September 11, 2023

Chiquita Brooks-LaSure, MPP
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1784-P
P.O. Box 8010
Baltimore, MD 21244-1850

RE: Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program (CMS-1784-P)

Dear Administrator Books-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) 2024 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 concurrent funding that serves to resource this EMTALA obligation. Furthermore, and 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 2024 MPFS conversion factor of nearly 3.4%. CY 2024 will be the fourth year in a row that the Medicare Physician Fee Schedule conversion factor has contracted due to policies implemented by CMS, requiring Congress to stabilize the Fee Schedule by averting large reimbursement reductions.

While some of 2024's reduction is due to the shrinking Congressional provision that boosted the CY 2023 conversion factor, the impact on our practices will be significant that stems from decisions that CMS implemented in CY 2021 - the increased valuation of the office and outpatient E/M code sets and now the finalization of a policy to pay for office and outpatient add-on code G2211.

EDPMA opposes the introduction of and payment for G2211. Office and outpatient E/M visit codes already received a substantial increase in CY 2021. G2211 is a poorly defined code that will create confusion about how and when it is appropriate to bill and is likely described by already existing care management services. Emergency medicine will never be able to bill G2211 for emergency department services meaning that emergency medicine is fully exposed to the 2% cut generated by CMS' introduction of this code. Essentially, CMS is proposing to take money directly from emergency physicians to give it to other providers. The state of emergency medicine in the context workforce shortages, continual decreased 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 the introduction of code that is so vaguely defined that it is unclear how its existence will help patients and may only just increase beneficiary cost-sharing in the future with no clinical benefit.

Amidst the numerous, ongoing economic challenges that emergency departments are facing, this reimbursement reduction is slated to occur after the reintroduction of the 2% Medicare sequestration cut from the *Budget Control Act,* a 2% reduction to the MPFS CY 2023 conversion factor, and a new potential sequestration reduction of 4% due to PAYGO rules that could be implemented at the end of the CY 2024 MPFS window for which this proposed rule is setting payment policy. These mounting cuts and financial pressures are short-sighted and wholly unwarranted. In this year's rule, CMS estimates that emergency medicine will experience a 2% decrease in allowed charges for CY 2024 under these new policies.[1] When combined with the decrease in Congressional conversion factor assistance, this alone results in a 3.25% cut to emergency medicine. All of these changes are compounding to place immense pressures on

[1] Table 140: *CY 2024 PFS Estimated Impact on Total Allowed Charges By Specialty*, 88 Fed. Reg. 52,680 (August 7, 2023).

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

Split (or Shared) Evaluation & Management (E/M) 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 twice allowed a transition to the new policy, CMS most recently 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" which had been set for January 1, 2024, implementation.

CMS proposes to delay the implementation of the "time only" "substantive portion" policy "through at least December 31, 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 emergency department (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, undermine the services that those codes are intended to represent, and introduce an entirely impractical and burdensome requirement into a fast-paced, multi-tasking patient care environment (i.e., emergency departments) that will ultimately reduce efficiencies and prolong patient waiting times.

If CMS were to proceed with implementation of a "time only" definition for "substantive portion" in 2025 or later, 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 in 2025 or later, 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" policy in CY 2025 or at any point in the future.*** 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 planned CY 2024 shared (or split) services policy and urges the Agency to maintain its current policy permanently***.

Medicare Approved Telehealth Services List

We appreciate the CMS effort to develop policy to ensure that the gains in access to health care due to the enhanced reliance on telehealth in COVID-19 era is not lost as we leave the public health emergency. As background, 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.

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

- **CPT 99281**
- **CPT 99282**
- **CPT 99283**
- **CPT 99284**
- **CPT 99285**
- **CPT 99291**
- **CPT 99292**

While these CPT codes remain on the List of Medicare Approved Telehealth Services as a Category 3 code through 2024, in the CY 2024 proposed rule, CMS reviewed requests to permanently add:

- **CPT 99281** (*Emergency department visit for the evaluation and management of a patient that may not require the presence of a physician or other qualified health care professional*)
- **CPT 99282** (*Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making*)
- **CPT 99283** (*Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making*)

These codes were discussed in the rule collectively with hospital inpatient E/M visits. Unfortunately, CMS declined to permanently designate these as Medicare Approved Telehealth Services. CMS states, "*[W]e believe these hospital and emergency department services may continue to be furnished safely via two way, audio-video communication technology. We are not proposing to add these services to the list on a permanent basis at this time, but we are*

proposing that they would remain available on the Medicare Telehealth Services List through CY 2024." EDPMA supports the continued status of these codes as approved Medicare Telehealth Services through at least 2024.
However, ***EDPMA encourages CMS to permanently add CPT 99281 – 99285 and CPT 99291 and 99292 to the List of Medicare Approved Telehealth Services.***

Quality Payment Program (QPP)

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

In addition to proposing new MVPs for the 2024 performance year, CMS proposes updates to its existing MVP inventory, including the Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP, which is available to clinicians starting with the 2023 performance year.

EDPMA is 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). Currently, the Emergency Care MVP includes only four clinical quality measures (CQMs), in addition to four QCDR measures. Two of the four CQMs are subject to scoring limitations for the 2023 performance year/2025 payment year due to being topped out or having a benchmark with less than 10 deciles, while the third CQM could be subject to a scoring cap later in the year if it continues to lack a performance year benchmark. As a result, there are very limited MVP reporting options available to practices that have chosen not to invest in a QCDR. **In light of this situation, EDPMA appreciates and strongly supports CMS' proposal to add the following CQMs to the Emergency Medicine MVP for the 2024 performance year:**

- **#65: Appropriate Treatment for Upper Respiratory Infection (URI)**
- **#416: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2-17 Years**
- **#487: Screening for Social Drivers of Health**

In addition to these proposals, we strongly urge 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 is proposing to add to this MVP, 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. Additionally, #332 would be a valuable addition to the

Emergency Medicine MVP since it is not currently subject to any scoring limitations, as is the case with just about every other CQM in the MVP. The lack of any scoring limitations also indicates that a performance gap persists and that there is still room for improvement on this measure. 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.

MIPS compliance is resource intensive for all participants and investing in a QCDR is an additional expense that not all practices can justify. Emergency medicine practices, in particular, face unique challenges when it comes to MIPS compliance. For example, they manage a wide range of often unpredictable clinical scenarios and disparate patient populations. They also struggle with data capture due to a lack of control over the facility's EHR system, which also poses challenges in regard to QCDR participation. Furthermore, smaller emergency practices that do not quite meet the definition of "small practice," but still have limited resources and staff, often find it challenging to meet the case minimum for many MIPS measures, even when reporting at the group level. If CMS wants to incentivize movement towards MVPs, then it must broaden the scope of quality measures offered under the Emergency Care MVP. Providing emergency physicians with a more diverse set of CQMs through this MVP will help ensure that practices of all sizes and levels of resource can take advantage of this new, more streamlined reporting pathway.

MIPS Performance Threshold

Under Section 1848(q)(6)(D)(i) of the Social Security Act, CMS is required to compute the MIPS performance threshold such that it is the mean or median (as selected by CMS) of the final scores for all MIPS eligible clinicians with respect to a "prior period" specified by CMS. CMS may reassess the selection of the mean or median every three years. In the CY 2022 PFS final rule, CMS established that for the CY 2022 performance period/2024 MIPS payment year through the CY 2024 performance period/2026 MIPS payment year, the performance threshold would be the *mean* of the final scores for all MIPS eligible clinicians from a *single* performance period (2017), which resulted in a performance threshold of 75 points.

In this rule, CMS proposes to revise its interpretation of "prior period" to mean three performance periods rather than a single performance period. As such, CMS proposes to use the mean of the 2017, 2018, and 2019 performance periods as the prior period to determine the performance threshold for the CY 2024 performance period/2026 MIPS payment year, which results in a performance threshold of 82 points.

EDPMA strongly opposes CMS' proposal to increase the MIPS performance threshold for the 2024 performance period. We believe that increasing the threshold by seven points is too aggressive of a change for a single year, particularly in light of current circumstances that will make it universally challenging for clinicians to avoid a penalty next year. As noted earlier, most of the current emergency medicine-relevant CQMs are subject to topped out scoring caps and other scoring limitations (e.g., no benchmarks or benchmarks with less than ten deciles) that will make it very difficult for emergency medicine clinicians to score above the proposed performance threshold, even among those who have historically done very well in the program

and for those who achieve near perfect performance next year. For example, CQM #254: Ultrasound Determination of Pregnancy Location for Pregnant Patients with Abdominal Pain is currently topped out and subject to a 7-point cap. For CQM # 416: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2-17 Years, the highest achievement score that a clinician with less than perfect performance can earn on this measure is 6.9 points. Clinicians should not be penalized for maintaining continuously high-quality care in clinical areas that are high priorities for both patients and clinicians.

CMS' proposal to increase the MIPS performance threshold also ignores the fact that the healthcare system is still struggling with the residual effects of the COVID-19 pandemic, including ongoing disruptions related to staffing, resources, and overall capacity. Emergency departments, in particular, have "been brought to a breaking point," according to a letter signed by 30 stakeholders and sent to the President in November,[2] which also highlighted the following:

- Unprecedented and rising staffing shortages are further spiraling the stress and burnout driving the current exodus of excellent physicians, nurses, and other health care professionals.
- Nursing shortages have stretched care teams to take on extra hours, care for more patients, and shoulder additional clinical and nonclinical duties.
- Nursing shortages accelerated due to COVID-19, with a recent American Nurses Foundation survey finding that 21 percent of nurses surveyed intended to leave their position, with another 29 percent considering leaving.

Similarly, this proposal fails to account for the deeply flawed Medicare physician fee schedule, 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.

Taking inflation into account, Medicare physician payment rates fell 26% from 2001 to 2023, while practice costs rose by 47% over the same period.[3] While emergency medicine practices seek to prioritize the provision of safe and high quality care, it is becoming increasingly difficult to divert resources towards MIPS compliance, especially when emergency medicine physicians face a potential 3.25% cut in Medicare payments in 2024. CMS estimates that if it finalizes an 82-point threshold for the 2024 performance year, 54% of clinicians could receive a penalty in 2026, with the average penalty being 2.4%. This would represent a dramatically higher number of clinicians receiving penalties than in the past, which EDPMA believes is entirely unreasonable, insensitive to the current state of affairs, and not an accurate reflection of the quality of clinician care.

EDPMA is also concerned about the number of practices that have needed to use the COVID-19 hardship exception over the past few years. Some of these practices have not participated in the program since 2019, when the performance threshold was 30 points, or even since 2018, when the performance threshold was 15 points. Since CMS is not expected to offer the COVID-19 hardship beyond 2023, these practices will be required to re-enter a program in 2024 that looks

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[2] https://www.acep.org/siteassets/new-pdfs/advocacy/emergency-department-boarding-crisis-sign-on-letter-11.07.22.pdf

[3] https://www.ama-assn.org/about/leadership/congress-must-act-now-medicare-physician-payment-reform#:~:text=Adjusted%20for%20inflation%2C%20Medicare%20physician,analysis%20of%20Medicare%20Trustees%20data.

dramatically different than when they last participated. These are the very practices that are struggling most under the weight of the challenges discussed above. To penalize them, at a time when CMS should instead be supporting their transition back into the program, seem distorted.

Finally, we are concerned that raising the performance threshold could also hamper CMS' efforts to encourage clinician movement into MVPs in 2024. Clinicians will be hesitant to test out this new pathway if they continue to face shifting goal posts and are unsure about how they will perform. Although MVPs require the reporting of fewer measures than traditional MIPS, each measure contributes more weight towards the final score, which makes this pathway riskier for specialties whose MVP measures are insufficiently diverse and subject to scoring limitations, as discussed above.

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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 MD, MMM, FACEP
Chair
Emergency Department Practice Management Association