Emergency Department EDPMA Practice Management Association

September 9, 2024

Chiquita Brooks-LaSure, MPP
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1807-P
P.O. Box 8010
Baltimore, MD 21244-1850

RE: Medicare and Medicaid Programs; CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments (CMS-1807-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) 2025 Medicare Physician Fee Schedule proposed rule.

EDPMA is the only 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, many of whom serve rural communities, 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 over half of the 146 million patients that visit U.S. emergency departments each year.

Medicare Physician Fee Schedule Reimbursement Pressures

EDPMA urges CMS 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, and as such, 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). Very different than any other specialty, the opportunity and the obligation inherent in this federal requirement (since 1987) puts a very significant and disproportionate burden on emergency

departments to provide timely access to patients 24/7, including access to underserved and uninsured populations. Meeting this obligation requires sufficient resources, and there is no specific funding that serves to resource this significant EMTALA obligation. As a result, emergency care services are extremely sensitive to reductions in payment for services, including both absolute cuts as well as the absence of inflation updates. It is noteworthy that increasingly, the emergency department is seen not as a health care resource to be avoided, but as a key stabilization and decision point for patient disposition that improves health care outcomes overall and increases the efficiency and effectiveness of the health care system. 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 2025 MPFS conversion factor of nearly 2.8%. CY 2025 will be the fifth year in a row that the Medicare Physician Fee Schedule conversion factor has decreased due to policies implemented by CMS, requiring Congress to partially stabilize the Fee Schedule by averting large reimbursement reductions. While some of 2025's reduction is due to the shrinking Congressional provision that boosted the CY 2024 conversion factor, the impact on our practices will be significant. This all stems from decisions that CMS implemented in CY 2021 when it increased valuation of the office and outpatient E/M code sets (along with the CY 2024 finalization of a policy to pay for office and outpatient add-on code G2211first proposed for CY 2021). Emergency medicine will never be able to bill G2211 for emergency department services meaning that emergency medicine is fully exposed to the cuts generated by CMS' introduction of this code, cuts that are spilling over into the CY 2025 conversion factor update. The state of emergency medicine in the context of workforce shortages, continually decreasing reimbursements, failure to update payments to account for inflation, and physician burnout warrants *adding* resources for these services, yet CMS is proposing to do precisely the opposite for emergency medicine.

Amidst the numerous, ongoing economic challenges that emergency departments are facing, this reimbursement reduction is slated to occur while the ongoing 2% Medicare sequestration cut from the *Budget Control Act* continues to impact reimbursements, a 1.77% reduction in the CY 2024 MPFS conversion factor from CY 2023, and a new potential sequestration reduction of 4% due to PAYGO rules that could be implemented in 2025 without Congressional intervention. All of these changes are compounding to place immense pressures on emergency medicine practices. Despite facing dire financial circumstances and a health care workforce more strained than ever, emergency physicians are required to provide EMTALA-mandated care; however, they have far fewer tools at their disposal to remain solvent than other specialties because of the EMTALA mandate. Meanwhile, statute and CMS continue to increase payments for virtually every other Medicare payment program, including inpatient hospitals, outpatient hospitals, and ASCs, essentially cutting payments *only* to certain physicians and other practitioners. We acknowledge the role that Congress plays in avoiding these cuts, but ***we urge you to consider these comments in this context***.

Payment & Other Provisions of the PFS Proposed Rule

Medicare Approved Telehealth Services List

We appreciate the CMS effort to develop policy to ensure that the gains in access to health care provided by the delivery furnished via telehealth continue beyond the circumstances of a public health emergency. In CY 2024, CMS designated the following codes as "provisional" telehealth services:

- **CPT 99281** – **99285 (**Emergency Department E/M visits levels 1-5); and
- **CPT 99291** – **99292** (Critical care services)**.**

While these CPT codes remain on the List of Medicare Approved Telehealth Services with provisional status, ***EDPMA continues to request that these codes be added to the list of Medicare Approved Telehealth Services on a permanent basis***. In this year's rule, CMS states,

> *We believe that, rather than selectively adjudicating only those services for which we received requests for potential permanent status, it would be appropriate to complete a comprehensive analysis of all provisional codes currently on the Medicare Telehealth Services List before determining which codes should be made permanent. We are therefore not making determinations to recategorize provisional codes as permanent until such time as CMS can complete a comprehensive analysis of all such provisional codes which we expect to address in future rulemaking*.[1]

EDPMA supports the continued provisional status of these codes as approved Medicare Telehealth Services through at least 2025. However, ***EDPMA urges CMS to permanently add CPT 99281 – 99285 and CPT 99291 and 99292 to the List of Medicare Approved Telehealth Services.***

Requirement to Use CMS-defined "Interactive Telecommunications System" to Furnish Telehealth Services

Current regulation defines "interactive telecommunications system" as "multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner." As directed by statute, CMS regulation also permits the use of audio-only equipment for telehealth services furnished to established patients in their homes for purposes of diagnosis, evaluation, or treatment of a mental health disorder (including substance use disorders) if the distant site physician or practitioner is technically capable of using an interactive telecommunications system as defined previously, but the patient is not capable of, or does not consent to, the use of video technology.

[1] 89 Fed. Reg. 61625 (July 31, 2024).

In the CY 2025 proposed rule, CMS proposes to broaden the exception for use of audio-only communication when delivering a service via telehealth. CMS proposes to revise regulation to state that an "interactive telecommunications system" may also include two-way, real-time audio-only communication technology for any telehealth service furnished to a beneficiary in their home if the distant site physician or practitioner is technically capable of using an interactive telecommunications system (defined as multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication), but the patient is not capable of, or does not consent to, the use of video technology. A modifier designated by CMS must be appended to the claim for these services to verify that these conditions have been met (i.e., CPT Modifier ~93; or, for rural health clinics (RHCs) and federally-qualified health centers (FQHCs), Medicare modifier "FQ").

EDPMA believes that CMS strikes an appropriate balance between encouraging higher level telecommunications technology with patient choice and/or technological capabilities with this policy. Therefore, ***EDPMA encourages CMS to finalize the policy that allows physicians or practitioners to deliver services via telehealth with audio-only telecommunications technology if the distant site physician or practitioner is technically capable of using an interactive telecommunications system (defined as multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication), but the patient is not capable of, or does not consent to, the use of video technology.*** As this would only apply to services furnished via telehealth when the patient is located in their home, we believe it is a narrowly-tailored, patient-focused policy that encourages access to care, particularly in rural and medically-underserved areas. We also note, however, that the utility of this provision will be severely diminished if Congress does not provide continuation of the waivers of the statutory geographic and originating site telehealth restrictions. Therefore, ***EDPMA urges CMS to work with Congress to make the telehealth flexibilities permanent.***

Request for Clarification on Telehealth and Virtual Care Billing Considerations
In addition to the proposals that CMS puts forward regarding telehealth services and virtual care for CY 2025, EDPMA requests that CMS provide clarification on a number of telehealth billing scenarios, as outlined in Attachment 1 to our letter.

While we recognize that many of the telehealth flexibilities are scheduled to expire at the end of the year, such that the scenarios where patients are receiving services from their homes may no longer be permitted except in limited circumstances, we highlight that the scenarios where patients are in office or facility settings would still be permitted. Furthermore, if Congress extends telehealth flexibilities beyond 2024, the scenarios addressing patients receiving telehealth services from their homes would benefit from clarification.

In addition to responding to these questions in the final rule, ***EDPMA asks that CMS update its Telehealth Fact Sheet – or otherwise provide a written resource – to provide the detail requested*** in Attachment 1.

Quality Payment Program (QPP)

Merit-Based Incentive Payment System (MIPS) Value Pathways (MVPs)

In addition to proposing new MVPs for the 2025 performance year, CMS proposes updates to its existing MVP inventory, including the Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP, which became available to clinicians starting with the 2023 performance year. EDPMA remains concerned that this MVP, as currently specified, does not offer a broad enough inventory of clinical quality measures (CQMs) to reflect the diversity of emergency medicine patient populations and the considerable expense of investing in a Qualified Clinical Data Registry (QCDR). While we appreciate the addition of CQMs last year, many of the CQMs in the MVP are subject to scoring limitations that would not be addressed by policies proposed in this rule. As such, ***EDPMA once again urges CMS to also add the following CQMs to the Emergency Medicine MVP:***

- ***#66: Appropriate Testing for Pharyngitis***
- ***#187: Stroke and Stroke Rehabilitation: Thrombolytic Therapy***
- ***#332: Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis***

All three of these measures are included in the MIPS Emergency Medicine Specialty Set and therefore, have been identified by CMS as relevant to the specialty. They are also commonly used by emergency physicians participating in MIPS. For example, clinicians who report #65: *Appropriate Treatment for Upper Respiratory Infection (URI),* which CMS added to this MVP last year, tend to also report on #66: *Appropriate Testing for Pharyngitis*. Similarly, #332: *Adult Sinusitis: Appropriate Choice of Antibiotic* tends to be reported on by emergency physicians alongside #331: *Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis*, which is already included in the Emergency Medicine MVP. Together, these measures target the critical goal of ensuring appropriate use of antibiotics. Finally, #187 *Stroke and Stroke Rehabilitation: Thrombolytic Therapy* is not only an important predictor of patient outcomes, but it is also one of very few CQMs applicable to emergency medicine that focuses on an acute diagnosis. Making this measure available through the Emergency Care MVP would bring diversity to the MVP's measure inventory and help to incentivize participation through this new pathway.

EDPMA questions why the Emergency Medicine MVP does not align with the Emergency Medicine specialty set. When an MVP is focused on a single specialty, as is the case with the Emergency Medicine MVP, there is no reason why the MVP should not include, at a minimum, all of the measures that CMS has already identified as most relevant to emergency medicine through the specialty set. ***We request that CMS provide more transparency here and clarify why the Emergency Care MVP does not align with the Emergency Medicine MIPS specialty set.***

RFI: Transforming the QPP

CMS seeks feedback on potentially sunsetting traditional MIPS and making MVPs mandatory by 2029. CMS also seeks feedback on what parameters, if any, are needed for multispecialty groups to place clinicians into subgroups when subgroup reporting becomes a requirement for multi-specialty practices choosing to report as an MVP participant starting in 2026.

While EDPMA supports the goal of MVPs, we strongly oppose making them mandatory and believe that MIPS should preserve choice over participation strategies to reflect the distinct needs of practices in different specialties, settings, size, and organizational set up. Preserving these flexibilities is especially important if MVPs fail to align with MIPS specialty measure sets and offer more limited reporting options, including an overreliance on QCDR measures. We remind CMS that QCDR measures are only accessible to practices who pay what are often high fees to participate in the registry. As a result, QCDR participants have access to a broader choice of measures, which can lead to material differences in quality measure performance.

EDPMA also urges CMS to reverse its policy that mandates subgroup reporting for multi-specialty practices choosing to report as MVP participants starting in 2026. Subgroup reporting should be allowed but not required. This will add an additional and unnecessary level of administrative burden for practices that already find MIPS complex and confusing. ***At the very least, there should be an exception for small practices to not have to break off into subgroups for purposes of MIPS compliance.***

We also urge CMS not to dictate or otherwise restrict the makeup of subgroups. Instead, CMS should monitor subgroup reporting data to determine whether there are particular trends that warrant attention over time.

MIPS Performance Threshold

For CY 2025 performance period/2027 MIPS payment year, CMS proposes to maintain the CY 2024 performance threshold of 75 points.

EDPMA strongly supports CMS' proposal to maintain the MIPS performance threshold for the 2025 performance period. A higher threshold would have made it universally challenging for clinicians to avoid a penalty next year and appreciate that this proposal recognizes the residual impact that the COVID-19 Public Health Emergency and more recent cyberattack events have had in terms of disrupting data and straining staff resources.

It is critical that CMS maintain a reasonable performance threshold in light of the deeply flawed Medicare physician fee schedule payment system, which fails to keep up with inflation and results in significant cuts in payments to physicians each year that put a further strain on practices, with a disproportionate impact falling on the shoulders of emergency physicians as discussed at the beginning of this letter. Taking inflation into account, Medicare physician payment rates fell 29% from 2001 to 2024, while practice costs rose by over 50% during the same period.[2] While emergency medicine practices seek to prioritize the provision of safe and high quality care, it is becoming increasingly difficult to divert resources toward MIPS compliance, especially when emergency medicine physicians face a potential 2.8% cut in Medicare payments in 2025 compared to 2024 (or 5.8% if PAYGO sequestration is allowed to go into effect).

[2] https://www.ama-assn.org/system/files/2024-medicare-updates-inflation-chart.pdf

Scoring for Topped Out Measures in Specialty Measure Sets with Limited Measure Choice
Currently, quality measures that are topped out for two consecutive years are capped at 7 points (vs. 10 points). CMS proposes that for select topped out measures each year, it would remove this cap and subject them to a separate defined benchmark known as a defined topped out measure benchmark that would allow them to earn a maximum of 10 points for perfect performance. To determine which measures would qualify for this special policy each year, CMS would conduct an evaluation of MIPS Specialty Measure Sets to determine which specialties have limited measure choice and limited opportunity to maximize their MIPS performance score due to the current topped out measure scoring policy. For 2025, CMS identified 16 topped out quality measures that would be subject to this policy, none of which are directly relevant to emergency medicine.

As noted earlier, multiple emergency medicine-relevant CQMs are subject to topped out scoring caps and other scoring limitations (e.g., benchmarks with less than ten deciles) that will make it challenging for emergency medicine clinicians to score above the proposed performance threshold as the CMS continues to raise the performance threshold in the future. EDPMA appreciates CMS' attempt to address the 7-point topped out scoring cap, but we are concerned about the limited application of this policy. CMS proposal to identify measures eligible for this policy based on an analysis of the measures available to a specialty through a specialty set means that specialties with larger sets will have less of a chance of ever benefiting from this policy. As we have stated in the past, clinicians should not be penalized for maintaining continuously high-quality care in clinical areas that are high priorities for both patients and clinicians. As such, ***we request that CMS broaden the application of this proposal so that it applies to all measures subject to the 7-point cap. CMS should not impose the 7-point cap on any measure going forward to encourage the reporting of important measures and to minimize year-to-year changes in scoring policies, which are administratively burdensome.***

We also request that CMS retain topped out measures proposed for removal. For example, CMS proposes to remove Q254: *Ultrasound Determination of Pregnancy Location for Pregnant Patients with Abdominal Pain*. According to CMS, this process measure has reached the end of the topped-out lifecycle and has a limited opportunity to improve clinical outcomes. ***We urge CMS to work with stakeholders to come up with a reasonable solution for maintaining measures with a median performance rate of 95 percent or higher, whether it is***

- ***Subjecting them to the newly proposed defined topped out measure benchmark;***
- ***Maintaining them as pay-for-reporting measures (which would allow a clinician to continue to earn points and track performance even if they are not being scored on performance); or***
- ***Some other innovative solution to ensure high performance on these measures is monitored and maintained over time.***

Complex Organization Adjustment for Virtual Groups and APM Entities
CMS proposes to apply a complex organization adjustment starting in performance year 2025, which is intended to encourage APM entities and virtual groups to report electronic clinical quality measures (eCQMs). This adjustment would add one point for each eCQM submitted by an APM entity or virtual group that meets data completeness and case minimum requirements. EDPMA reminds CMS that challenges related to the reporting of eCQMs are not limited to APM

entities and virtual groups. Emergency medicine practices, in particular, face unique challenges when it comes to the use of eCQMs since they lack direct control over the facility's EHR system. ***EDPMA recommends that CMS broaden this policy so that it applies to any MIPS eligible clinician, group, or entity reporting an eCQM.***

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EDPMA appreciates the opportunity to provide input on this 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,

Andrea Brault

Andrea Brault MD, MMM, FACEP
Chair
Emergency Department Practice Management Association

Attachment 1

Emergency Medicine Scenarios

Scenario 1:
Patient presented to the ED. Consented to be seen via telehealth due to volume and wait times in the ED. ED physician is at home and provides a telemedicine visit for the patient. The patient is discharged to home after the telemedicine visit.

- What would the POS be for the encounter? (Patient in ED and physician at home)
- Is there a modifier required? If so, would modifier 95 be applied?

Scenario 2:
Patient presented to the ED. Consented to be seen via telehealth due to volume and wait times in the ED. ED physician is at the hospital but provides a telemedicine visit for the patient. The patient is discharged to home after the telemedicine visit.

- What would the POS be for the encounter? (Patient in ED and physician at hospital)
- Is there a modifier required? If so, would modifier 95 be applied?

Scenario 3:
Patient at home and called ED to be seen via telemedicine. Consented to be seen via telehealth. ED physician is at the hospital and provides a telemedicine visit for the patient.

- What would POS be for the encounter? (Patient at home and physician at hospital)
- Is there a modifier required? If so, would modifier 95 be applied?

Scenario 4:
Patient at home and called ED to be seen via telemedicine. Consented to be seen via telehealth. ED physician is at home and provides a telemedicine visit for the patient.

- What would POS be for the encounter? (Patient at home and physician at home)
- Is there a modifier required? If so, would modifier 95 be applied?

Would the ED EM code set be used in all four of the above scenarios?

Other Telehealth Scenarios by Patient Settings

Scenarios 1 – Patient is SNF resident.
Patient is SNF resident. Physician is at home and provides a telemedicine visit for the patient initiated by the SNF nurse.
Plan of care is typically – Go to ER if worsening tonight and See PCP in AM.

- What would the POS be for the encounters?
- What would the appropriate EM code set be?
- Is 95 mod required?

Patient is SNF resident. Physician is at Urgent Care and provides a telemedicine visit for the patient initiated by the SNF nurse.
Plan of care is typically – Go to ER if worsening tonight and See PCP in AM.

- What would the POS be for the encounters?
- What would the appropriate EM code set be?
- Is 95 mod required?

Patient is SNF resident. Physician is at ED and provides a telemedicine visit for the patient initiated by the SNF nurse.
Plan of care is typically – Go to ER if worsening tonight and See PCP in AM.

- What would the POS be for the encounters?
- What would the appropriate EM code set be?
- Is 95 mod required?

Scenarios 2 – Patient is at the Office.

Patient is at the office. Physician is at home.

- What would the POS be for the encounters?
- What would the appropriate EM code set be?
- Is 95 mod required?

Patient is at the office. Physician is at hospital.

- What would the POS be for the encounters?
- What would the appropriate EM code set be?
- Is 95 mod required?

Scenarios 3 – Patient is a Hospital Inpatient.

Patient is an inpatient. Physician is at home.

- What would the POS be for the encounters?
- What would the appropriate EM code set be?
- Is 95 mod required?

Patient is an inpatient. Physician is on the hospital campus.

- What would the POS be for the encounters?
- What would the appropriate EM code set be?
- Is 95 mod required?

Scenarios 4 – Patient is at Home.

Patient is at their home. Physician is in their office.

- What would the POS be for the encounters?
- What would the appropriate EM code set be?
- Is 95 mod required?

Patient is at their home. Physician is at the hospital.

- What would the POS be for the encounters?

- What would the appropriate EM code set be?
- Is 95 mod required?

Patient is at their home. Physician is at home.

- What would the POS be for the encounters?
- What would the appropriate EM code set be?
- Is 95 mod required?

<u>Scenarios 5 – Patient is Not at Home or a Healthcare Facility (e.g., Workplace)</u>

Patient is at their workplace. Physician is in their office.

- What would the POS be for the encounters?
- What would the appropriate EM code set be?
- Is 95 mod required?

Patient is at their workplace. Physician is at the hospital.

- What would the POS be for the encounters?
- What would the appropriate EM code set be?
- Is 95 mod required?

Patient is at their workplace. Physician is at home.

- What would the POS be for the encounters?
- What would the appropriate EM code set be?
- Is 95 mod required?