bonus. Although individual facility-based MIPS eligible clinicians are not required to submit data for at least one MIPS performance category, CMS believes they should be eligible to receive the complex patient bonus. Thus, CMS proposes that beginning with the 2023 performance period, a facility-based MIPS eligible clinician would be eligible to receive the complex patient bonus even if they do not submit data for at least one MIPS performance category.

EDPMA strongly supports CMS' proposal to allow facility-based clinicians to receive the complex patient bonus. The majority of emergency medicine physicians qualify as facility-based clinicians under MIPS and treat patients who are uniquely complex. The challenges and additional costs associated with providing care to medically complex patients with social risk factors should be accurately reflected in their MIPS final score, regardless of how it is calculated.

Quality Category: Data Completeness Criteria

CMS proposes to raise the data completeness criteria from 70 percent to 75 percent for the CY 2024 and CY 2025 performance periods. If finalized, a MIPS eligible clinician or a group submitting QCDR measures, MIPS CQMs, or eCQMs would need to submit data on at least 75 percent of the clinician or group's patients that meet the measure's denominator criteria, regardless of payer. A clinician or a group submitting data on claims-based measures would need to submit data on at least 75 percent of Medicare Part B patients to which the measure applies.

EDPMA opposes CMS' proposal to increase the data completeness threshold for the CY 2024 and CY 2025 performance periods. While CMS presents data to suggest that it is feasible for eligible clinicians and groups to achieve a higher data completeness threshold without jeopardizing their ability to participate and perform well under MIPS, its analysis was based on 2017 performance year data when clinicians had the option, under "Pick Your Pace" to submit only one quality measure, for one patient, for one day. CMS' conclusion about the feasibility of

this proposal also was based only on average data completeness rates, which does not reflect the experiences of outlier practices that might face distinct hardships.

Emergency medicine practices, in particular, face many unique challenges related to satisfying the data completeness threshold. Our practices often provide services across multiple sites (and multiples sites of service) that are affiliated with the same NPI/TIN, but not all of these sites may participate in MIPS, the registry, or the EHR that the clinicians opt to use for MIPS data collection. It is particularly challenging for our hospital-based clinicians to obtain data in a timely manner such that current thresholds can be met. EHR systems are often not controlled by our member practices, and revisions to accommodate new measure requirements take time to design and implement. Additionally, sub-regulatory guidance is usually not available until late in the performance year, which disrupts reporting strategies. For data completeness to meet 75 percent, data must be captured starting no later than early March, which is often not a feasible timeline when EHRs are required to implement these changes. ***Until reporting is more seamlessly integrated across providers and settings, EDPMA recommends against increasing the data completeness threshold.***

Quality Category: Scoring
Starting with the 2023 performance year, CMS proposed that quality measures that do not meet the case minimum will no longer be eligible the 3-point floor (except small practices). These measures will earn 0 points, while small practices will continue to earn 3 points.

EDPMA opposes CMS' proposal to remove the 3-point floor from measures that do not meet case minimums. There are a number of measures in the Emergency Medicine specialty measure set that, when reported both at the individual and group levels, do not achieve case minimums even at larger facilities. We are concerned that CMS' proposal to assign these measures 0 points will disincentivize the reporting of these measures since the scoring risk would outweigh the cost of capturing, monitoring, and reporting the data. Instead, practices could turn to more generic screening measures to ensure achievement of a larger denominator cohort. While screening measures are important, they are not as clinically applicable as some other measures in the Emergency Medicine specialty set and are not generally reflective of the quality of care provided by emergency clinicians to support improved patient outcomes.

Extreme and Uncontrollable Circumstances (EUC) Hardship Exception Due to COVID-19
In this rule, CMS does not discuss whether it plans to extend the MIPS EUC Hardship Exception Due to COVID-19 for 2023, which has been offered since the 2019 performance year. ***EDPMA urges CMS to continue to offer the EUC application during the 2023 performance year to allow clinicians and groups to submit an application requesting reweighting of one or more MIPS performance categories due to the COVID-19 PHE.*** Our nation has seen an increase in case counts in recent weeks and trends suggest a Fall/Winter spike. Regardless of actual case counts over the next year, clinicians are still recovering from volume disruptions and critical staffing shortages, on both the clinical and administrative side, as well as constantly changing protocols to respond to the PHE. Without a doubt, our practices continue to face challenges that have impacted their "normal processes" and have made it difficult to prioritize compliance

with federal reporting mandates. In addition, we remind CMS that the *Consolidated Appropriations Act of 2022* (P.L. 117-103) provided a 151-day extension to some COVID-19-related flexibilities once the federal PHE ends. Passage of this legislation reflects the ongoing need to provide clinicians with support when the PHE winds down, but it also is a reminder of the looming transitional policies that practices may face next year in terms of coding and documentation, which will inevitably impact MIPS participation.

2. Qualifying Participants (QP) in Advanced Alternative Payment Models (APMs)

In accordance with the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA), clinicians who participate sufficiently in an Advanced APM are considered QPs, qualify for a 5 percent lump sum incentive payment, and are excluded from MIPS. However, after the 2022 performance year, there is no further statutory authority for a 5 percent APM incentive payment for QPs. Beginning with the 2024 performance year/2026 payment year, MACRA authorizes an enhanced conversion factor (CF) update for QPs. QPs will receive a 0.75 percent base CF update and those who are not QPs (including MIPS eligible clinicians, who will still be subject to MIPS up and downward payment adjustments) will receive a 0.25 percent based CF update. Also under MACRA, the minimum patient or payment thresholds that must be met to achieve QP status will increase starting in 2023 to 75 percent (vs. 50 percent) for the Medicare payment amount and 50 percent (vs. 35 percent) for the Medicare patient count.

EDPMA appreciates and agrees with CMS' concerns about the forthcoming changes in these policies. There are still very few Advanced APMs that are relevant and supportive of emergency medicine and other hospital-based specialists, who see the most vulnerable and expensive patients. As a result, these clinicians have had few opportunities to qualify for the APM track of the QPP to date and have had little choice but to participate in MIPS. Even if an opportunity for emergency physicians to participate in an APM were to arise in the near future, there would be little incentive for them to move in that direction. CMS estimated in the proposed rule that the QP conversion factor, with the compounded differentially higher 0.75 percent update each year starting in 2024/2026, is not expected to equate to the anticipated maximum available positive payment adjustment under MIPS *until after CY 2038*. If these estimates are accurate, not only will there be little inventive for clinicians to move *into* APMs over the next 15 years, but we will likely begin to see clinicians shift *out* of these models so that they can participate in MIPS—particularly since QPs are currently excluded from the definition of "MIPS eligible clinician" under MACRA. As these more experienced and potentially well-resourced clinicians enter the MIPS pool, it will increase the relative number of high-performing MIPS eligible clinicians that earn a positive MIPS payment adjustment, which would reduce the average and maximum positive MIPS payment adjustment amounts under this budget neutral program. While quality improvement should be the main driver of participation in MIPS, these additional incentive payments cannot be ignored at a time when Medicare physician payment updates have failed to even keep up with inflation.

EDPMA strongly urges CMS' Center for Medicare and Medicaid Innovation (CMMI) to work with relevant stakeholders to develop more specialty-specific APMs, as well as opportunities for specialists to partner with and/or play a more actionable role in existing models. EDPMA also believes CMS-sponsored models should provide incentives upfront to ensure clinicians have sufficient capital to develop the operational infrastructure to support improved care.

We also urge CMS to work with Congress to pass legislation that extends the 5% APM Incentive Payment, provides CMS with the authority to maintain the current QP patient and payment threshold levels, and provides CMS with the flexibility to allow QPs to choose whether they want to be considered under MIPS or the Advanced APM track of the QPP.

Again, we appreciate the opportunity to provide input the CY 2023 MPFS proposed rule. If you have any questions or we can provide any additional information, please do not hesitate to contact EDPMA Executive Director Cathey Wise at cathey.wise@edpma.org.

Sincerely,

Don Powell, DO, FACEP
EDPMA
Chair of the Board