

January 14, 2021

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: ACEP Comments on Issues and Questions Identified and Discussed at MVP Town Hall on January 7, 2021

Dear Administrator Verma:

On behalf of our 40,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to comment on issues related to the design, reporting, and scoring of Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs) that were identified and discussed during the MVP Town Hall on January 7, 2021. Jeffrey Davis, ACEP's Director of Regulatory Affairs, participated in the Town Hall, and we wish to follow-up on his comments and respond to other questions posed during this public meeting. In doing so, we are reiterating many of our previous targeted comments on specific MVP proposals included in our official responses to the calendar years (CY) 2020 and 2021 Physician Fee Schedule (PFS) and Quality Payment Program (QPP) proposed rules.¹

ACEP has long supported streamlining MIPS reporting processes and making the program more meaningful to clinicians. Therefore, we are generally supportive of the MVP framework and are currently developing an emergency medicine-specific MVP that we intend to submit to the Centers for Medicare & Medicaid Services (CMS) for consideration. While we do believe that MVPs have the potential to reduce burden for clinicians and improve quality of care, we do have some concerns with CMS' current implementation strategy and requirements.

Transition to Alternative Payment Models

During the Town Hall, CMS raised some questions about how MVPs could align with alternative payment models (APMs) and facilitate participation in them. While the transition to APMs is a laudable goal, it is extremely unclear how participating in MVPs would help make this goal into a reality. The Center for Medicare & Medicaid Innovation (CMMI) operates most of the existing APMs. Their criteria for developing new models are quite stringent, and their internal process for developing a new model can take years. Thus, even if an MVP proves to be successful in helping to drive down costs and improve quality, it would be a multi-year process before the MVP itself could transition to an APM. The Qualifying APM Participant

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¹ ACEP's comments on the CY 2020 PFS and QPP proposed rule can be found [here](#) and ACEP's comments on the CY 2021 PFS and QPP proposed rule can be found [here](#).

(QP) five percent payment bonus is only available through 2024, leaving no time for this multi-year process to unfold.

If the goal of MVPs is simply to prepare clinicians to participate in an APM, we then must first acknowledge and address the fact that there is a gap in available APMs in which emergency physicians and other specialists can participate. While many emergency physicians are ready to participate in APMs, there simply are not any opportunities to do so. ACEP developed a physician-focused payment model (PFPM) called the Acute Unscheduled Care Model (AUCM). Structured as a bundled payment model, the AUCM would improve quality and reduce costs by allowing emergency physicians to accept some financial risk for the decisions they make around discharges for certain episodes of acute unscheduled care. It would enhance the ability of emergency physicians to reduce inpatient admissions, and observation stays when appropriate through processes that support care coordination. Emergency physicians would become members of the continuum of care as the model focuses on ensuring follow-up, minimizing redundant post-ED services, and avoiding post-ED discharge safety events that lead to follow-up ED visits or inpatient admissions.

ACEP submitted the AUCM proposal to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) for consideration. We presented the AUCM proposal before the PTAC on September 6, 2018. The PTAC, established by the Medicare Access and CHIP Reauthorization Act (MACRA), is a federal advisory committee with the primary responsibility for evaluating physician-focused payment models and providing recommendations to the Secretary. The PTAC recommended the AUCM to the Secretary of the Department of Health and Human Services (HHS) for full implementation. The AUCM met all ten of the established criteria, and the PTAC gave one of the criteria (“Scope”) a “Deserves Priority Consideration” designation since the PTAC felt that the model filled an enormous gap in terms of available APMs to emergency physicians and groups. The PTAC submitted its report to the Secretary in October 2018. The HHS Secretary responded to the PTAC’s recommendation in September 2019, requesting that CMMI examine ways to incorporate key elements of the AUCM into APMs that it is developing. We are still waiting for CMMI to act on the Secretary’s request, and we look forward to working with the Center to improve emergency patient care through the implementation of the model.

Thus, overall, while we support CMS’ goal of using MVPs as a bridge between MIPS and APMs, we have a long way to go until that goal has a chance of becoming an actual achievable reality. The first, and most important, step is for CMMI to develop more specialty-specific APMs, starting with the AUCM for emergency physicians.

MVP Participation and Scoring Requirements

CMS during the Town Hall laid out questions related to MVP participation and scoring requirements. **ACEP does NOT believe that MVPs should simply replace the current MIPS program that is in place, and we strongly support CMS’ decision to make participation in MVPs voluntary, not mandatory.** As emergency physicians, we do not want to lose the flexibilities that are available to us and other hospital-based clinicians, primarily the facility-based scoring option. We would like to preserve the existing policy for the facility-based scoring option in which applicable individuals and groups automatically receives a facility-based quality and cost score and CMS takes the higher of that score and a traditional MIPS score for purposes of determining an individual or group’s MIPS performance.

We also strongly encourage CMS to phase in the reporting requirements. Just as 2017 was a transition year for MIPS, CMS could implement a similar type of “pick-up your pace” approach for the first year of a newly established MVP. Thus, if a clinician decided to participate in a new MVP, CMS could loosen scoring requirements for the first year to give that clinician the time he or she needs to adjust his or her practice patterns and previously-established MIPS reporting processes.

CMS should also institute incentives for participating in MVPs. Clinicians may in fact have a better chance of scoring higher under traditional MIPS than under an MVP. Currently, clinicians can report on as many quality measures as they so choose, and CMS picks the six that the clinician performs the best on when calculating the clinician's performance score. If clinicians are only allowed to report on a select few measures under MVPs, they may have less of a chance of receiving a high score. While we are not suggesting that CMS mandate that clinicians report more measures under MVPs, we do recommend that CMS refine their scoring approach so that clinicians have as much of an opportunity to do well under an MVP than they do under traditional MIPS. **CMS should therefore consider providing a scoring bonus to clinicians who voluntarily participate in an MVP in order to entice them to make the transition.**

Specific scoring rules and reporting requirements can be refined and improved over time as clinicians gain experience with MVPs. While CMS states that many of its decisions around MVP design and scoring requirements are constrained by the statute (Section 1848(q) of the Social Security Act), we believe that CMS could consider using its authority under Section 1115A of the Social Security Act (CMMI's authority) to test out different MVP scoring and design methodologies that would possibly yield improvements to patient care. Under Section 1115A(d)(1) of the Social Security Act, CMS can waive any section of Title XVIII of the Social Security Act necessary to carry out a CMMI model. In other words, CMS could create a mini CMMI model and use this authority to test out various MVP design and scoring constructs. If MVPs truly represent the future of MIPS and can help clinicians' transition to APMs, CMS should think "outside the box" and use all its possible authorities to help clinicians successfully participate in MVPs and ensure that MVPs maximize the potential for clinicians to improve patient care.

MVP Reporting Requirements

During the Town Hall, CMS noted that clinicians have indicated that they want to have a choice of measures and activities within in an MVP on which to report. CMS asked whether it is reasonable for the agency to assume that a clinician electing an MVP will report on a minimum number of measures or activities for cost, quality, and improvement activities. **While ACEP agrees that clinicians should have the flexibility to report on a subset of measure and activities within an MVP, we do *not* believe that there should be a minimum number of measures that are both included in an MVP and must be reported.** As ACEP begins to develop an emergency medicine-focused MVP, we are consciously aware of the low number of viable QPP measures for emergency physicians and are concerned that some of them could become topped-out in the near future. If CMS were to require that clinicians report on a minimum of quality measures in an MVP (such as six measures, which is the current MIPS requirement), it would be nearly impossible for ACEP to construct an emergency medicine-MVP with enough measures, yet alone include more than the bare minimum in order to give emergency physicians some flexibility and choice in reporting. Although we are also considering including qualified clinical data registry (QCDR) measures in addition to QPP measures in our MVP proposal, we still believe it would be challenging to design an MVP with a minimum measure requirement in place.

CMS also acknowledged during the Town Hall that it will take some time to identify or develop applicable cost measures for all clinicians and specialty types and asked what it should do in the interim for MVPs in which clinicians do not have an applicable cost measure. **ACEP notes that there are currently no available episode-based cost measures that can be attributable to emergency physicians.** Since all MVP proposals must include at least one cost measure, we will be required to include the Medicare Spending Per Beneficiary (MSPB) measure and/or the Total Per Capita Cost measure in our MVP proposal. We could wait for emergency medicine episode-based measures to be developed before submitting an MVP proposal, but that process could take years, and we believe that it is important to put forth a viable MVP option for emergency physicians before that cost measure development process concludes.

Unfortunately, we do not believe the MSPB measure and the Total Per Capita Cost measure are meaningful or relevant to emergency physicians. They were developed for hospital-level accountability and are inappropriate for emergency physician practices, which do not have Medicare patient populations that are large enough or heterogeneous enough to produce an accurate picture of their resource use. Further, even with the recent risk adjustment changes finalized in the CY 2020 PFS and QPP final rule, the measures are still insufficiently adjusted for risk, which punishes physicians repeatedly for caring for the most vulnerable patients with high cost, multiple chronic conditions.

Therefore, in the short term, cost will not be adequately captured in any emergency medicine-focused MVP. CMS, through a contract with Acumen, is considering developing emergency medicine episode-based cost measures in the future. If/when an emergency medicine episode-based cost measure(s) is developed, ACEP believes it will be important to integrate that cost measure into an emergency medicine MVP, if applicable, as soon as possible. **ACEP does not think that an already-approved emergency medicine MVP should have to be completely reintroduced or reapproved once an episode-based cost measure is developed that can be included in it. Any such modification to an already approved MVP should go through a streamlined reapproval process.** Forcing stakeholders to resubmit and obtain full reapproval of MVPs in order to incorporate new cost measures would disincentivize stakeholders from introducing MVP concepts to CMS before episode-based cost measures are developed—thereby pushing back the timeline for implementing specialty-specific MVPs by several years.

We appreciate the opportunity to share our comments. If you have any questions, please contact Jeffrey Davis, ACEP's Director of Regulatory Affairs at jdavis@acep.org.

Sincerely,

A handwritten signature in black ink that reads "Mark Rosenberg". The signature is written in a cursive, slightly slanted style.

Mark S. Rosenberg, DO, MBA, FACEP

ACEP President