American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

January 16, 2026

The Honorable John Joyce, M.D.
2102 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Kim Schrier, M.D.
1110 Longworth House Office Building
Washington, D.C. 20215

Dear Dr. Joyce and Dr. Schrier,

On behalf of the American College of Emergency Physicians (ACEP) and our nearly 40,000 members, thank you for the opportunity to provide our feedback on your request for input on modernizing the Medicare Access and CHIP Reauthorization Act (MACRA; P.L. 114-10). We deeply appreciate this bipartisan effort by the GOP Doctors Caucus and the Congressional Doctors Caucus and thank you for your thoughtful consideration of policy proposals needed to modernize and stabilize the Medicare physician payment system.

We recognize that you and your staff are well-versed in the many challenges facing physicians and are deeply familiar with the concerns raised by the physician community, whether primary or specialty care. ACEP strongly supports the broader calls for fundamental stability in the Medicare physician payment system, including the need for an inflationary update based upon the Medicare Economic Index (MEI), improvements and updates to the Physician Fee Schedule's budget neutrality rules to mitigate year-to-year fluctuations in the conversion factor, and necessary improvements to the Medicare and CHIP Reauthorization Act of 2015 (MACRA) to assist in the transition toward more value-based payment models.

Our responses to your questions follow below:

1. **What legislative reforms are most needed to ensure future CMMI models deliver real improvements in cost and quality, while also ensuring successful scaling of innovations?**

   In addition to ensuring future CMMI models deliver real improvements in cost and quality while ensuring successful scaling of innovations, we urge Congress to consider a range of options to examine why specialists, including emergency physicians, have largely been precluded from participating in APMs.

   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.

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ACEP encourages Congress to consider legislative options including giving more weight or authority to recommendations made by the Physician Payment Technical Advisory Committee (PTAC); mandating that CMMI implement new models that have been recommended for adoption by the Secretary of the Department of Health and Human Services (HHS); or, at minimum, ensuring greater transparency by requiring CMMI to report to Congress why models that have been approved or recommended for adoption have not been implemented (such a report should be retroactive to encompass all models that have already gone through this process). We also urge Congress to exercise its critical oversight role to examine why emergency physicians and other specialists have largely been precluded from participating in APMs.

For context, 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 Azar responded[1] 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.

[1] https://downloads.cms.gov/files/ptac-hhssecresponse-sep18-dec18.pdf

ACEP has repeatedly raised our concerns with CMS that the agency is not doing enough to engage emergency physicians in value-based payment initiatives. For example, in our response to the CY 2026 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.

At this point, with little action from CMS on the AUCM, we are working with other payers beyond Medicare to try to advance the model's core principles – including Medicaid and private payers. As these payers continue to move away from traditional fee-for-service (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 payer APMs will be different from the AUCM depending on the specifics and needs of the targeted patient population.

2. **If MIPS were to be reformed or replaced entirely, what would a new physician-led quality program look like? How can we ensure a new program reduces administrative burdens and is applicable to all types of clinicians in all settings, while focusing meaningfully on real outcomes.**

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:

- 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 included in the first batch of MVPs starting in 2023. While we appreciate the implementation of this Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP, we are generally concerned that based upon the reporting trends from its first performance year of 2023, there is limited uptake; likely as there are still not sufficient incentives to encourage clinicians to report through this MVP. Clinicians who report MVP data also have the option of reporting through Traditional MIPS, and CMS takes the highest score. Based on the first year of data, not only did only a small number of clinicians report through MVPs, but most who did also chose to report Traditional MIPS. These clinicians received a higher score overall in Traditional MIPS than in MVPs. For the emergency medicine MVP, 2,912 clinicians registered to report the MVP and 1,112 reported MVP data--but only 45 clinicians received a final score from the MVP in the 2023 performance year. It is still too early to tell whether participation will increase and whether the MVP approach is a viable pathway for MIPS going forward.

There are some structural flaws within MVPs that may be leading to low participation rates. 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 – and since clinicians are generally performing better in Traditional MIPS than MVPs anyway, it may not be worthwhile for clinicians to spend additional time and effort to report to an MVP.

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.

As it stands, MIPS is currently set up for larger groups to perform well and may be a more attractive and financially viable option as there is less risk, which suggests that there should be better incentives to encourage larger groups to participate in Advanced APMs. And while MIPS is burdensome, the development of quality measures requires significant effort, time, and resources, and we do not want those to simply go away. Qualified clinical data registry (QCDR) measures should still be used – they have been refined and maintained, are specialty-specific, and have been developed for the sole purpose of improving care for patients seen by such specialists.

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 dozens of EM-specific measures and QPP measures spanning five domains of care.[2] 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)(l) 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, **and we strongly urge the Committee to ensure that registries like CEDR can continue to succeed and be developed further.**

To address the broader underlying issues with MIPS, ACEP offers the following recommendations to improve the program:

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-led QCDR should be qualified as fully achieving all points for the Promoting Interoperability

[2] https://www.acep.org/cedr/

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 to be 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 an EM cost measure. The measure includes elements of ACEP's proposed APM, the AUCM, and the emergency medicine MVP. The final EM episode-based cost measure was incorporated into MIPS in CY 2024. However, even with an EM cost measure, we are still concerned about emergency physicians' ability to understand their performance on this measure and make improvements year-over-year.

Therefore, 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)

Again, ACEP believes that CMS should do more to promote the use of clinical data registries, and we urge the Committee to do the same as you consider proposals to modify MIPS. 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 steps going forward to help improve data exchange between hospital EHRs and registries. In addition, hospitals often charge clinicians 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. ACEP encourages Congress 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 difficult for some smaller QCDRs to continue participating in the MIPS program. The development and testing process for measures is a lengthy and costly process, and these requirements inhibit the ability of new measures to be incorporated into MVPs.

Eliminate Budget Neutrality Requirement in MIPS

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. However, even these higher performing health systems do not receive much of an incentive under the program. With the notable exception of performance year 2022/payment year 2024, MIPS performance adjustments have been relatively small, since most clinicians have either claimed an exception or surpassed the performance threshold. In fact, final payment adjustments for performance year 2024/payment year 2026 were just made available to clinicians, and the maximum positive adjustment (for a score of 100%) was only 1.05%, the lowest of any year to date.

<u>Recommended Changes to MVPs</u>

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 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.

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's 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 5% APM Incentive Payment through performance year 2022/payment year 2024. This bonus was extended multiple times at lower rates. 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.

We were disappointed that emergency physicians never had the opportunity to take advantage of the full 5% bonus. This basic lack of fairness to emergency physicians and other specialists once again highlights one of MACRA's key underlying flaws. Significant portions of the clinician workforce are precluded from collaborating in the transition to a value-based health care system. Congress should revisit providing greater APM incentives going forward for participation in Advanced APMs.

Additional Recommendation: Create Incentives to Reduce ED Boarding

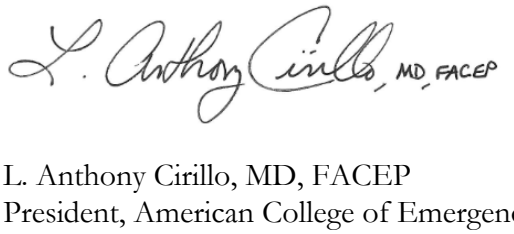
ED "boarding," a scenario where patients are kept in the ED for extended periods of time due to a lack of available inpatient beds or space in other facilities where they can be transferred, is a longstanding challenge for EDs but is now at crisis levels across the country, with many hospitals near or 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).

Once again, thank you for the opportunity to share our response to your request for input on MACRA modernization. As you develop policy proposals to address the challenges and questions you have outlined, we ask you to take special consideration on how the unique nature of emergency medicine can be better integrated into a modernized Medicare program. We look forward to continuing to work with you and your staff as you advance these critical efforts to improve the Medicare physician payment system and provide much needed stability and certainty for physicians and beneficiaries alike. Should you have any questions, please do not hesitate to reach out to Ryan McBride, ACEP Congressional Affairs Director, at rmcbride@acep.org.

Sincerely,



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