American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

September 12, 2025 **RE: CMS-1832-P**

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program

Dear Administrator Oz:

On behalf of our nearly 40,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to comment on the Calendar Year (CY) 2026 Medicare Physician Fee Schedule (PFS) and Quality Payment Program (QPP) Proposed Rule, as many of the proposed policies have a significant impact on our members and the patients we serve. A summary of our comments follows, with each section linked to our more in-depth comments that begin on page 9.

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Executive Summary of Comments

The Physician Fee Schedule

- Physician Fee Schedule (PFS) Conversion Factor: In this proposed rule, the Centers for Medicare & Medicaid Services (CMS) proposes CY 2026 physician fee schedule (PFS) conversion factors (CFs) of $33.5875 for physicians who meet certain participation thresholds in Advanced Alternative Payment Models (APMs) and $33.4209 for other clinicians. These CF amounts represent increases of 3.8% and 3.3%, respectively, from the final CY 2025 CF of $32.3465. Most emergency physicians will receive the lower CF since they do not participate in Advanced APMs. The majority of the increase in the CFs for CY 2026 is due to the one-time payment increase provided in the One Big Beautiful Bill Act (OBBBA). However, CMS has introduced overarching payment policies, including a new efficiency adjustment and a reduction to the indirect practice expense for facility-based services, which will lead to large discrepancies in payment among different physicians with some receiving overall payment increases and others payment decreases. Congress, through the OBBBA, intended to create some stability to Medicare physician payments after five straight years of CF cuts, but CMS' proposals could potentially undermine that goal.

ACEP urges CMS not to adopt these policies, especially without permanent reform to the PFS that addresses the underlying payment challenges of the fee schedule. Without needed statutory changes, these changes will further destabilize physician reimbursement.

- **Efficiency Adjustment:** CMS believes that non-time-based services, such as those describing procedures, radiology services, and diagnostic tests, should become more efficient as they become more common, professionals gain more experience, technology improves, and other operational improvements are implemented. CMS therefore proposes a 2.5 percent efficiency adjustment to the work relative value units (RVUs) and the intra-service physician time for non-time-based services. ACEP appreciates CMS' goal of ensuring that PFS valuations appropriately reflect changes in resource use over time. Accounting for such changes—when they occur—is important to maintaining a sustainable payment system for both patients and the Medicare program. However, we are concerned that the proposed across-the-board methodology does not differentiate between services that can realize these efficiencies and those that cannot, or that have already undergone recent revaluation through existing processes. We also disagree with CMS's assumption that improvements in technology directly reduce the time it takes to conduct specific services and interpret results. **ACEP therefore strongly urges CMS not to finalize this policy.** If the agency proceeds with an efficiency adjustment, it should at least refine its approach by incorporating service-specific analysis and exempting codes that have been recently reviewed. The agency should also then delay implementation by at least one year to allow specialty societies to provide input on where efficiencies are achievable and where the nature of the service precludes such gains.

- **Determination of Practice Expense RVUs:** Beginning in CY 2026, CMS proposes to reduce the indirect PE RVUs in the facility setting to half the amount used in the non-facility setting. ACEP has significant concerns about the proposal. CMS's proposal does not appropriately take into account the fact that groups that practice primarily in facilities have different types of financial and contractual arrangements with those facilities. Many emergency physicians are not employed by hospitals, but instead provide services in hospitals through contracts for their professional services. These physicians operate independently and therefore have their own set of operating expenses. ***ACEP therefore urges CMS not to finalize the proposal.*** We also believe that the policy would have a disproportionate impact on emergency physicians who mainly perform evaluation and management (E/M) services in the facility-setting. While many other clinicians provide E/M services in non-facility settings (or a mixture of facility and non-facility settings), emergency physicians exclusively provide emergency department (ED) E/M services in the facility-setting. As well, CMS itself acknowledges in this rule[1] that facilities may incur higher overhead costs because they must be equipped and able to furnish services 24 hours a day and 7 days per week under the Emergency Medical Treatment and Labor Act (EMTALA). Accordingly, ***while we strongly urge CMS not to finalize the proposed practice expense facility policy, if the agency proceeds, we respectfully request that ED E/M services be excluded from its application in the facility setting.*** Should such an exclusion not be finalized***, we encourage CMS to consider a more refined policy that would appropriately account for practices that operate independently from hospitals and have their own set of operating expenses and overhead costs.*** Since CMS may need to collect additional information to create such a refined policy, we believe it would be prudent for CMS to delay implementation of any such policy until this more comprehensive analysis is completed.

[1] Section 4. Valuation of Specific Codes for CY 2026, https://www.federalregister.gov/d/2025-13271/p-620

- **E/M Visit Complexity Add-on:** CMS also proposes to expand the use of Healthcare Common Procedure Coding System (HCPCS) code G2211 to be billed as an add-on code with the home or residence evaluation and management visits code family. ACEP has previously expressed concern regarding the implementation of the complexity add-on code. Review of 2024 Medicare utilization data indicates that the Biden Administration severely overestimated utilization of this code, dramatically impacting the Medicare conversion factor under budget neutrality. As the agency continues to explore expansion and use of this code, ACEP looks forward to increased transparency on methodology and more accurate utilization estimates of G2211 based upon actual claims data.

- **Payment for Services in Urgent Care Centers:** In the CY 2025 PFS proposed rule, CMS sought public comment on how urgent care centers could serve as an appropriate setting to treat patients with non-emergent urgent care needs and could play a role in addressing some of the capacity issues in EDs. In this rule, CMS follows up on that comment solicitation by seeking input on whether separate coding and payment is needed for E/M visits furnished at urgent care centers— especially "enhanced" urgent care centers that offer specific diagnostic and therapeutic services and operate outside typical business hours. ACEP believes that enhanced urgent care centers play a role in providing care for patients who have urgent, but non-emergent conditions. Therefore, we support payment policies that would incentivize the creation of urgent care centers with these advanced capabilities and extended hours. As CMS considers adopting new payments for enhanced urgent care centers, we also believe that it is essential to preserve the fundamental right for patients to seek emergency care when they think they are experiencing a medical emergency. CMS should also consider how best to educate beneficiaries about when they should seek emergency treatment, their right to do so, and when another setting such as an urgent care center may be appropriate to address their health care needs. Finally, if individuals have questions about where to go to seek treatment, emergency clinicians, especially emergency physicians, are the best suited to help patients understand whether their symptoms could be signs of a medical emergency.

- **Payment for Medicare Telehealth Services**

    - ***Changes to the Medicare Telehealth Services List and Review Process:*** CMS is proposing to simplify the telehealth list review process by removing the distinction between provisional and permanent services and focusing our review on whether the service can be furnished using an interactive, two-way audio-video telecommunications system. ACEP supports this proposal and appreciates CMS' assertion that the complex professional judgment of the physician or practitioner is sufficient to ensure a service can be safely furnished via telehealth and that the service will be clinically beneficial to the beneficiary. As we previously commented, telehealth is simply a means by which health care providers deliver services—an extremely useful tool that providers can employ to expand access to care. We had requested that CMS eliminate the unnecessary, burdensome multistep approach to adding services to the Medicare Telehealth Services List and instead automatically permanently add services covered by Medicare that can be delivered via telehealth to the Medicare Telehealth Services List and thank CMS for adopting our recommendation. With respect to the emergency medicine codes specifically, ACEP supports keeping these emergency medicine codes on the Medicare Telehealth Services List.

    - ***Direct Supervision Via Use of Two-Way Audio/Video Communications Technology:*** During the COVID-19 public health emergency (PHE), CMS temporarily modified the direct supervision requirement to allow for the virtual presence of the supervising physician to be considered "immediately available" through virtual presence using interactive audio/video real-time

communications technology. In response to requests and support to extend this policy permanently, CMS is proposing to continue to build on this incremental approach to allow certain services to be furnished under direct supervision that allows "immediate availability" of the supervising practitioner using audio/video real-time communications technology (excluding audio-only). ACEP believes the direct supervision flexibility has been helpful over the last few years and is therefore supportive of the proposed permanency of the policy. Finalizing this proposal would extend the reach of board-certified or board-eligible emergency physicians to areas of the country where there may not be any such physicians available.

- ***Proposed Changes to Teaching Physicians' Billing for Services Involving Residents with Virtual Presence:*** In the CY 2025 PFS final rule, CMS finalized a temporary policy that allowed the teaching physician to have a virtual presence in all teaching settings, but only in clinical instances when the service was furnished virtually. This permitted teaching physicians to have a virtual presence during the key portion of the Medicare telehealth service for which payment was sought, through audio/video real-time communications technology, in all residency training locations through December 31, 2024 (extended through December 31, 2025, via telehealth extenders). However, CMS is now proposing not to extend this policy and instead revert to pre-PHE policy, which would maintain the rural exception established in the CY 2021 PFS final rule recognizing the unique challenges and importance of expanding medical education opportunities in rural settings. ACEP understands CMS's rationale for this proposal but does believe that teaching physicians have the ability to provide appropriate oversight over residents when services are delivered virtually in all residency training locations.

- **Enhanced Care Management:**
  - ***Integrating Behavioral Health into Advanced Primary Care Management (APCM):*** CMS proposes to create optional add-on codes for APCM services that would facilitate providing complementary behavioral health integration services. ACEP supports CMS's efforts to improve care and outcomes for patients with behavioral health conditions. While emergency physicians will likely not bill these add-on codes, we believe that it is important for CMS to address the unmet need of patients with these conditions who may end up in the ED. Due to the fragmented nature of mental health care infrastructure in the U.S., persistent lack of sufficient resources, and longstanding shortages of mental and behavioral health professionals, far too many Americans have limited options for the longer-term follow-up treatment they need and deserve. These health care resource challenges contribute to long ED wait times and aggravate "boarding" issues, 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 to which they could be transferred. Reducing boarding and mitigating its effects on all patients is critical in improving patient outcomes and patients' overall health, especially for those with mental or behavioral health needs. Across the country, communities have adopted innovative alternative models to improve emergency psychiatric care and reduce psychiatric patient boarding, the goals of which can also be met by community-based crisis stabilization units. These innovative approaches have helped communities improve coordination of emergency psychiatric care, and they can serve as models for other communities to implement and build upon – through crisis stabilization units or otherwise – to help alleviate the overall load on the mental health care system.
  - ***Prevention and Management of Chronic Disease – Request for Information:*** ACEP agrees that we are experiencing a chronic disease epidemic in this country. The ED is the entry point to the health care system for millions of Americans and therefore we believe that we play an essential role in helping to address this epidemic. To help better manage care for patients with complex conditions who wind

up in the ED, ACEP believes that emergency physicians need to be integrated into APMs ACEP developed an APM called the Acute Unscheduled Care Model (AUCM) to help improve care coordination and the follow-up care that patients receive once they are discharged from the ED. The AUCM was highly recommended by a federal advisory committee called the Physician-Focused Payment Model Technical Advisory Committee (PTAC) and endorsed by the former HHS Secretary. However, ever since the former HHS Secretary, Alex Azar, endorsed the AUCM in 2019, we have been waiting on the CMS Innovation Center to adopt the model's framework. We look forward to continuing to work with CMS on the adoption of this model, as we strongly believe it is a key piece in helping to achieve the overall goal of better managing individuals with chronic diseases.

- **Ambulatory Specialty Model:** The CMS Innovation Center plans to launch a new mandatory, five-year APM, the Ambulatory Specialty Model (ASM), beginning January 1, 2027. Though emergency physicians would not be direct participants in the ASM, we continue to be concerned about mandatory participation in models. We believe that participation in all APMs, including ASM, should be voluntary. We also are concerned that CMS is using the Merit-based Incentive Payment System (MIPS) Value Pathway (MVP) framework as the basis for designing the model, as MVPs are a relatively new reporting pathway and participation in them thus far has been limited. CMS may want to wait until more robust participation data is available for MVPs before it designs a whole APM based off of this framework.

- **Medicare Shared Savings Program (MSSP):** CMS continues to propose changes to advance MSSP's long-term sustainability and encourage participation from a broader range of providers, including those serving underserved and rural populations. ACEP overall supports these proposals, as we believe that they will help increase participation in accountable care organizations (ACOs) and enable ACOs to focus more on underserved populations—an extremely important step towards helping to reduce disparities in health outcomes and better address the needs of patients with social risk factors. However, we note that not many emergency physicians directly participate in the MSSP. Going forward, we urge CMS to create additional incentives for specialists, like emergency physicians, to get engaged in the MSSP and other ACO initiatives.

The Quality Payment Program

Merit-Based Incentive Payment System (MIPS)

- **MIPS Performance Threshold:**. CMS proposes to maintain the 2025 MIPS performance threshold of 75 points not only in performance year 2026 but through performance year 2028. **ACEP strongly supports this proposal, as it provides more stability and predictability to the program. It would also help smaller physician practices and those located in rural areas avoid negative adjustments, as these practices may not have the resources necessary to perform as well in MIPS.**

- **Quality Performance Category***:* CMS proposes to update the benchmarking methodology for administrative claims quality measures to align with the benchmarking methodology for cost measures beginning with the CY 2025 performance period/2027 MIPS payment year. CMS also proposes further refinements to topped out measures by proposing to remove the scoring cap and adjust measure benchmarks for 19 measures in the CY 2026 performance period. These measures belong to specialty sets and MVPs with limited measure choice and in areas that lack measure development, which precludes meaningful participation. ACEP supports CMS's efforts to improve MIPS scoring issues, including those related to topped-out measures, and recommends that CMS finalize the proposals. With respect to the benchmarking methodology, we urge CMS to consider applying this methodology to all quality measures in addition to administrative claims quality measures. We believe that expanding the methodology to all quality measures

will encourage physicians to report more condition-specific measures. Further, we urge CMS to apply the topped out policy to all measures. Limiting it to a select set of measures adds complexity to the program, is subjective, and favors some specialties over others.

- **Cost Performance Category:**
  - ***Total Per Capita Cost (TPCC) Measure:*** CMS is proposing to modify the TPCC measure candidate event and attribution criteria for the TPCC measure. ACEP has expressed concern about this measure in the past and thanks CMS for taking active steps to address some of the underlying methodological issues with the measure. We urge CMS to finalize these proposed changes. However, even beyond these changes, we urge CMS going forward to address other fundamental flaws of the measure.
  - ***Proposal to Adopt a Two-Year Informational-Only Feedback Period for New MIPS Cost Measures:*** CMS is proposing a two-year informational-only feedback period for new cost measures beginning with the CY 2026 performance period. ACEP supports this proposal. Informational feedback would be helpful so that clinicians and groups can learn and understand how the new measures work. It would additionally be helpful if CMS could provide detailed information (perhaps at the encounter level) about the cost calculations and how they compare to benchmarks.

- **MIPS Value Pathways (MVPs):**
  - ***General Comments:*** ACEP continues to believe it may be premature to consider the mandatory transition to MVPs, as there has been limited uptake of the MVP based upon the reporting trends from the first year (the only year with available data). We believe that the primary reason why so few emergency physicians have reported the emergency medicine MVP is because there are not sufficient incentives in place that would encourage them to do so. Further, whilst we see the value of MVPs as a reporting option and acknowledge that broader participation in MVPs supports CMS' long-term goal to transition clinicians to participate in APMs, we have concerns about the ambiguous and dubious pathways that will transition clinicians from MVP participation to APM participation. There are several barriers for clinicians to participate in MVPs that are both perceived and actual, and both operational and financial. For many clinicians, these obstacles to MVP participation simply outweigh the benefits from reporting. We offer several suggestions in our comments for additional incentives that CMS could offer to encourage clinicians to participate in MVPs.
  - ***Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP:*** CMS is proposing to remove one quality measure and remove three improvement activities from the "Adopting Best Practices and Promoting Patient Safety within Emergency Medicine" MVP. ACEP understands the rationale for these changes and appreciates CMS's efforts to update this MVP appropriately over time.
  - ***Subgroup Reporting:*** CMS introduces new subgrouping reporting requirements to help transition to MVP reporting. ACEP is concerned that CMS is continuing to move forward with making subgroup reporting mandatory for multispecialty groups (that are not small groups) and believes that subgroup reporting should be optional for all groups for the foreseeable future. We are concerned with how CMS defines subgroups, and we do not think that subgroup composition should be based on specialty, geographic location, size, or any other factors.
  - ***Core Elements Request for Information (RFI):*** CMS is concerned that MVP reporting may not produce sufficient comparative performance data on standardized measures to support patient choice of care. Thus, CMS is considering a policy to require an MVP Participant to select one quality measure

from a subset of quality measures in each MVP, referred to as "Core Elements," to ensure more direct comparability by requiring the reporting of a subset of measures within an MVP that are meaningful for clinicians and patients. Should CMS proceed with such a proposal in the future, ACEP urges CMS to continue to provide clinicians with the opportunity to choose the measures that are most relevant to their practice, including both qualified clinical data registry (QCDR) measures and QPP measures. Clinicians should also have the opportunity to note to CMS, through an attestation, that no core elements apply to them. We also recommend that CMS solicit input from physicians regarding the measures they believe are most important to use and whether current reporting options are too limited, and then take steps to ensure there are an adequate number of reporting options for those measures that physicians feel are most appropriate to report.

  - ***Medicare Procedural Codes RFI:*** CMS is considering utilizing Medicare procedural codes to further facilitate more MVP specialty reporting and to encourage and potentially require specialists to report an MVP applicable to their specialty or scope of care by requiring clinicians to report a specific MVP based on the procedural codes that they bill. ACEP believes that clinicians should be allowed to choose their MVP based on applicable measures and relevance to their specialty. This means that sufficient MVPs need to be available for clinicians to choose the best MVP.
  - ***Third-Party Intermediaries Support of MVPs:*** CMS proposes to allow QCDRs and qualified registries additional time to fully support finalized MVPs. Currently, QCDRs and qualified registries must immediately support MVPs that are applicable to their customers once an MVP is approved. CMS proposes that, beginning with the CY 2026 performance period/2028 MIPS payment year, QCDRs and qualified registries can have a one-year grace period after a new MVP is finalized before they must be able to support it. ACEP supports this proposal, but overall, we continue to believe that CMS should do more to promote the use of QCDRs. A number of challenges and burdens limiting the uptake of QCDRs persist.

- **Well-being and Nutrition Measures Request for Information (RFI):** CMS is seeking input on well-being and nutrition measures for future years in the QPP that assess overall health, happiness, and satisfaction in life that could include aspects of emotional well-being, social connections, purpose, and fulfillment. ACEP agrees that preventive care, nutrition, and well-being can improve health outcomes. However, we want to make clear that quality measures cannot be developed within a short timeframe. In addition, CMS does not directly support or fund the development of new measures, but relies on outside entities, including clinical data registries, to develop and test new measures. However, despite CMS relying on outside entities to conduct this work, the requirements placed on these clinical registries around developing measures lead to a time-consuming and expensive process that can significantly inhibit the development of new measures in priority areas—such as nutrition and well-being. CMS must alleviate some of these burdensome and cost-prohibitive requirements.

- ***Toward Digital Quality Measurement in CMS Quality Programs – Request for Information:*** In conjunction with the transition to digital quality measurement for CMS programs, CMS issued a RFI to gather input to inform the ongoing strategy to implement a fully digital quality landscape, including potential challenges to adhering to the Fast Healthcare Interoperability Resources (FHIR) data standard. While ACEP supports the overall goal of improving the exchange of information and using electronic and digital quality measures in CMS quality reporting programs, there are significant financial barriers which are making this objective difficult to achieve. From our members' perspective, electronic health record (EHR) vendors appear to be approaching the FHIR initiative as a strong revenue and profit opportunity. Initial fees and per-transaction fees vary and will be cost-prohibitive for most physician groups and hospitals with large patient

populations. Thus, CMS should put guardrails in place to prevent price gouging, which will then allow for more participants in FHIR implementation, fostering data harmonization and reducing reporting burden across entities.

- ***RFI Regarding Data Quality:*** CMS seeks comment on how to improve data quality. ACEP's QCDR, the Clinical Emergency Data Registry (CEDR), represents about 200 physician groups (about 170 currently active) to collect, analyze, and report MIPS on their behalf annually. Data acquisition is our biggest challenge, with legal issues being the most challenging aspect. CMS could markedly improve this process by working with hospitals and relevant QCDRs to develop a universal contract, and data use agreement that both parties would be required to accept upon appropriate request. In addition, it would be helpful if CMS would reiterate that hospitals are required to provide appropriate data to support their clinicians' MIPS reporting. Another data acquisition challenge occurs when a hospital changes EHRs. This is an infrequent occurrence, but invariably causes issues collecting data timely since such transitions occur throughout the year. It would be helpful if CMS would consider an extreme and uncontrollable circumstances (EUC) exception designed specifically for this issue. There are situations where such an EUC would need to be offered for two consecutive years due to timing of the change. CMS could require an attestation from the hospital to prevent inappropriate use.
- Query of Prescription Drug Monitoring Program (PDMP) Measure RFI: ACEP does not support changing the Query of PDMP measure from an attestation-based measure to a performance-based measure. We do not believe that shifting this measure to a performance-based construct will yield meaningful improvements in patient outcomes or tangible benefits for physicians and PDMPs can be useful sources of information, but they are not diagnostic or clinical instruments; they present prescription history and do not link patients to treatment.

Advanced APMs

- **Proposed Changes to QP Threshold Calculation:** To become a qualified participant (QP), clinicians must receive at least 75% of payments or see at least 50% of patients through an advanced APM. Given stakeholders' reported challenges meeting this statutorily mandated threshold, CMS proposes changes to better align with modern advanced APM designs. ACEP supports these proposals, but remains extremely concerned about the trajectory of the Advanced APM track of the Quality Payment Program. It is imperative that CMS make it a priority to create additional APM opportunities for emergency physicians and other specialists—or figure out how to modify current APMs in order to better engage specialists and allow them to actively participate. We also encourage CMS to work with Congress to ensure that there are better incentives for participating in an Advanced APM.

The Physician Fee Schedule

Physician Fee Schedule (PFS) Conversion Factor

In this proposed rule, the Centers for Medicare & Medicaid Services (CMS) proposes CY 2026 physician fee schedule (PFS) conversion factors (CFs) of $33.5875 for physicians who meet certain participation thresholds in Advanced Alternative Payment Models (APMs), and $33.4209 for other clinicians. These CF amounts represent increases of 3.8% and 3.3%, respectively, from the final CY 2025 CF of $32.3465. Most emergency physicians will receive the lower CF since they do not participate in Advanced APMs.

The proposed CF update is primarily based on three factors:

1. Statutory update in the Medicare Access and CHIP Reauthorization Act (MACRA): 0.25% for non-qualifying APM participants (QPs) and 0.75% for QPs
2. A 0.55% positive budget neutrality adjustment;
3. A 2.5% one-year payment increase from the One Big Beautiful Bill Act (OBBBA)

As indicated above, the majority of the increase in the CFs for CY 2026 is due to the one-time payment increase provided in the OBBBA. However, CMS has introduced overarching payment policies, including a new efficiency adjustment and a reduction to the indirect practice expense for facility-based services, that will lead to large discrepancies in payment among different physicians with some receiving overall payment increases and others payment decreases. Congress, through the OBBBA, intended to create some stability to Medicare physician payments after five straight years of CF cuts, but CMS' proposals in this rule could potentially undermine that goal. **ACEP urges CMS not to adopt these policies, especially without permanent reform to the PFS that addresses the underlying payment challenges of the fee schedule.** Without needed statutory changes, these changes will further destabilize physician reimbursement.

While emergency physicians may get a small increase in payment from the higher CFs, the increase will by no means make up for the year-after-year reductions in payment. An analysis conducted by ACEP found that ***Medicare payments have decreased by 29 percent when comparing Medicare payments to inflation*** between 2001 and 2024. In fact, despite the increases summarized above, the CY 2025 proposed CF is still 12% less than it was in 1998 when first established, despite the fact that costs have increased by 92% over the same time period.[2] Even the 2025 Medicare Trustees Report acknowledges that updates for physician reimbursement are not sufficient. The Trustees believe that, absent a change in the delivery system, access to Medicare-participating physicians will become a significant issue in the long term.[3] Given the fact that annual updates to physician payments are already not keeping up with the cost of providing physician services, adding further instability to the PFS through the new proposals would make it even more difficult for emergency medicine and a number of other physician specialties to continue providing care.

CMS must do everything within its authority to add stability to the PFS. We recognize that the complete resolution of this issue will require action by Congress, and we therefore urge the agency to work with Congress on a permanent fix to the broken Medicare payment system. We would also like to note that a small

[2] From July 1998 to July 2024, the CPI-U has increased from 163.2 to 314.540 (Sources: Bureau of Labor Statistics (https://www.bls.gov/cpi/tables/historical-cpi-u-201710.pdf, https://www.bls.gov/news.release/pdf/cpi.pdf)). The CPI-U for Medical Care grew at an even higher percentage, 149.7%, from 244.7 to 611.137 during the same timeframe (Consumer Price Index 1998 and CPI- U by Expenditure Category, 2024).

[3] The 2025 Medicare Trustees Report is available at: https://www.cms.gov/files/document/2025-medicare-trustees-report.pdf.

increase to Medicare reimbursement for emergency physicians and other emergency medicine health care professionals would nonetheless be offset by the ongoing sequestration cuts. Combined with these additional cuts, the low payment update will have rippling effects across the health care system and have a detrimental impact on access to care. For the safety and wellbeing of the American public, ***EVERY emergency physician and emergency physician group must be supported and protected to preserve the safety net on which millions of Americans rely.***

Efficiency Adjustment

CMS believes that non-time-based services, such as those describing procedures, radiology services, and diagnostic tests, should become more efficient as they become more common, professionals gain more experience, technology improves, and other operational improvements are implemented. CMS therefore proposes an efficiency adjustment to the work relative value units (RVUs) and the intra-service physician time for non-time-based services. To calculate the efficiency adjustment, CMS proposes adding the last five years of the Medicare Economic Index (MEI) productivity adjustment, which equals a 2.5 percent reduction. CMS proposes to update and apply this efficiency adjustment every three years. Under this schedule, the next efficiency adjustment after CY 2026 would be calculated and applied in CY 2029 PFS rulemaking, reflecting efficiency gains measured from 2027 through 2029.

ACEP appreciates CMS' goal of ensuring that PFS valuations appropriately reflect changes in resource use over time. Accounting for such changes—when they occur—is important to maintaining a sustainable payment system for both patients and the Medicare program. However, we are concerned that the proposed across-the-board methodology does not differentiate between services that can realize these efficiencies and those that cannot, or that have already undergone recent revaluation through existing processes. Applying a uniform 2.5 percent reduction every three years in perpetuity risks creating a downward payment spiral for certain services, without empirical evidence that further efficiencies are even achievable.

We also disagree with CMS's assumption that improvements in technology directly reduce the time it takes to conduct specific services and interpret results. Newer technologies, in some cases, lead to an increase in the interpretive complexity and demand placed upon the performing physician in the evaluation and treatment of patients. For example, while interoperable electronic health records provide valuable clinical information, they also require emergency physicians to sift through large volumes of linked medical data before making treatment decisions. A patient who once would have been assessed and treated based primarily on their reported history may now necessitate review of records from multiple prior encounters across several different providers, substantially increasing the time and cognitive effort required during an ED visit. Since work RVUs are a measure of both time and intensity, both these factors could increase, not decrease, as technology improves and new analytical techniques are employed.

ACEP strongly urges CMS not to finalize this policy. If the agency proceeds with an efficiency adjustment, it should at least refine its approach by incorporating service-specific analysis and exempting codes that have been recently reviewed. The agency should then also delay implementation by at least one year to allow specialty societies to provide input on where efficiencies are achievable and where the nature of the service precludes such gains. This would better align the policy with its intended purpose—to protect patient access to care—and avoid repeating the experience in other payment contexts where blunt payment shifts have unintentionally disrupted care delivery patterns.

Determination of PE RVUs

In the rule, CMS argues that because fewer physicians who primarily work in facilities still own their own practices, their indirect PE costs do not need to be the same as those physicians who work in non-facility settings. CMS therefore proposes revising the methodology for allocating indirect PE costs for facility-based services. Specifically, beginning in CY 2026, CMS proposes to reduce the indirect PE RVUs in the facility setting to half the amount used in the non-facility setting. CMS acknowledges that physicians practicing in facility settings may still incur indirect PE costs and seeks comment on several key issues, including the types and magnitude of indirect PE costs still incurred and attributable to physicians who practice in part or exclusively in a facility.

Groups that practice primarily in facilities have varying types of financial and contractual arrangements with those facilities. Many emergency physicians are not employed by hospitals, but instead provide services in hospitals as a group through contracts for their professional services. These physician groups operate independently and therefore have their own set of operating expenses. Applying a uniform 50 percent reduction to the indirect PE for all services provided in facility settings would especially not account for the variations in the sizes and structures and associated operating expenses of physician practices such as these. **ACEP therefore urges CMS not to finalize the proposal.**

The policy would also have a disproportionate impact on emergency physicians since they mainly perform evaluation and management (E/M) services in the facility setting. While many other clinicians and specialties provide E/M services in non-facility settings (or a mixture of facility and non-facility settings), emergency physicians exclusively provide ED E/M services in the facility setting. CMS also acknowledges in this rule[4] that facilities may incur higher overhead costs because they must be equipped and able to furnish services 24 hours a day and 7 days per week under the Emergency Medical Treatment and Labor Act (EMTALA). **ACEP appreciates CMS's recognition of the unique impact of EMTALA requirements on emergency departments. Accordingly, while we strongly urge CMS not to finalize the proposed practice expense facility policy, if the agency proceeds, we respectfully request that ED E/M services be excluded from its application in the facility setting.**

Should such an exclusion not be finalized, **we encourage CMS to consider a more refined policy that would appropriately account for practices that operate independently from hospitals and have their own set of operating expenses and overhead costs.** Since CMS may need to collect additional information to create such a refined policy, we believe it would be prudent for CMS to delay implementation of any such policy until this more comprehensive analysis is completed.

E/M Visit Complexity Add-on

CMS proposes to expand the use of Healthcare Common Procedure Coding System (HCPCS) code G2211 to be billed as an add-on code with the home or residence evaluation and management visits code family. This office/outpatient evaluation and management (O/O E/M) visit complexity add-on code "reflects the time, intensity, and PE resources involved when practitioners furnish the kinds of O/O E/M visit services that enable them to build longitudinal relationships with all patients (that is, not only those patients who have a chronic condition or single high-risk disease) and to address the majority of a patient's health care needs with consistency and continuity over longer periods of time." The agency states that home and residence E/M visits exhibit the longitudinal care developed from a trusting practitioner/patient relationship characteristics that the G2211 code represents.

[4] Section 4. Valuation of Specific Codes for CY 2026, https://www.federalregister.gov/d/2025-13271/p-620

In previous comment letters,[5] ACEP has expressed concern regarding the implementation of the complexity add-on code. Review of 2024 Medicare utilization data indicates that the Biden Administration severely overestimated utilization of this code, dramatically impacting the Medicare conversion factor under budget neutrality. As the agency continues to explore expansion and use of this code, ACEP looks forward to increased transparency on methodology and more accurate utilization estimates of G2211 based upon actual claims data. More accurate utilization assumptions will add more stability to the PFS over time.

Payment for Services in Urgent Care Centers

In the CY 2025 PFS proposed rule, CMS sought public comment on how urgent care centers could serve as an appropriate setting to treat patients with non-emergent urgent care needs and could play a role in addressing some of the capacity issues in EDs. In this rule, CMS follows up on that comment solicitation by seeking input on whether separate coding and payment is needed for E/M visits furnished at urgent care centers— especially "enhanced" urgent care centers that offer specific diagnostic and therapeutic services and operate outside typical business hours.

ACEP believes that enhanced urgent care centers play a role in providing care for patients who have urgent, but non-emergent conditions. Therefore, we support payment policies that would incentivize the creation of urgent care centers with these advanced capabilities and extended hours. Patients who know that they have a non-emergency medical condition, but do not know where to seek treatment, should go to an urgent care setting to receive care. Many times, patients with minor conditions have no viable alternative to seeking care, especially at nights and on weekends, then going to the ED. Many urgent care centers are closed after 8 pm and entirely on Sundays; if urgent care centers are available 24 hours a day, 7-days a week, they may be able to present a viable option for these patients rather than the ED.

As CMS considers adopting new payments for enhanced urgent care centers, we also believe that it is essential to preserve the fundamental right for patients to seek emergency care when they think they are experiencing a medical emergency. This right is embedded in our health care system through a series of legal protections, including the Prudent Layperson Standard (PLP). The PLP requires patients to be covered for emergency care based on their symptoms, not on the final diagnosis. Specifically, under the PLP, an emergency medical condition is defined as one "manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part."

For example, if a patient presented to the ED with chest pain, but it turned out to be gastric reflux or non-cardiac related, that service must be fully covered—since patients, under the PLP, were experiencing what they thought was an emergency medical condition. Emergency and non-emergency symptoms frequently overlap and in many cases emergency physicians do not know if a patient's symptoms require emergency treatment without first performing a medical examination and testing. People who believe they are having a medical emergency should not hesitate in seeking care in the ED, and fears that their health coverage (including Medicare) will refuse to cover such a visit should not be a contributing factor in their decision. ACEP has put out a resource, called "know when to go" that

[5] ACEP's comments on the CY 2025 PFS proposed rule are available at https://www.regulations.gov/comment/CMS-2024-0256-6176.

lists out some of the common symptoms that could be signs of a medical emergency and should trigger individuals to call 911 or seek immediate medical care. As CMS contemplates the role of urgent care centers, we would encourage CMS to consider how best to educate beneficiaries about when they should seek emergency treatment, their right to do so, and when another setting such as an urgent care center may be appropriate to address their health care needs.

Finally, if individuals have questions about where to go to seek treatment, emergency clinicians, especially emergency physicians, are the best suited to help patients understand whether their symptoms could be signs of a medical emergency. Emergency physicians are highly trained in evaluating and analyzing patients with acute, undifferentiated conditions and making quick determinations about the general severity of a patient's condition. As a result of this unique skill set, ACEP has also discussed opportunities for emergency physicians to work outside the four walls of the ED, including doing more telehealth and triage services and helping to staff urgent care centers and other facilities.

Payment for Medicare Telehealth Services Under Section 1834(m) of the Act

Changes to the Medicare Telehealth Services List and Review Process

In the CY 2024 PFS final rule, CMS created a new "provisional category" when considering whether to add, remove, or change the status of a service on the Medicare Telehealth Services List, along with a permanent category and established criteria for codes to be added to each category. If added to the provisional category, CMS did not specify how long it could remain there before being removed. CMS added all five ED E/M code levels 1-5 (CPT codes 99281-99285), the critical care codes, and the observation codes on the approved telehealth list.

In this year's proposed rule, CMS is proposing to simplify the telehealth list review process by removing Step 4 (Consider whether the service elements of the requested service map to the service elements of services on the list that has a permanent status described in previous final rulemaking) and Step 5 (Consider whether there is evidence of clinical benefit analogous to the clinical benefit of the in-person service when the patient, who is located at a telehealth originating site, receives a service furnished by a physician or practitioner located at a distant site using an interactive telecommunications system).

Additionally, CMS is proposing to simplify the Medicare Telehealth Services List review process by removing the distinction between provisional and permanent services and focusing our review on whether the service can be furnished using an interactive, two-way audio-video telecommunications system. Under this proposal, services on the Medicare Telehealth Services List would no longer be designated "permanent" or "provisional," and all services listed or added on the Medicare Telehealth Services List would be considered added on a permanent basis, including the ED E/M code levels 1-5 (CPT codes 99281-99285), the critical care codes, and the observation codes.

ACEP supports this proposal and appreciates CMS' assertion that the complex professional judgment of the physician or practitioner is sufficient to ensure a service can be safely furnished via telehealth and that the service will be clinically beneficial to the beneficiary. As we previously commented, telehealth is simply a means by which health care providers deliver services—an extremely useful tool that providers can employ to expand access to care. If a physician provides a specific high-quality service to a patient, as is already determined by its inclusion in Medicare coverage, we should expect it to be as effective and add as much clinical value regardless of whether it was delivered in-person or via telehealth. We had requested that CMS eliminate the unnecessary, burdensome multistep approach to adding services to the Medicare Telehealth Services List and instead automatically permanently add services covered by Medicare that can be delivered via telehealth to the Medicare Telehealth Services List and thank CMS for adopting our recommendation.

With respect to the emergency medicine codes specifically, ACEP supports keeping these emergency medicine codes on the Medicare Telehealth Services List. We have made great strides in the delivery of emergency telehealth services, enabling patients to get timely, personalized, high-quality care. Being able to provide these services remotely has also helped the nation's hospitals maintain the capacity they need to provide emergency care at all times. Further, the results from current innovative emergency telehealth initiatives suggest that having the ability to provide emergency and observation services remotely to Medicare beneficiaries improves care and lowers costs across the country, in both urban and rural areas. In general, studies have shown that physicians and patients are extremely satisfied with the care being provided through these models, and costs have decreased due to avoided ED visits and inpatient admissions.

Direct Supervision Via Use of Two-Way Audio/Video Communications Technology

Under Medicare Part B, certain types of services, including diagnostic tests and services incident to a physician's (or other practitioner's) professional services are required to be furnished under specific minimum levels of supervision by a physician or other practitioner, including "direct supervision" for various types of services. During the COVID-19 public health emergency (PHE), CMS temporarily modified the direct supervision requirement to allow for the virtual presence of the supervising physician to be considered "immediately available" through virtual presence using interactive audio/video real-time communications technology. Multiple PFS rules subsequently extended these policies, with the most recent extension through December 31, 2025.

In response to requests and support to extend this policy permanently, CMS is proposing to continue to build on this incremental approach to allow certain services to be furnished under direct supervision that allows "immediate availability" of the supervising practitioner using audio/video real-time communications technology (excluding audio-only).

ACEP believes the direct supervision flexibility has been helpful over the last few years and is therefore supportive of the proposed permanency of the policy. Finalizing this proposal would extend the reach of board-certified or board-eligible emergency physicians to areas of the country where there may not be any such physicians available. We believe that it is essential to have board-certified or board-eligible emergency physicians directly supervise all care delivered in EDs, and telehealth represents a viable tool to accomplish this goal. ACEP therefore supports this proposal.

Proposed Changes to Teaching Physicians' Billing for Services Involving Residents with Virtual Presence

In the CY 2021 PFS final rule, CMS established a policy that after the end of the PHE for COVID-19, teaching physicians may meet the requirement that they must be present for the key or critical portions of services when furnished involving residents through audio/video real-time communications technology (virtual presence), but only for services furnished in residency training sites located outside of OMB-defined metropolitan statistical areas (MSAs). However, in the CY 2025 PFS final rule, CMS finalized a temporary policy that allowed the teaching physician to have a virtual presence in all teaching settings, but only in clinical instances when the service was furnished virtually. This permitted teaching physicians to have a virtual presence during the key portion of the Medicare telehealth service for which payment was sought, through audio/video real-time communications technology, in all residency training locations through December 31, 2024 (extended through December 31, 2025, via telehealth extenders).

CMS is now proposing not to extend this policy and instead revert to pre-PHE policy, which would maintain the rural exception established in the CY 2021 PFS final rule recognizing the unique challenges and importance of expanding medical education opportunities in rural settings. CMS is concerned that continuing to permit teaching physicians to

bill for services furnished involving residents when they are virtually present, outside the conditions of the PHE for COVID-19, may not allow the teaching physician to have personal oversight and involvement over the management of the portion of the case for which the payment is sought, and therefore believe that permitting Medicare payment to continue is unnecessary.

ACEP understands CMS's rationale for this proposal but does believe that teaching physicians have the ability to provide appropriate oversight over residents when services are delivered virtually in all residency training locations.

Enhanced Care Management

Integrating Behavioral Health into Advanced Primary Care Management

In the CY 2025 PFS final rule, CMS finalized separate coding and payment for advanced primary care management (APCM) services (HCPCS codes G0556, G0557, and G0558). CMS believes that patients with chronic health conditions are more likely to have related behavioral health concerns and find it easier to improve chronic conditions when these concerns are also addressed. Integrating behavioral health with primary care has been shown to improve outcomes, for example by reducing depression severity and enhancing patients' care experience. In CMS's view, physicians and practitioners who furnish APCM services should be able to provide behavioral health integration (BHI) and collaborative care model (CoCM) services without documenting their time spent performing the service, because doing so would help facilitate a more holistic, team-based approach to care coordination and reduce burden. For CY 2026, CMS proposes to create optional add-on codes for APCM services that would facilitate providing complementary BHI services by removing the time-based requirements of the existing BHI and CoCM codes.

ACEP supports CMS's efforts to improve care and outcomes for patients with behavioral health conditions. While emergency physicians will likely not bill these add-on codes, we believe that it is important for CMS to address the unmet need of patients with these conditions who may end up in the ED. The ED serves as the critical health care safety net not only for acute injuries, but for psychiatric emergencies as well. However, most EDs are not ideal facilities to provide longer-term care for patients experiencing a mental health crisis – they are often hectic, noisy, and particularly disruptive for behavioral health patients. But due to the fragmented nature of mental health care infrastructure in the U.S., persistent lack of sufficient resources, and longstanding shortages of mental and behavioral health professionals, far too many Americans have limited options for the longer-term follow-up treatment they need and deserve. Therefore, even though the ED is not the best option for these patients, it is often their only option. These health care resource challenges contribute to long ED wait times and aggravate "boarding" issues, a scenario where patients are kept in the ED for extended periods of time following the decision to admit to the hospital or transfer due to a lack of available inpatient beds or space in the other facilities to which they could be transferred. Overcrowding and boarding are not failures of the ED or the emergency physicians who care for patients; 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.

Reducing boarding and mitigating its effects on all patients is critical in improving patient outcomes and patients' overall health, especially for those with mental or behavioral health needs. ED boarding challenges disproportionately affect patients with behavioral health needs who wait on average three times longer than medical patients because of these significant gaps in our health care system. Some research has shown that 75 percent of psychiatric emergency patients, if promptly evaluated and treated in an appropriate location – away from the active and disruptive ED setting – have their symptoms resolve to the point they can be discharged in less than 24 hours, further highlighting the need to provide timely, efficient, and appropriate mental health care.

Across the country, communities have adopted innovative alternative models to improve emergency psychiatric care and reduce psychiatric patient boarding, the goals of which can also be met by community-based crisis stabilization units. Some examples include:

- Behavioral Health Emergency Rooms (BHERs). BHERs are separate areas of the ED that specialize in proactive rapid-assessment, stabilization, and treatment of patients in experiencing a behavioral health crisis. Care is delivered via a multidisciplinary team of emergency physicians, psychiatrists, psychiatric nurses, and social workers. This service is operational 24 hours a day, 7 days a week, 365 days a year. These dedicated spaces provide patients with a safer, private, and more peaceful setting in which to de-escalate and receive specialized care.

  By initiating proactive assessments in a BHER, 40-50 percent of patients can be safely discharged home, reducing ED boarding time. Additionally, optimizing transition of care through Integrated Outpatient Care clinics ensures ongoing high-quality medical and behavioral health care follow-up with convenient and comprehensive treatment options for patients.

- EmPath (Emergency Psychiatric Assessment Treatment and Healing) Units. The EmPath Unit is a separate, hospital-based setting solely for psychiatric emergencies with the safe, calming, homelike environment of a community mental health crisis clinic combined with the ED's ability to take care of any patient who presents for treatment. This unit accepts all suitable patients regardless of the severity of their illness, legal status, dangerousness, substance use intoxication or withdrawal, or co-morbid medical problems – all factors that typically exclude such patients from community programs and thus who would likely experience boarding in an ED in the traditional medical system.

  EmPath units provide immediate access to individualized care from a comprehensive mental health care team of psychiatrists, psychologists, mental health nurses, social workers, and other licensed mental health care professionals. This team partners directly with patients and their families to address the immediate mental crisis and to develop a longer-term care plan through appropriate follow-up services. In some instances, EmPath units have reduced regional ED boarding by 80 percent and have also reduced the need for—and incidence of—coercive measures (such as physical restraints), episodes of agitation, and psychiatric hospitalizations.

These innovative approaches have helped communities improve coordination of emergency psychiatric care, and they can serve as models for other communities to implement and build upon – through crisis stabilization units or otherwise – to help alleviate the overall load on the mental health care system.

Prevention and Management of Chronic Disease – Request for Information

Per the Trump Administration Executive Order, "Establishing the President's Make America Healthy Again Commission," the Administration is directing their focus towards understanding and drastically lowering chronic disease rates, including thinking on nutrition, physical activity, healthy lifestyles, over-reliance on medication and treatments, the effects of new technological habits, environmental impacts, and food and drug quality and safety. CMS is broadly soliciting feedback to help the agency better support prevention and management of chronic disease.

ACEP agrees that we are experiencing a chronic disease epidemic in this country. The ED is the entry point to the health care system for millions of Americans and therefore we believe that we play an essential role in helping to address this epidemic. EDs provide a place where those in need of the most immediate attention can receive care, including patients who have delayed or deferred treatment for more minor conditions or symptoms of chronic disease due to barriers in receiving primary care. Such deferral or delay will often result in their condition or symptoms becoming exacerbated, and, due to the progression of their condition, their care in the ED will be much costlier and

more complex than if they had earlier access to more routine primary care. Thus, ED visits present an opportunity to initiate a coordinated care plan from the most acute medical episode or symptoms of a chronic disease.

To help better manage care for patients with complex conditions who wind up in the ED, ACEP believes that emergency physicians need to be integrated into alternative payment models (APMs). Many current models have as primary objective to reduce unnecessary ED visits. Thus, they often focus on all the care provided outside the ED to prevent an ED visit and ignore the care that is provided at the ED. While reducing unnecessary ED visits is a worthwhile objective, it should not be the end goal. There are roughly 150 million ED visits a year— it is impossible to avoid them all. ACEP supports a value-based framework that would help provide emergency physicians and other emergency clinicians the tools, payment and care-delivery flexibilities, and resources they need to manage these millions of patients who have an ED visit every year and improve the follow-up care that they receive. That way, once these patients are discharged from the ED, they do not wind up right back in the ED or admitted to the hospital because their follow-up care is uncoordinated and their underlying condition continues to be unmanaged.

ACEP developed an APM called the Acute Unscheduled Care Model (AUCM) to help improve care coordination and the follow-up care that patients receive once they are discharged from the ED. The model could be adapted as a stand-alone model or incorporated into a larger APM, like an accountable care organization (ACO) initiative. The AUCM, if implemented, would reward emergency physicians for reducing inpatient admissions and observation stays when appropriate. Emergency physicians would become key members of the continuum of care, as the model focuses on ensuring follow-up care for emergency patients, minimizing redundant post-ED services, and avoiding post-ED discharge safety events. The AUCM was highly recommended by a federal advisory committee called the Physician-Focused Payment Model Technical Advisory Committee (PTAC) and endorsed by the former HHS Secretary. However, ever since the former HHS Secretary, Alex Azar, endorsed the AUCM in 2019, we have been waiting on the CMS Innovation Center to adopt the model's framework.

Overall, the model would help emergency physicians manage and treat patients with chronic diseases. It provides payments that would compensate emergency physicians for the additional work it takes to manage patients and improve care coordination—and help emergency physicians ensure a smooth and safe discharge for patients back to the community. Helping patients connect with their primary care physicians and ensure that they receive appropriate follow-up services will help ensure that patients better manage their chronic diseases and do not wind up back in the ED or admitted to the hospital.

The AUCM stipulates payment waivers for ED acute care transition services, telehealth services, and post discharge home visits. The model does not involve any changes to ED clinical guidelines. Concurrent to clinical care provided during the patients ED visit, an EM healthcare professional will administer a safe discharge assessment (SDA) to identify potential barriers to safe discharge, needs related to care coordination, and additional assistance that may be necessary. It is imperative that the coordinated care plan is patient-centered, with shared decision-making at the forefront of post-ED care plans to empower patients to make the best choices for their disease management. Research reveals that patients who are empowered to make health care decisions that reflect their personal preferences often report feeling more engaged in their health care and experience better health outcomes, like decreased anxiety, quicker recovery and increased compliance with treatment regimens. Payment mechanisms should be put in place so that emergency physicians have the capacity to collaborate with patients to assess and address potential barriers to safe discharge, needs related to care coordination, and additional assistance that may be necessary, such as telehealth or in-person follow-up services. If patients feel empowered to make choices and comfortable with their care plan, they will be more inclined to comply with the treatment plan to manage their conditions, therefore leading to cost savings in the long run. Finally, the ED organization arranges follow-up services by telephone, in-person visits, or telehealth outreach.

We look forward to continuing to work with CMS on the adoption of this model, as we strongly believe it is a key piece in helping to achieve the overall goal of better managing individuals with chronic diseases.

Ambulatory Specialty Model

The CMS Innovation Center plans to launch a new mandatory, five-year APM, the Ambulatory Specialty Model (ASM), beginning January 1, 2027. The ASM aims to improve quality and reduce costs by holding individual specialists (not at the organizational level) accountable for performance on targeted quality, cost, care coordination, and EHR use metrics when managing heart failure and low back pain. CMS will adopt the Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs) framework to streamline reporting. ASM would adjust Part B payments (positively, neutrally, or negatively) based on clinician performance compared to peers in the same specialty and condition. Like MIPS, these payment adjustments would take place two years after the performance year in which the physician reported quality measures (*e.g.*, 2027 performance year/2029 payment year). In the first payment year, these adjustments would range from -9% to +9%. All participants would be subject to this risk. The payment approach would ensure that the total positive adjustments for high performers do not exceed the total negative adjustments for low performers. Similar to other CMS Innovation Center models, CMS would apply a discount to provider payments to ensure savings to the Medicare program.

Though emergency physicians would not be direct participants in the ASM, we continue to be concerned about mandatory participation in models. We believe that participation in all APMs, including ASM, should be voluntary. Mandatory participation in ASM could affect clinicians' willingness and ability to successfully participate in other APMs, including those with significant potential for cost savings and quality improvements, such as accountable care organization (ACO) initiatives. Clinicians selected for participation in ASM that find themselves participating in multiple initiatives at one time could struggle to keep up with all the various quality and financial incentives—which could impact their overall operations and actually lead to higher overall administrative and regulatory compliance costs. CMS should therefore make ASM, and all other APMs, voluntary and allow clinicians to opt in. Having this flexibility for participation would ensure that ASM does not duplicate the efforts that ACOs already have underway.

We also are concerned that CMS is using the MVP framework as the basis for designing the model, as MVPs are a relatively new reporting pathway and participation in them thus far has been limited. During the 2023 performance period, the first year of MVP reporting and the latest year in which MIPS participation data are available, 41,765 clinicians (7.7 percent of all clinicians in MIPS) registered for MVPS and nearly half submitted MVP data (20,484). Clinicians who reported MVP data also had the option of reporting through traditional MIPS, and CMS took the highest score. Nearly all (98 percent) of clinicians who reported through an MVP also reported through traditional MIPS. Only 16% of clinicians received a final MIPS score based on their MVP participation (6,790). Thus, 84 percent of clinicians who reported through an MVP wound up receiving a score based on their reporting through traditional MIPS. There were only 12 MVPs available in the 2023 performance period, the Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP. Only 2,912 clinicians registered for the MVP and 1,112 reported MVP data-- but only 45 clinicians received a final score from the MVP. Similar participation figures applied to the Advancing Care for Heart Disease MVP, which is being used as the basis for the heart failure component of the ASM. CMS may want to wait until more robust participation data is available for MVPs before it designs a whole APM based off of this framework.

Medicare Shared Savings Program (MSSP)

CMS continues to propose changes to advance MSSP's long-term sustainability and encourage participation from a broader range of providers, including those serving underserved and rural populations. ACEP overall supports these

proposals, as we believe that they will help increase participation in ACOs and enable ACOs to focus more on underserved populations—an extremely important step towards helping to reduce disparities in health outcomes and better address the needs of patients with social risk factors. However, we note that not many emergency physicians directly participate in the MSSP. Going forward, we urge CMS to create additional incentives for specialists, like emergency physicians, to get engaged in the MSSP and other ACO initiatives. Engaging specialists in ACOs will truly help improve quality and reduce costs. Currently, ACOs have not effectively engaged specialists to help meet their cost targets and quality metrics. We believe that there is a lot of potential for ACOs to perform even better if they get specialists more involved in the care of their assigned patients.

The Quality Payment Program

CMS introduces policies that impact the 2026 performance year in the Quality Payment Program (QPP). The QPP includes two tracks: the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). MIPS includes four performance categories: Quality, Cost, Improvement Activities, and Promoting Interoperability. Performance on these four categories (which are weighted) roll up into an overall score that translates to an upward, downward, or neutral payment adjustment that providers receive two years after the performance period (for example, performance in 2026 will impact Medicare payments in 2028). The 2026 performance year is the fourth year in which a new reporting option in MIPS called MIPS Value Pathways (MVPs) is available. MVPs represent an approach that will allow clinicians to report on a uniform set of measures on a particular episode or condition in order to get MIPS credit.

Merit-Based Incentive Payment System (MIPS)

MIPS Performance Threshold

To avoid a negative adjustment and be eligible for a positive payment adjustment, a clinician's MIPS total score must reach a performance threshold. CMS proposes to maintain the 2025 MIPS performance threshold of 75 points not only in performance year 2026 but through performance year 2028. Historically, CMS had increased the MIPS performance threshold, but during the COVID-19 PHE, the agency maintained a 75-point threshold for consecutive years, allowing MIPS participants to avoid additional quality reporting challenges.

ACEP strongly supports this proposal, as it provides more stability and predictability to the program. It would also help smaller physician practices and those located in rural areas avoid negative adjustments, as these practices may not have the resources necessary to perform as well in MIPS.

Quality Performance Category

The rule proposes to update the benchmarking methodology for administrative claims quality measures to align with the benchmarking methodology for cost measures beginning with the CY 2025 performance period/2027 MIPS payment year. The scoring methodology would be based on the standard deviation, the median, and an achievement point value derived from the performance threshold. For a MIPS-eligible clinician whose performance rate under an administrative-claims-based measure was equal to the median performance rate for all MIPS-eligible clinicians scored on that measure, CMS would assign an achievement point value equal to 10% of the performance threshold.

While CMS revised its "topped out" policy for quality measures in last year's rulemaking, the agency also proposes to remove the scoring cap and adjust measure benchmarks for 19 measures in the CY 2026 performance period. These

measures belong to specialty sets and MVPs with limited measure choice and in areas that lack measure development, which precludes meaningful participation.

ACEP supports CMS's efforts to improve MIPS scoring issues, including those related to topped-out measures, and recommends that CMS finalize these proposals. With respect to the benchmarking methodology, we urge CMS to consider applying this methodology to all quality measures in addition to administrative claims quality measures. We believe that expanding the methodology to all quality measures will encourage physicians to report more condition-specific measures. Further, we urge CMS to apply the topped out policy to all measures. Limiting it to a select set of measures adds complexity to the program, is subjective, and favors some specialties over others.

Cost Performance Category

Total Per Capita Cost (TPCC) Measure

The TPCC is a population-based cost measure that assesses the overall cost of care delivered to a patient with a focus on the primary care they receive from their providers. Based on feedback, CMS is proposing to modify the TPCC measure candidate event and attribution criteria by making the following changes:

- Exclude any candidate events initiated by an advanced care practitioner Taxpayer Identification Number - National Provider Identifier (TIN-NPI) if all other non-advanced care practitioner TIN-NPIs in their group are excluded based on the specialty exclusion criteria;

- Require the second service used to initiate a second candidate event to be an E/M service or other related primary care service provided within 90 days of the initial candidate event service by a TIN-NPI within the same TIN; and

- Require the second service used to initiate a candidate event be provided by a TIN-NPI that has not been excluded from the measure based on specialty exclusion criteria.

ACEP has expressed concern about this measure in the past and thanks CMS for taking active steps to address some of the underlying methodological issues with the measure. We urge CMS to finalize these proposed changes. However, even beyond these changes, we urge CMS going forward to address other fundamental flaws of the measure. The measure continues to include aspects and types of costs that physicians cannot influence, such as changes in the prices of physician-administered drugs and coverage decisions for high priced supplies. Furthermore, because the TPCC measure includes all Medicare Part A and B spending, not just the portions of spending that physicians can control, the TPCC measure provides physicians with little or no actionable information about how to lower their spending, and it gives patients no useful information about how to lower their out-of-pocket costs or how to select physicians. CMS must make the measure more actionable and meaningful to physicians.

Proposal to Adopt a Two-Year Informational-Only Feedback Period for New MIPS Cost Measures

CMS is proposing a two-year informational-only feedback period for new cost measures beginning with the CY 2026 performance period. Under this proposal, MIPS eligible clinicians, groups, virtual groups, and subgroups would receive informational-only scoring feedback on a new cost measure (or measures) for two years before it contributes to their final score.

ACEP supports this proposal. Informational feedback would be helpful so that clinicians and groups can learn and understand how the new measures work. It would additionally be helpful if CMS could provide detailed information (perhaps at the encounter level) about the cost calculations and how they compare to benchmarks.

MIPS Value Pathways (MVPs)

General MVP Comments

As stated above, the 2026 performance year is the fourth year in which a reporting option in MIPS called MIPS Value Pathways (MVPs) is available. ACEP developed an emergency medicine-focused MVP called the "Adopting Best Practices and Promoting Patient Safety within Emergency Medicine" MVP that became available in 2023. In last year's rule, CMS sought comment, but did not propose, a target sunset date for traditional MIPS reporting of performance year 2029/payment year 2031— making MVPs mandatory at that point in time. While CMS does not propose such a target date in this year's rule, it is clear that CMS still plans on making MVPs mandatory at some future date.

ACEP continues to believe it may be premature to consider the transition to MVPs. We do appreciate the implementation of the "Adopting Best Practices and Promoting Patient Safety within Emergency Medicine" MVP. However, as described in our response to the ambulatory specialty care model above, we are generally concerned that there has been limited uptake of the MVP based upon the reporting trends from last year. We believe that the primary reason why so few emergency physicians have reported the emergency medicine MVP is because there are not sufficient incentives in place that would encourage them to do so. Further, whilst we see the value of MVPs as a reporting option and acknowledge that broader participation in MVPs supports CMS' long-term goal to transition clinicians to participate in APMs, we have concerns about the ambiguous and dubious pathways that will transition clinicians from MVP participation to APM participation.

The emergency medicine MVP was constructed based off of the Acute Unscheduled Care Model (AUCM) described earlier in this letter, which ACEP developed to fill the gap in available emergency medicine APMs. As there is significant synergy between this MVP and the AUCM, the overlap of measures will allow the MVP to serve as the vehicle needed to incrementally phase emergency clinicians into APMs. However, because of the delayed implementation by CMS Innovation Center of the AUCM despite the "Deserves Priority Designation" given to the model by the Physician-Focused Payment Model Technical Advisory Committee (PTAC), emergency clinicians continue to be left out of the process of transitioning to APMs and thus fail to see the practicality and advantage of reporting under the MVP.

There are several barriers for clinicians to participate in MVPs that are both perceived and actual, and both operational and financial. For many clinicians, these obstacles to MVP participation simply outweigh the benefits from reporting. We offer several suggestions for additional incentives that CMS could offer to encourage clinicians to participate in MVPs.

ACEP believes there should be additional incentives for initially participating in an MVP over traditional MIPS. Although we had hoped that participating in the emergency medicine MVP would 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, many emergency physicians have been hesitant to make any changes to their reporting patterns. To encourage clinicians to go through the effort of making necessary reporting changes, 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 these critical initial stages.

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 as broad a range of quality measures and improvement activities. Under traditional MIPS, clinicians report on as many quality measures as possible, 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 10 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.

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, and 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.

In addition, should CMS decide to sunset traditional MIPS, the agency must consider the implications on quality measures that have been developed and maintained by medical societies. The development of quality measures has required significant effort, time, and resources, and we do not want those to simply go away as needed changes are brought to the program. **Qualified clinical data registry (QCDR) measures have been developed for the sole purpose of improving care for patients seen by such specialists, and such a valuable tool must be maintained.**

Though emergency medicine is included as one of the current MVPs, many specialties do not currently have reportable MVPs. CMS asks if the agency should consider developing a more global MVP with broadly applicable measures as an interim bridge for those clinicians with too few specialty-specific quality measures. ACEP supports a generic MVP approach. It should embody the same special circumstances as other MVPs and traditional MIPS. This generic MVP would rely on CMS-calculated quality measures and only include participant input for promoting interoperability and improvement activities performance categories. In addition, although some emergency physicians can report the emergency medicine MVP, given different practice arrangements amongst emergency physicians, not all of them may find that this MVP is appropriate for their practice. Therefore, we appreciate the flexibility that a more global MVP would provide so more clinicians can participate in the MVP reporting process.

Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP

In this year's rule, CMS is proposing to remove 1 quality measure and remove 3 improvement activities from the Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP. ACEP understands the rationale for these changes and appreciates CMS's efforts to update this MVP appropriately over time.

Subgroup Reporting

In the CY 2022 PFS final rule, CMS finalized the option for MIPS eligible clinicians to participate as subgroups for reporting MVPs beginning in the CY 2023 performance period/2025 MIPS payment year. Beginning with the CY 2026 MIPS performance period/2028 MIPS payment year, multispecialty groups will no longer be able to report MVP as a single group. This will mean that if a multispecialty group would like to report an MVP, beginning with the CY 2026 MIPS performance period/2028 MIPS payment year, MIPS eligible clinicians in multispecialty groups must divide into and report as subgroup or report as an individual to report an MVP. Alternatively, MIPS eligible clinicians in multispecialty groups may continue to participate in traditional MIPS reporting.

Given that CMS "intends to sunset traditional MIPS in a future year," CMS is now proposing to modify the definition of an MVP participant to provide that, for the CY 2026 performance period/2028 MIPS payment year and future years, CMS is proposing that an MVP Participant means "an individual MIPS eligible clinician, single-specialty group, multispecialty group that meets the requirements of a small practice, subgroup, or APM Entity that is assessed on an MVP for all MIPS performance categories." Thus, a multispecialty group that meets the requirements of a small practice would not be required to divide and report a subgroup. CMS believes that this modification will reduce barriers for small group practices to transition to MVP reporting.

Further, CMS proposes that to report an MVP, a group practice which is either a single-specialty group or a multispecialty group that meets the requirements of a small practice, would be required to attest to its designation as a group that meets the requirements of a single specialty group, or a multispecialty group that meets the requirements of a small practice, respectively.

ACEP is concerned that CMS is continuing to move forward with making subgroup reporting mandatory for multispecialty groups (that are not small groups) and believes that subgroup reporting should be optional for all groups for the foreseeable future. We are also concerned with how CMS defines subgroups, and we do not think that subgroup composition should be based on specialty, geographic location, size, or any other factors. One reason not to constrain the composition of subgroups is that some MVPs are built around conditions, which can span multiple specialties. Further, it is difficult to define a subgroup for clinicians who practice in multiple settings. For example, in rural areas, clinicians can cover the ED, the observation unit, and the inpatient floor. If these clinicians have to choose a subgroup that delineates ED versus other settings, they may not have enough patients to meet the measure thresholds.

Subgroup reporting will also highly discourage MIPS participation in the future as multispecialty tax identification numbers (TINs) will find the cost of reporting MIPS exceeding the penalties. A group with three to four specialties will need as many as four different solutions (third party intermediaries, web reporting, etc.). In many cases, these subgroups may only have one or two eligible physicians. Simply put, the cost of reporting will likely outweigh any MIPS payment adjustments. The likely reaction will be that groups will choose to report nothing and take the penalty as that will cost less than reporting. Thus, subgroup reporting should be optional.

Finally, we have concerns about ensuring that clinicians are placed in the most appropriate subgroup. There should also be a process for rectifying any unintentional mistakes made in the subgroup registration process.

Core Elements RFI

CMS is concerned that MVP reporting may not produce sufficient comparative performance data on standardized measures to support patient choice of care. Thus, CMS is considering a policy to require an MVP Participant to select

one quality measure from a subset of quality measures in each MVP, referred to as "Core Elements," to ensure more direct comparability by requiring the reporting of a subset of measures within an MVP that are meaningful for clinicians and patients. MVP participants would select the other three required quality measures and would still have to meet existing MVP reporting requirements.

Should CMS proceed with such a proposal in the future, ACEP urges CMS to continue to provide clinicians with the opportunity to choose the measures that are most relevant to their practice, including both qualified clinical data registry (QCDR) measures and QPP measures. Clinicians should also have the opportunity to note to CMS through an attestation that no core elements apply to them. We do not believe it is either feasible or desirable to define a fixed number or percentage of measures that would be required for all MVPs. We also recommend that CMS solicit input from physicians regarding the measures they believe are most important to use and whether current reporting options are too limited, and then take steps to ensure there are an adequate number of reporting options for those measures that physicians feel are most appropriate to report.

Medicare Procedural Codes RFI

CMS is considering utilizing Medicare procedural codes to further facilitate more MVP specialty reporting and to encourage and potentially require specialists to report an MVP applicable to their specialty or scope of care by requiring clinicians to do so based on the procedural codes that they bill. ACEP believes that clinicians should be allowed to choose their MVP based on applicable measures and relevance to their specialty. This means that sufficient MVPs need to be available for clinicians to choose the best MVP.

Third-Party Intermediaries Support of MVPs

CMS proposes to allow qualified clinical data registries (QCDRs) and qualified registries additional time to fully support finalized MVPs. Currently, QCDRs and qualified registries must immediately support MVPs that are applicable to their customers once an MVP is approved. CMS proposes that, beginning with the CY 2026 performance period/2028 MIPS payment year, QCDRs and qualified registries can have a one-year grace period after a new MVP is finalized before they must be able to support it.

ACEP supports this proposal, but overall, we continue to believe that CMS should do more to promote the use of QCDRs. A number of challenges and burdens limiting the uptake of QCDRs persist. For ACEP's QCDR, the Clinical Emergency Data Registry (CEDR), the biggest challenge has been garnering the cooperation of hospitals on behalf of our clinician client base. Hospitals currently 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 at all 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 actions 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 urge CMS to consider requiring hospitals to share data with hospital-based clinician groups.

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.

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. 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 be a certified QCDR that has 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 overly stringent, place a significant burden on QCDRs, and make it difficult for some smaller QCDRs to continue participating in the MIPS program. We also suggest that QCDR statisticians familiar with sample sizes and populations should be the ones to decide the level of testing (clinician, facility, or group) required. We therefore reiterate our request that CMS 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.

CMS must create an exemption for hospital-based clinicians when the hospital changes their EHR vendor. These conversions create chaos in data acquisition and registry participation as patient care is the focus of the hospital when converting. Complicating matters, the prior EHR vendor often becomes completely unresponsive for issues long before the conversion takes place, preventing effective participation for a full year of data. The new vendor is focused on patient care; thus, registry data becomes a low priority, hampering the integration to the registry. Physician groups are in no position to elevate the MIPS data need over patient care.

Well-being and Nutrition Measures RFI

CMS is seeking input on well-being and nutrition measures for future years in the QPP that assess overall health, happiness, and satisfaction in life that could include aspects of emotional well-being, social connections, purpose, and fulfillment.

ACEP agrees that preventive care, nutrition, and well-being can improve health outcomes. However, we want to make clear that quality measures cannot be developed within a short timeframe. In fact, CMS does not directly support or fund the development of new measures, but relies on outside entities, including clinical data registries, to develop and test new measures. However, the requirements placed on these clinical registries around developing measures lead to a time-consuming and expensive process that can significantly inhibit the development of new measures in priority areas—such as nutrition and well-being. Thus, , we strongly recommend that CMS take a careful look at all the existing regulations impacting clinical data registries. In particular, 42 CFR § 414.1400 currently mandates slews of burdensome, unnecessary requirements that should be modified or eliminated. These requirements make the standard for clinical data registries to operate, develop, and maintain measures far greater than that to which CMS holds itself when it comes to maintaining QPP measures. Developing and fully testing a single new quality measure costs between $250,000 and $1 million. In order for measure development to be a more clinician-driven process that has clinicians

who see patients every day leading the creation of evaluative measures that assess patients' nutrition, well-being, and overall health and happiness, CMS must alleviate some of these burdensome and cost-prohibitive requirements.

Toward Digital Quality Measurement in CMS Quality Programs RFI

To support CMS's goal of transitioning to digital quality measurement for CMS programs, CMS issued an RFI to gather input to inform the ongoing strategy to implement a fully digital quality landscape, including potential challenges to adhering to the Fast Healthcare Interoperability Resources (FHIR) data standard.

While ACEP supports the overall goal of improving the exchange of information and using electronic and digital quality measures in CMS quality reporting programs, there are significant financial barriers which are making this objective difficult to achieve. From our members' perspective, electronic health record (EHR) vendors appear to be approaching the FHIR initiative as a strong revenue and profit opportunity. Initial fees and per-transaction fees vary and will be cost-prohibitive for most physician groups and hospitals with large patient populations. Thus, CMS should put guardrails in place to prevent price gouging, which will then allow for more participants in FHIR implementation, fostering data harmonization and reducing reporting burden across entities.

RFI Regarding Data Quality

CMS seeks comment on how to improve data quality, including the following question:

- *What data quality challenges does your health care organization experience (for example, discrepancies in data accuracy, completeness, reliability, and consistency)? How are you working to address data quality challenges? What data quality challenges persist longitudinally across your patient population(s)?*

ACEP's QCDR, CEDR, represents about 200 physician groups (about 170 currently active) to collect, analyze, and report MIPS on their behalf annually. Data acquisition is our biggest challenge, with legal issues being the most challenging aspect. CMS could markedly improve this process by working with hospitals and relevant QCDRs to develop a universal contract and data use agreement that both parties would be required to accept upon appropriate request.

In addition, as stated previously, it would be helpful if CMS would reiterate that hospitals are required to provide appropriate data to support their clinicians' MIPS reporting. CEDR has successfully mitigated the technical aspect of data acquisition by developing standard data extraction scripts for certain EHR vendors. This approach significantly reduces the burden on hospital information technology and accelerates the acquisition process. However, this was costly and has necessitated CEDR investing over a million dollars to date to do so. It would be helpful if CMS would offer an alternative to Promoting Interoperability for groups that use a QCDR that acquires and analyses data electronically, versus manual abstraction. Other incentives might also be considered such as additional bonus points (e.g., 10 points) to boost the final MIPS score.

As for data completeness, our electronic approach to data acquisition mitigates this challenge, except where we have not been able to garner the cooperation from all hospitals from which a group needs data. For this (and other reasons), maintaining the current 75 percent data completeness threshold is important for groups in this situation.

Another data acquisition challenge occurs when a hospital changes EHRs. This is an infrequent occurrence, but invariably causes issues collecting data timely since such transitions occur throughout the year. It would be helpful if CMS would consider an extreme and uncontrollable circumstances (EUC) designed specifically for this issue. There are situations where such an EUC would need to be offered for two consecutive years due to the timing of the change. CMS could require an attestation from the hospital to prevent inappropriate use.

Query of Prescription Drug Monitoring Program (PDMP) Measure RFI

ACEP does not support changing the Query of PDMP measure from an attestation-based measure to a performance-based measure. We do not believe that shifting this measure to a performance-based construct will yield meaningful improvements in patient outcomes or tangible benefits for physicians and PDMPs can be useful sources of information, but they are not diagnostic or clinical instruments; they present prescription history and do not link patients to treatment. Moreover, while PDMP technology and usability have improved markedly over the past decade, tying PDMP use to performance would disproportionately disadvantage physician practices—particularly those that have not been able to invest millions of dollars to integrate PDMP functionality into their EHRs.

Advanced APMs

Qualifying APM Participant Calculation

To become a qualified participant (QP), clinicians must receive at least 75% of payments or see at least 50% of patients through an advanced APM. Given stakeholders' reported challenges meeting this statutorily mandated threshold, CMS proposes changes to better align with modern advanced APM designs, including:

- Adding QP determinations at the NPI level in addition to existing APM entity-level calculations. This change would ensure that clinicians who actively participate in an advanced APM can achieve QP status even if their APM entity does not.
- Broadening the definition of "attribution-eligible beneficiary" to include beneficiaries receiving any covered professional services (not just E/M services) from a participating clinician. This change would begin with the 2026 QP performance period and is designed to support greater recognition of specialists' contributions to value-based care.

ACEP supports these proposals but remains extremely concerned about the trajectory of the Advanced APM track of the Quality Payment Program. As previously discussed in multiple sections throughout our letter, ACEP created the emergency medicine APM called the Acute Unscheduled Care Model (AUCM) in 2017. We believe that emergency physicians are eager and ready to be in an APM and that their participation in APMs is vital to our collective goal of improving quality and reducing costs. Every day, emergency physicians act as gatekeepers to hospitals, making critical decisions about whether the patient should be kept for observation, admitted to the hospital, or discharged. The AUCM is designed to reflect and reward this important role that emergency physicians play in the health care system. However, despite the promise of AUCM and the benefit that engaging emergency physicians in APMs can bring, to date, most health care delivery reforms, 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. These are undoubtedly critical aspects of our health care system – but neglecting to incorporate acute care delivery in large-scale health system redesign is a lost opportunity. It also 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 patients at their greatest time of need. Even the best managed patients may have acute needs that cannot be adequately addressed in another setting or occur after regular hours. Thus, it is imperative that CMS make it a priority to create additional APM opportunities for emergency physicians and other specialists—or figure out how to modify current APMs in order to better engage specialists and allow them to actively participate.

We also encourage CMS to work with Congress to ensure that there are better incentives for participating in an Advanced APM. Under the Medicare Access and CHIP Reauthorization Act (MACRA), eligible clinicians who become Qualifying APM Participants (QPs) were initially eligible for a 5 percent APM Incentive Payment. However,

after performance year 2022 (with a corresponding payment year of 2024), there was no further statutory authority for this bonus in MACRA. Congress extended the bonus for performance year 2023 (payment year 2025) in the CAA, 2023 at a lower rate of 3.5 percent. ACEP believes these bonuses should be extended further. Beginning in 2026, there is a separate conversion factor update for clinicians who participate in MIPS and those who are QPs (as is reflected in this year's proposed rule). It is simply unfair that most specialists had no reasonable chance to qualify for the now expired five percent APM incentive payment. Thus, CMS should work with Congress to prioritize extending the five percent bonus for participation in Advanced APMs.

We appreciate the opportunity to provide comments. If you have any questions, please contact Laura Wooster, ACEP's Associate Executive Director of Advocacy and Practice Affairs at lwooster@acep.org.

Sincerely,

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