

October 31, 2022

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Washington, D.C. 20515

The Honorable Larry Bucshon, MD
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The Honorable Brad Wenstrup, DPM
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The Honorable Kim Schrier, MD
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The Honorable Bradley Schneider
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The Honorable Michael Burgess, MD
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The Honorable Marianne Miller-Meeks, MD
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Dear Representatives Bera, Bucshon, Schrier, Burgess, Blumenauer, Wenstrup, Schneider, and Miller-Meeks:

On behalf of the American College of Emergency Physicians and our 40,000 members, thank you for the opportunity to share our ideas and recommendations for establishing a more affordable and sustainable health care system that ensures our patients have access to the high-quality care they need and deserve. As we all work together to better carry out the goals of the Medicare Access and CHIP Reauthorization Act (MACRA; P.L. 114-10) and transition to a health care system that incentivizes the delivery of efficient, high-value care, it is critical that emergency physicians, and all physicians, are able to meaningfully participate in innovative new payment models and pathways, while also ensuring that Medicare payments for physician services are not only stable, but also account for inflation reflective of contemporary financial realities.

MACRA was intended to permanently resolve Medicare's flawed Sustainable Growth Rate (SGR) payment formula and transition our health care system to one that rewards value, rather than volume. As we looked to move away from fee-for-service (FFS) as the standard, MACRA was designed to establish value-based payment pathways – the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs) – as well as streamline the numerous quality reporting programs under Medicare.

However, the implementation of MACRA has not proven to be the fix that was promised. While the law helped avoid short-term physician payment issues, according to the 2022 Medicare Trustees Report, there are "...important long-range concerns

that will almost certainly need to be addressed by future legislation.”¹ In fact, the Trustees project that by 2048, physician payments under Medicare will be lower under MACRA than they would have been if the SGR had remained in effect. The Trustees note that without changes, future access to Medicare-participating physicians will become a significant long-term problem. ACEP strongly agrees with this assessment.

We believe that with improvements, developed through collaboration with Congress, regulators, and stakeholders as originally intended, MACRA can be significantly more effective in facilitating the transition to value-based care delivery. It does not necessitate the wholesale dismantling of the current system as we did with the SGR, but does require more regular oversight and iteration to help us attain a sustainable payment system that truly incentivizes high-quality, cost-effective care and to ensure that we do not expend our time and resources in vain trying to achieve that ultimate goal.

Once again, we are deeply grateful for your attention to this important issue and appreciate the opportunity to share our experiences and suggestions in the pages that follow. Should you have any questions or require any further information, please do not hesitate to contact Ryan McBride, ACEP Congressional Affairs Director, at rmcbride@acep.org.

Sincerely,



Christopher S. Kang, MD, FACEP
ACEP President

¹ <https://www.cms.gov/files/document/2022-medicare-trustees-report.pdf>

Fundamental Issues Regarding Medicare Payment Stability

The emergency department (ED) serves as the “front door” to the health care system, receiving 150 million visits each year, with more and more of our patients older in age and arriving via emergency medical services (EMS) transport. Of these visits, 16 to 18 percent of patients are admitted to the hospital, accounting for approximately two-thirds of all inpatient admissions nationwide². And for many Americans, the ED may be the first – and only – interaction they have with the health care system, especially for safety-net and otherwise underserved populations.

Given this foundational role that emergency physicians and other ED clinicians play in our health care system, we believe that we should be at the center of value-based payment initiatives. However, one of MACRA’s most fundamental flaws is the failure to appropriately integrate emergency care into the transition to value-based care. MACRA, and most health care delivery reforms and alternative payment models (APMs), have focused on primary care and chronic disease management for the purpose of decreasing the need for acute care and reducing ED utilization and spending. But neglecting to incorporate acute care delivery in large scale system redesign perpetuates an incorrect and harmful notion of the ED as a “failure” of the health care system, rather than recognizing the unique role of emergency physicians as the safety net who care for people at their greatest time of need. As a result, emergency physicians have largely been left out of opportunities to meaningfully engage in Accountable Care Organizations (ACOs) and other APM initiatives, including the Advanced APM pathway under MACRA’s Quality Payment Program (QPP). Emergency physicians essentially have no other option than to participate in and report under measures in the Merit-based Incentive Payment System (MIPS), which can be burdensome and includes some underlying flaws that truly hinder its ability to help clinicians improve the quality of care they provide and reduce health care costs.

MIPS includes four performance categories: Quality, Cost, Improvement Activities, and Promoting Interoperability (formerly “Meaningful Use”). Performance on these four categories roll up into an overall score that translates to an upward, downward, or neutral payment adjustment provided two years after the performance period. The maximum penalty is 9 percent, while the maximum bonus is dynamic and adjusted to preserve overall budget neutrality. In other words, CMS first determines which clinicians will receive a penalty, then uses that pool of penalties to pay out bonuses. MIPS, as opposed to the APM paradigm, is effectively a one-size-fits-all system as all participants are weighed against each other in these same categories and measures regardless of specialty. But this one-size-fits-all system is not capable of accounting for the differences in how care is delivered for episodic, acute unscheduled care compared to primary care or other non-episodic scheduled care. While the MIPS Value Pathways (MVP) approach, described later, attempts to resolve this concern, we are concerned that the current structure of MVPs is not dissimilar enough from traditional MIPS as to provide an attractive alternative to traditional MIPS reporting.

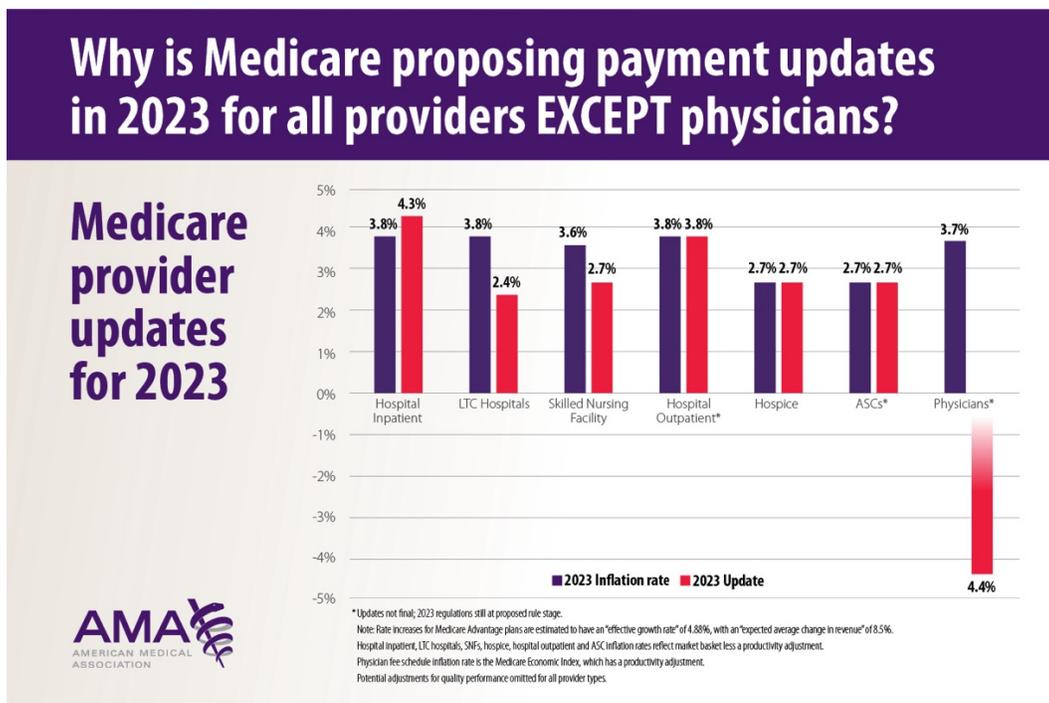
ACEP shares your desire to stabilize the Medicare payment system without dramatic increases in Medicare spending, but even with all necessary improvements to MACRA, this goal is unachievable without addressing the root of this instability. We firmly believe any effort that seeks to comprehensively address the stability of Medicare physician payments will be incomplete without resolving key structural problems in the system, chiefly, Medicare’s “budget neutrality” requirements and the lack of an inflationary measure tied to physician payments. Annual updates to physician payments already fail to keep up with the cost of providing physician services, and additional large-scale payment reductions such as those imposed by budget neutrality and sequestration will make it even more difficult for many physician specialties like emergency medicine (EM) to continue providing care. Medicare rates were never designed to represent the fair market value of health care services or to even cover provider costs, and they fluctuate based on variables unrelated to the services provided. They function more as a federal budget mechanism rather than as a full representation of the value of the physician service.

In the Calendar Year (CY) 2023 Physician Fee Schedule (PFS) and Quality Payment Program (QPP) proposed rule, the Centers for Medicare & Medicaid Services (CMS) proposed a Physician Fee Schedule (PFS) conversion factor of \$33.08, a decrease of \$1.53 from the CY2022 PFS conversion factor of \$34.61. The conversion factor reflects the

² <https://www.acepnow.com/article/long-term-trends-emergency-department-visits-patient-care-highlighted-national-reports/?singlepage=1>

expiration of a 3.0 percent increase that Congress added to the conversion factor for 2022 (mitigating most of the 3.75 percent cut that would have otherwise gone into effect). These reductions stem from CMS decision to increase the office and outpatient evaluation and management (E/M) services in 2021. There is also an additional cut of 1.4 percent due to the budget neutrality requirement. As required by law, CMS must preserve budget neutrality in cases where relative value unit (RVU) changes may cause PFS spending to increase or decrease by more than \$20 million. In total, the estimated cut to the conversion factor in CY 2023 is roughly 4.4 percent.

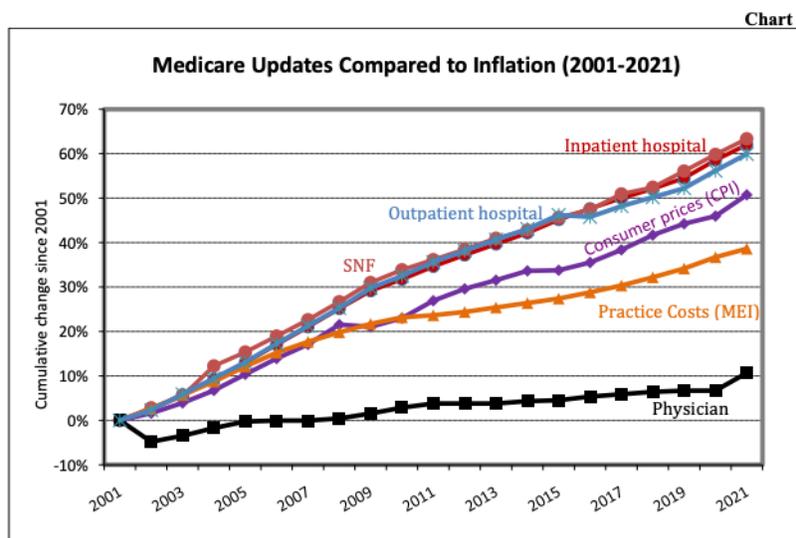
The PFS is one of the only Medicare payment systems that does not receive a market basket update or other inflationary adjustment. While Section 1848 of the Social Security Act, which governs the PFS, includes the budget neutrality provision described above, most other payment systems do not have that type of statutory constraint. Thus, other facilities and health plans within the Medicare program get appropriate updates each year. For example, under the fiscal year (FY) 2023 Inpatient Prospective Payment System (IPPS) final rule, hospitals will receive a 4.3 percent *increase* in Medicare reimbursement, an increase of 1.1 percent from the FY23 IPPS proposed rule. Even more starkly, Medicare Advantage plans will receive an 8.5 percent revenue increase in 2023 – similar to the hospital bump, this rate is also even larger than the 7.98 percent increase initially proposed in the 2023 Medicare Advantage and Part D Advance Notice in February 2023.



For physicians, in addition to the 4.4 across-the-board reduction to the PFS conversion factor, the 2.0 percent sequestration reduction continues to apply year after year, with no end in sight. Even further, there is once again a threat of a statutory “PAYGO” sequester of 4.0 percent scheduled to take effect in 2023. **Combined, this will result in a total physician reimbursement cut of 10.4 percent on January 1, 2023.**

Although physicians can also receive incentive payments through successful MIPS participation or participation in an Advanced APM, **it is impossible to avoid a cut under the current system.** Even with perfect performance in these programs, physicians would still receive a payment cut while other participants in the Medicare program will receive payment increases – in some cases, substantial. Again, recognizing the intent of this RFI to look for ways to improve MACRA and stabilize the Medicare payment system, our point is that improvements to MACRA alone cannot provide the stability we are all seeking.

An analysis conducted by ACEP found that Medicare payments have decreased by 53 percent when compared to inflation (CPI-U index) between the start of the Resource-based Relative Value Scale (RBRVS) in 1992 and 2016.³ As seen in the chart below, over the course of the last twenty years, the payment systems for other Medicare providers types like hospitals and skilled nursing facilities (SNFs), as well as actual practice costs reflected in the Medicare Economic Index (MEI), have far exceeded Medicare payments under the PFS.



Sources: Federal Register, Medicare Trustees' Reports and U.S. Bureau of Labor Statistics

Given that annual updates to physician payments already fail to keep up with the cost of providing services, adding large-scale payment reductions will only make it even more difficult for many physician specialties, including EM, to continue providing care. Medicare’s access problems present differently for EM when compared with other specialties and primary care. While continued cuts and insufficient reimbursement may incentivize other physician specialties to ultimately opt out of Medicare, emergency physicians are essentially required to participate given the nature of emergency medicine staffing and contracting practices. And as economic incentives and continued system consolidation have encouraged hospitals to outsource physician specialties like EM and others, emergency physicians tend to practice in groups – small, mid-size, or large – that contract with a hospital or system to provide emergency care. Since emergency physicians must treat every patient that walks through the doors of the ED, regardless of insurance status or ability to pay, these contracts almost always require the emergency physician group to participate in Medicare. In theory, these dynamics would guarantee access to emergency care regardless of the reimbursement environment; however, as physician payments continue to decrease, new generations of physicians will have fewer incentives to pursue EM when compared with other more competitive and financially-viable specialties that provide greater freedom of practice.

Financial stability and certainty are critical in ensuring that Medicare can fulfill its promise to the millions of American seniors that deserve and depend upon this program. The annual issue of significant Medicare payment cuts not only threatens the viability of the health care safety net, but also affects our ability to effectively partner with Congress to address other critical challenges facing the physician community, and most importantly, our ability to advocate on behalf of our patients. We share legislators’ significant frustrations with the perennial task of finding costly, short-term fixes for long-term problems.

Recommended Changes: Eliminate the Budget Neutrality Requirement

As noted above, the PFS includes an arbitrary budget neutrality requirement, mandating an overall across-the-board adjustment to the conversion factor if any changes in relative value units (RVUs) result in Medicare payments being increased by greater than \$20 million. This policy truly pits specialties against each other, as any upward adjustment to a particular code results in an automatic reduction to the conversion factor—which has a greater practical impact

³ <https://www.acep.org/globalassets/uploads/uploaded-files/acep/advocacy/state-issues/medicare-versus-inflation.pdf>

on those clinicians who do not typically bill that code. This unfortunate policy result played out most acutely during the CY 2021 PFS and QPP rulemaking cycle where CMS increased the office and outpatient evaluation and management (E/M) codes as well as created an add-on code for complexity. These policies resulted in an 10.2 percent reduction to the CY 2021 PFS conversion factor, which Congress fortunately mitigated in the Further Consolidated Appropriations Act, 2020 ([P.L. 116-94](#).) Without congressional action, all clinicians would have been negatively affected by this 10.2 percent conversion factor reduction, but primary care physicians, who typically bill the office and outpatient E/M services would have actually come out ahead and benefited overall. Therefore, these clinicians were not as concerned about this significant cut to the conversion factor, while specialists who did not bill these codes, such as emergency physicians and other specialists, were extremely anxious about how the cut would impact their practices. This discrepancy in how the budget neutrality requirement affects different clinicians depending on which codes are modified is fundamentally unfair and not how a viable payment system should operate. Certain clinicians should not be penalized simply because other clinicians benefited from a particular policy.

ACEP strongly believes that the budget neutrality requirement must be eliminated. As an alternative, the budget neutrality trigger of \$20 million should be increased. It was established in 1989, before the establishment of the PFS, and there have been no adjustments for inflation since. Thus, the trigger threshold should be increased to \$100 million to better account for past inflation.

ACEP also believes that benefits or services for which utilization is expected to increase due to changes in law or regulations should be exempt from budget neutrality adjustments, including:

- Newly covered Medicare services
- Services that are being incentivized
- Services specifically designed to be used within an APM that are already intended to lower Medicare expenditures
- Benefit or access expansions
- New technology

APMs and Emergency Medicine

As mentioned previously, emergency physicians play a vital role in their communities, providing a safety net for individuals during their greatest time of need. As they treat each patient, emergency physicians must make the critical decision about whether the patient should be kept for observation, admitted to the hospital, or discharged. Essentially, they act as a gateway to the hospital for many patients. Emergency physicians are therefore in a prime position to be meaningful participants in APMs that attempt to shift our health care system to one that rewards value over volume. However, while many emergency physicians are ready to take on the downside risk and participate in Advanced APMs, there simply are not any opportunities to do so.

In order to address the gap in available Advanced APMs for emergency physicians, ACEP developed an emergency medicine-focused APM, the [Acute Unscheduled Care Model](#) (AUCM; affectionately pronounced “*awesome*”), that we have presented to regulators for incorporation into various APM initiatives. ACEP established an internal APM Task Force to review various APM proposals, eventually resulting in the development of the AUCM. In October 2017, ACEP submitted the AUCM proposal to the Physician-Focused Payment Model Technical Advisory Committee (PTAC). Established by MACRA, the PTAC is tasked under statute with commenting on and recommending physician-focused APM proposals to the Secretary of Health and Human Services (HHS) for consideration, based on a set of ten criteria established by the Secretary. After months of discussions with a Preliminary Review Team (PRT) within the PTAC, ACEP officially resubmitted the model in June 2018.

In September 2018, three emergency physicians presented the model to PTAC during a public meeting. PTAC voted on the ten criteria and determined that the AUCM proposal met all ten criteria.

PTAC Rating of Proposal by Secretarial Criteria

Criteria Specified by the Secretary	Full PTAC Rating
1. Scope (High Priority)	Meets and Deserves Priority Consideration
2. Quality and Cost (High Priority)	Meets
3. Payment Methodology (High Priority)	Meets
4. Value over Volume	Meets
5. Flexibility	Meets
6. Ability to be Evaluated	Meets
7. Integration and Care Coordination	Meets
8. Patient Choice	Meets
9. Patient Safety	Meets
10. Health Information Technology	Meets

The PTAC then voted to submit the model to the HHS Secretary for full implementation, agreeing that the model has great potential to improve the way emergency care is delivered and that it fills a huge gap in the current portfolio of APMs. One member of the PTAC even stated that it was the best APM that they had reviewed to that point. Based on the vote and recommendations made during this meeting, PTAC then formally issued a report to the HHS Secretary in October 2018 stating that AUCM deserves priority consideration based upon the scope criterion.

In September 2019, HHS Secretary Alex responded⁴ to the PTAC’s recommendation by stating that he was, “interested in exploring how the concepts in the AUCM model for care management by emergency physicians after an ED encounter could be incorporated into models under development at the CMS Center for Medicare and Medicaid Innovation (CMMI).” But despite subsequent conversations with CMMI has not made any tangible progress on the implementation of the model at this point.

ACEP has repeatedly raised our concerns with CMS that the agency is not doing enough to engage emergency physicians in value-based payment initiatives. Most recently, in our [response to the CY 2023 PFS and QPP proposed rule](#), ACEP reiterated our call that CMS prioritize the creation of additional APM opportunities for emergency physicians and other specialists, or determine how to modify existing APMs to better engage specialists and allow them to actively participate. We urge Congress to exercise its oversight role to examine why have largely been precluded from participating in APMs.

At this point, we are trying to work with other payors beyond Medicare to try to advance the principles of the AUCM. We created our own initiative to promote participation in emergency medicine-focused APMs offered by Medicaid and private payors. As these payors also move away from traditional FFS contracts toward value-based payment arrangements, the AUCM could be an ideal APM construct for them to adopt, at least in terms of core concepts. We anticipate that some features of these private payor APMs will be different from the AUCM depending on the specifics and needs of the targeted patient population.

Improving MIPS, APMs, and Increasing Participation in Value-Based Payment Models

Broadly, MACRA as implemented is a “one-size-fits-all” approach for physicians and other clinicians, regardless of specialty or practice model, thereby ignoring core differences between different modalities of care. A truly transformative, value-based payment system must recognize and be able to encompass different models of care:

⁴ <https://downloads.cms.gov/files/ptac-hhsresponse-sep18-dec18.pdf>

- Non-episodic/scheduled care (primary care including chronic/longitudinal care management)
- Episodic/scheduled care (typically elective procedures, mostly specialty care)
- Episodic/unscheduled care (emergency care, urgent care)

CMS tried to address this one-sized-fits-all constraint through the creation of the MIPS Value Pathways (MVPs). Under this optional approach, clinicians can report on a uniform set of measures on a particular episode or condition in order to get MIPS credit. ACEP developed an emergency medicine-focused MVP that CMS will be including in the first batch of MVPs starting in 2023. While we are excited about the implementation of this MVP, the Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP, we are generally concerned that not many clinicians will actually report through the MVP next year.

MVPs generally include the same sets of measures as traditional MIPS and have the same overall scoring rules. There are no additional financial incentives for participating in an MVP. Due to the COVID-19 public health emergency, hardship exemptions have been in place for the 2019, 2020, 2021, and 2022 MIPS performance periods. Therefore, for some clinicians, 2023 may be the first time they participate in MIPS in four years. These clinicians may not be willing to take a risk and try a new method for reporting in MIPS, especially when the potential downside is significant – a nine percent reduction in reimbursement on all Medicare covered professional services.

To help ensure MACRA’s success, we ask Congress to consider refining MIPS overall, including the MVP approach established by CMS,] in order to better tailor the program to the type of care a physician typically delivers. For example, there could be a system in which primary care continues to use traditional quality and cost measures, scheduled care could use episodes-of-care and MVP measures, and emergency care could use its own paradigm, relying on more relevant measures like the EM cost measure with a 14-day episode (as opposed to 30-day for other specialties). Such a system would better reflect the type of work a physician performs the majority of the time.

Further, the clinician community believed when MACRA was passed that the ultimate goal was for most clinicians to transition away from MIPS to participate in Advanced APMs. Besides there not being opportunities for most specialists to participate in Advanced APMs, there should also be better, and more sustainable incentives to participate in these models.

To address these underlying issues, we provide the following recommendations that we have also previously shared with regulators:

Recommended Changes to MIPS

Streamline MIPS Reporting Requirements

CMS has taken a number of efforts to try to streamline MIPS reporting. Under the MVP approach, there is a more limited set of measures within the Quality and Improvement Activities Performance Categories on which clinicians can report. Further, CMS has created the “facility-based scoring option” that has been effective since the 2019 performance year. With this scoring option, clinicians who deliver 75 percent or more of their Medicare Part B services in an inpatient hospital, on-campus outpatient hospital, or emergency room setting will automatically receive the quality and cost performance score for their hospital through the Hospital Value-based Purchasing (HVBP) Program. Most emergency physicians qualify for this option.

Despite these efforts, CMS still must work within the statutory constraints of the MIPS program, which require clinicians to meet standards under four separate performance categories. ACEP has long supported the concept of allowing clinicians to report on one set of measures and receive credit in multiple categories of MIPS, as it will help reduce the burden of reporting for physicians and also link elements of the program together into one cohesive function. We also believe that clinicians who use certified electronic health records (EHRs) to participate in a clinician-qualified clinical data registry (QCDR) should be qualified as fully achieving all points for the Promoting

Interoperability category. In all, Congress should provide more flexibility to CMS to allow clinicians to receive full MIPS credit for reporting on certain measures or conducting certain improvement activities that are most relevant to their practice. As described earlier, emergency care is unique and requires its own paradigm in order to reflect the fact that it is episode-based, acute, and unscheduled. Emergency physicians, like other specialties, should have the flexibility to improve their overall cost and quality performance in a way that aligns with that paradigm.

Invest in Quality Measure Development

Over the last several years, CMS has reduced the number of available quality measures on which clinicians are able to report. Part of this trend is due to the increase in “topped out” measures. A measure can become “topped out” when most clinicians are performing extremely well on the measure and performance on the measure cannot be meaningfully improved. Topped out measures are being phased out of the program.

Given this movement to eliminate, not add, measures to the MIPS quality measure inventory, some specialists have a paucity of measures that are clinically relevant to their specialty on which they can report. Instead of CMS investing in the development of new quality measures, CMS relies on specialty societies to fund the development of measures. This is truly a costly endeavor, as it could cost anywhere from \$250,000 to \$1 million to develop and fully test a new quality measure. Many specialty societies cannot afford to develop measures and therefore the number of reliable measures will continue to decrease. Congress should provide CMS with adequate funding to develop additional clinically-relevant and evidence-based measures that clinicians of all specialty types will find meaningful.

Reduce Reliance on Inaccurate Cost Measures

The Cost Category of MIPS represents 30 percent of the total MIPS performance score. However, as with quality measures, there is a lack of relevant cost measures for certain specialties. CMS currently employs a single contractor, Acumen LLC, to develop new episode-based cost measures. If specialists do not have an episode-based cost measure, they could be attributed to two program-wide cost measures: the Total Per Capita Cost (TPCC) and Medicare Spending Per Beneficiary (MSPB) measure.

Some emergency physicians are attributed to the MSPB measure specifically. This measure captures the “cost of services performed by hospitals and other healthcare providers during the period immediately prior to, during, and following a beneficiary's hospital stay.” It attributes all Medicare Part A and B costs occurring in the episode window to the clinician(s) responsible for care—which could end up indirectly being an emergency physician. ACEP believes this unfair, as emergency physicians are generally not the physician driving the cost of care delivered during a hospital stay. Another issue is that this measure is truly a “black box” calculated by CMS using administrative data, and we have expressed concerns about the validity of the measure and its attribution methodology.

To help address the lack of emergency medicine-specific cost measures, CMS and their contractor, Acumen, convened an expert panel to develop a cost measure that could be directly attributable to emergency medicine clinicians. ACEP has helped lead the way in that process. An ACEP member had the opportunity to chair the expert panel, and other ACEP members served on the panel as well. Using the insights from the panel, Acumen constructed a draft EM cost measure. The draft measure includes elements of ACEP’s APM, the AUCM, and the emergency medicine MVP. The earliest the EM episode-based cost measure could be incorporated into MIPS is CY 2024. It must first go through CMS rulemaking to officially be adopted.

Since the development of meaningful cost measures is a lengthy process, and the currently available cost measures are not clinically relevant, ACEP recommends that Congress eliminate the statutorily-mandated 30 percent weight for the Cost Category, and provide CMS the discretion to set the Cost Performance Category at a lower weight.

Continue to Support Qualified Clinical Data Registries (QCDRs)

QCDRs are third-party intermediaries that help clinicians report under MIPS, and they have proven to be an excellent way to collect data and report quality measures. ACEP developed its own QCDR, the Clinical Emergency Data Registry (CEDR), offering 25 EM specific measures and 22 QPP measures spanning five domains of care.⁵ QCDR measure owners invest significant resources into measure development, data collection, and validation. Additionally, QCDR measure owners develop these measures for use beyond MIPS reporting (e.g., research, guideline development, quality improvement, etc.). Section 1848(q)(5)(B)(ii)(I) of the Social Security Act, as added by Section 101 of MACRA requires HHS to encourage the use of QCDRs to report quality measures under MIPS. In line with this statutory requirement, ACEP has urged CMS to continue refining the QCDR option under MIPS to streamline the self-nomination process and provide better incentives for organizations, including medical associations such as ours, to continue to invest in their QCDRs and develop new, meaningful measures for specialists to use for MIPS reporting and other clinical and research purposes. Conversely, CMS should refrain from finalizing proposals that would impose significant and unreasonable burdens on QCDRs.

In general, ACEP believes that CMS should do more to promote the use of clinical data registries. A number of challenges and burdens limiting the uptake of QCDRs persist. For CEDR, the biggest challenge has been garnering the cooperation of hospitals on behalf of our clinician client base. Hospitals have no incentive to build or maintain data feeds to serve their contacted clinicians. In fact, a substantial number of emergency physicians that use CEDR to report quality measures are unable to receive any data from their hospitals. Without these data elements, the quality measures cannot be fully calculated and scored. Hospitals may claim that they cannot share the data for privacy and security purposes, but there are no regulations that impede hospitals from doing so. Thus, these hospital-based clinicians may also need to rely on the MIPS facility-based scoring option unless CMS takes more concrete going forward to help improve data exchange between hospital EHRs and registries – however, CMS decided to eliminate the facility-based scoring option under MIPS in 2022. In addition, hospitals often charge clinician groups exorbitant fees to build these data feeds. We have urged CMS to consider requiring hospitals to share data with hospital-based clinician groups. Congress should consider legislation to create safe harbors and reduce other barriers to facilitate the transfer of data between hospitals and clinical data registries.

Further, as emergency physicians strive to provide high-quality, objective, and evidence-based medicine, we should ensure clinician-led registries have access to Medicare claims data. These data are critical in tracking patient outcomes over time, expanding the ability to assess the safety and effectiveness of care, and providing information necessary to assess the cost of delivered care. We urge Congress to consider H.R.5394, the Meaningful Access to Federal Health Plan Claims Data Act of 2021, to allow clinician-led clinical data registries to access to these data in the effort to ensure better patient outcomes and health care affordability.

Another major ongoing issue for specialists is not being able to report on measures that are meaningful to them. Emergency physicians have experienced this problem in the past, and that is specifically why ACEP developed CEDR. Through CEDR, ACEP reduces the burden for our members and makes MIPS reporting a meaningful experience for them. We strive to make reporting as integrated with our members' clinical workflow as possible and constantly work on improving their experiences and refining and updating our measures so that they find value in reporting them. We have found that if our members can report on measures that are truly clinically relevant, they become more engaged in the process of quality improvement. For each measure we develop, a Technical Expert Panel comprised of clinical, measurement, and informatics experts in the field of emergency medicine is assembled, and several criteria are considered when designing a measure, including each measure's impact on emergency medicine, as well as whether the measures are scientifically acceptable, actionable at the specified level of measurement, feasible, reliable, and valid. Through our work and partnership with CMS, we are proud to have been a certified QCDR and have helped tens of thousands of emergency physicians participate successfully in MIPS.

With respect to QCDR measure approval requirements, while testing measures and ensuring their validity is critical, we believe that the QCDR testing requirements are stringent, place a significant burden on QCDRs, and make it

⁵ <https://www.acep.org/cedr/>

difficult for some smaller QCDRs to continue participating in the MIPS program. We also believe that, because the COVID-19 extreme and uncontrollable circumstances exception policy decreased the number of groups reporting to MIPS via QCDRs, CMS should only require face validity for the first two MIPS payment years for which the measures are approved or until two years after the end of the COVID-19 PHE, whichever is later. We also suggest that QCDR statisticians familiar with sample sizes and populations should decide the level of testing (clinician, facility, or group) required. We have further requested that CMS also delay the testing requirements for measures in MVPs. The development and testing process for measures is a lengthy and costly process and will inhibit the ability of new measures to be incorporated into MVPs.

Extend the \$500 Million Exceptional Performance Bonus

ACEP opposes the application of budget neutrality in Medicare physician payment, including MIPS payment adjustments. Budget neutrality in MIPS means penalizing small and independent practices, as these practices tend to receive lower overall MIPS score and their penalties are used to fund incentives for large health systems that have the staff and technological resources to manage and report metrics to CMS. The continuation of the \$500 million exceptional performance bonus is crucial to eliminating the need for budget neutrality within the MIPS program.

Provide CMS flexibility to set performance thresholds based on data

CMS is required by law to set the MIPS performance threshold at the mean or median of the performance score from a prior performance period. Since many large systems are able to receive high scores, the mean or median has been high overall. CMS has used the lowest possible score, 75 points, which is based on 2017 performance. However, even this “low” score may be extremely difficult for small and independent practices to obtain.

CMS, as opposed to a statutorily mandated threshold, is in a better position to determine each year whether physicians are ready to move to an increased performance threshold given that the Agency has access to all the previous year’s performance data and can adjust based on unforeseen circumstances, such as the COVID-19 pandemic. CMS may also decide to establish different thresholds for small and large practices.

This flexibility is especially important as the COVID-19 pandemic has substantially disrupted MIPS implementation, and the program was largely paused between 2019 until 2022. When MIPS requirements ramp up in full in 2023, CMS estimates one-third of physicians will receive a MIPS financial penalty averaging -1.64 percent. These financial penalties will not be attributable to a drop in the quality of care or higher costs of care in 2023 versus 2022, but rather due to the lapse of COVID-19 flexibilities and increase in the reporting requirements in a zero-sum game. Congress must act now to give CMS the authority to set the MIPS performance threshold, which is the benchmark for avoiding a penalty, based on the current program data and circumstances as physicians emerge from a once-in-a-century pandemic to high inflation and a staffing crisis.

Recommended Changes to MVPs

To encourage participation in MVPs, ACEP recommends the following changes to the MVP structure:

Create More Incentives for Participating in MVPs

ACEP believes there should be additional incentives for initially participating in an MVP over traditional MIPS. Although we hope that participating in the emergency medicine MVP in 2023 will reduce administrative burden for emergency physicians and allow them to focus on specific quality measures and activities that improve the quality of care they deliver, we also think that many emergency physicians may be hesitant to make any changes to their reporting patterns. ACEP recommends that CMS include at least a five-point bonus for participating in an MVP initially. While we understand that CMS may receive pushback at a later date if and when the agency decides to eliminate such a bonus, we truly believe that an incentive is necessary to maximize participation in MVPs at the start.

In addition to establishing a participation incentive bonus, clinicians who participate in MVPs should also be held harmless from downside risk for at least the first two years of participation while they gain familiarity with reporting the defined measures within the MVP. While the scoring rules for MVPs are slightly more advantageous than they are for MIPS (for example, clinicians are only scored on four quality measures instead of six), they have fewer options overall and are not able to choose from a broad range of quality measures and improvement activities. Under traditional MIPS, clinicians report on as many quality measures as possible (10-15 measures), with the understanding that CMS will score the top six highest performing measures. If these clinicians were to report under the Adopting Best Practices and Promoting Patient Safety within the Emergency Medicine MVP, they would only be able to report up to nine measures and would be scored on the top four. Therefore, even though clinicians are scored on fewer measures if they choose to report under the MVP, the chances of them receiving high scores on their selected measures may actually be lower.

Eliminate the Foundational Layer

CMS should also eliminate the foundational layer of population-based measures included in each MVP. Overall, ACEP believes that measures included in MVPs should be those that have been developed by specialty societies to ensure they are meaningful to a physician's particular practice and patients, and measure things that are actually under the control of the physician. As hospital-based clinicians, we are concerned about the measure reliability and applicability, case size, attribution, risk adjustment, application at the clinician or group level, and degree of actionable feedback for improvements. Further, many of the existing population claims measures have not been tested at the physician level, are based on a retrospective analysis of claims, and do not provide sufficiently granular information for physicians to make improvements in practice. Physicians do not treat a defined population, but rather treat patients as individuals tailored to their specific needs.

Recommended Changes to Advanced APMs

Under MACRA, eligible clinicians who become Qualifying APM Participants (QPs) were eligible for a five percent APM Incentive Payment. However, after performance year 2022 (with a corresponding payment year of 2024) there is no further statutory authority for this bonus. In performance year 2023 (payment year 2025), statute does not provide for any type of incentive for eligible clinicians who become QPs. Beginning in 2026, there is a separate conversion factor update for clinicians who participate in MIPS and those who are QPs. The conversion factor update for QPs is 0.75 percent, and the update for non-QP MIPS clinicians is 0.25 percent. After 2026, CMS believes that clinicians who participate in MIPS and receive a positive MIPS adjustment (in addition to the general 0.25 percent conversion factor adjustment they will receive) may actually receive a *higher* overall payment under the PFS than those who participate in Advanced APMs and only receive a 0.75 percent conversion factor increase.

We share CMS' concern that this may incentivize more clinicians to participate in MIPS than Advanced APMs but reiterate that many specialists like emergency physicians simply have no opportunity to participate in Advanced APMs. This basic lack of fairness to specialists who had no reasonable chance to qualify for the now-expired five percent APM incentive payment once again highlights one of MACRA's key underlying flaws, in that significant portions of the clinician workforce are precluded from collaborating in the transition to a value-based health care system. Congress should prioritize extending the five percent bonus for participation in Advanced APMs.

Extending the five percent bonus would also create a better incentive for large health care systems already participating in Advanced APMs to continue doing so instead of potentially reverting back to the MIPS program. Since these organizations have more staff and technical resources to manage and reports metrics to CMS, they tend to score much better than small and independent practices in MIPS. If all of these large organizations believe that MIPS is more financially viable than Advanced APMs and therefore stop participating in Advanced APMs, then MIPS scores will become heavily skewed and only these entities will receive positive payment adjustments at the expense of small and independent practices. This trend will not necessarily result in an increase in quality or a decrease in costs – the goal of MIPS – but may actually exacerbate negative health outcomes since smaller practices that care for underserved populations may wind up receiving downward payment adjustments.

Additional Recommendation: Create Incentives to Reduce ED Boarding

ED “boarding,” a scenario where patients are kept in the ED for extended periods of time due to a lack of available inpatient beds or space in other facilities where they can be transferred, is a longstanding challenge for EDs but is now at crisis levels across the country, with many hospitals near or at their breaking point. Overcrowding and boarding are not failures of the ED; rather, they are symptoms of larger systemic issues that must be addressed to eliminate bottlenecks in health care delivery and reduce the burden on the already-strained health care safety net. While the causes of ED boarding are multifactorial, growing staffing shortages throughout the health care system have recently brought this issue to a critical point, and the resulting added stress and burnout are leading to an exodus of physicians and nurses – further exacerbating the crisis and spiraling the system towards a very real risk of collapse. As you know, these staffing shortages are also not limited to just the hospital setting, as inpatient units feel the direct impact of staffing challenges in skilled nursing facilities (SNFs) and long-term care facilities (LTCFs). Additionally, psychiatric boarding issues worsen each day due to a severe lack of available psychiatric beds outside of acute care hospitals.

Efforts to address the pervasive issue of boarding are not only necessary to ensure the continued health and availability of the health care safety net but will also provide downstream benefits throughout the entire health care system. MIPS, MVPs, and APMs alike could all be improved by implementing incentives to reward hospitals and physicians for addressing boarding through safe discharge and coordination of post-discharge care. To improve quality and reduce costs, we urge Congress to consider these proposed enhancements:

- Hold physicians accountable for quality and cost during and after an ED visit for a pre-determined period;
- Focus on services provided to populations with moderately complex conditions *and* high ED visit rates;
- Center around the disposition to admission, observation care, or the home;
- Reward efficient treatment and effective post-acute care coordination;
- Harmonize with other value-based models to allow rapid adoption in organizations already engaged in APMs; and,
- Incorporate relevant quality measures, including those related to appropriate disposition and post-ED visit events (e.g., return to ED, readmission, and death).